North Middlesex University Hospital NHS Trust

Evidence appendix

Sterling Way
Haringey
London
N18 1QX

Date of inspection visit:
22 May to 24 May 2018
and 19 to 21 June 2018

Date of publication:
14 September 2018

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

A list of the acute hospitals at the trust is below:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Middlesex University Hospital NHS Trust</td>
<td>Sterling Way, London, N18 1QX</td>
<td>Full range of functions across all core services</td>
<td>Enfield, Haringey, Barnet, Waltham Forest</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites)

Is this organisation well-led?

Leadership

The trust was led by Chair Dusty Amroliwala and Chief Executive Maria Kane. The trust board comprised of seven non-executive directors (NEDs), a chairman and seven executive directors.
(senior staff of the hospital), including the chief executive. The executive directors are responsible for the daily running of the hospital and together with the non-executive directors have collective responsibility for setting the strategic direction of the trust, ensuring its achievement against performance targets and upholding high standards of governance and integrity. The executive directors are full time employees of the trust, the NEDs are part time and are appointed by NHS Improvement. Through its chair the trust is accountable to NHS Improvement.

At the time of the inspection, the board held monthly public and private meetings however the plan from September 2018 was to alternate board meetings with board development sessions. The trust had six committees which reported directly to the board which were: clinical quality and patient safety committee, audit committee, charitable funds committee, finance, performance and investment committee, patient and staff experience committee and remuneration committee.

The trust had continued to make improvements since the last inspection in September 2016, despite experiencing an unsettling period of changes in the executive team. The previous chief executive officer (CEO), who was seconded for just over a year and stepped down in September 2017. The current CEO, Maria Kane, was appointed in December 2017. In October 2017 an interim medical director (MD) was appointed. Following his retirement in February 2018 the role had been covered by the deputy MD. At the time of the inspection the recruitment for a substantive MD post was ongoing. The finance director and chief operating officer joined the trust in February 2017. The director of strategic development and director of nursing and midwifery had been the longest standing members of the executive team having been in post from May 2016 and August 2016 respectively. The director of human resources was the most recent appointee commencing his role two weeks prior to the well led inspection. Prior to his appointment the role had been covered on an interim basis since March 2017.

Dusty Amroliwala, the Chair was appointed in February 2017. Of the remaining NEDs the longest serving director had been appointed in 2013 and the newest member in June 2018.

In September 2017 two associate NEDs were appointed to ensure better representation of the local community. At the time of the inspection, of the non-executive board members, 50% were black minority ethnic (BME) and, with the recent appointment of another female NED, 25% were women.

The executive board members did not reflect the diversity of the local population, although there was a good gender mix amongst the group. Of the executive board members at the trust, there were no BME and 42.8% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>50.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>26.6%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity)

We spoke with all seven of the executive directors and four of the NEDs including the trust chair. The trust board members had diverse backgrounds and a wide range of skills. They brought experience from NHS organisations and other private and public sectors. Their skills included accountancy, audit, education, management, consultancy, legal and health knowledge. Most of
the trust board members had the appropriate range of skills, knowledge and experience to perform their role, although this was not universally so. For example, we were made aware of some gaps in leadership skills and experience of some executive directors.

Most of the executive and non-executive directors we spoke with had a clear understanding of their roles and responsibilities. However, we noted that portfolios and range of responsibilities amongst executive team as well as their accountability was not always aligned with their executive roles. For example, there was heavy reliance on a finance director for operational issues.

The leadership at board level had a good understanding of the financial position of the trust. A consistent position was described by both executive and non-executive directors. However, we found not all directors were knowledgeable about or appreciated key risks and challenges of the trust. For example, oversight of outstanding deaths reviews or outstanding actions from serious incident investigations, clinical risks such as gaps in out of hours upper gastrointestinal (GI) bleeding rota, or awareness of issues around equality and diversity.

Within the previous 12 months, the trust has re-purposed what was the finance and investment committee to include oversight of performance as well; this was now the integrated finance, performance and investment committee. There appears to be adequate oversight and challenge over financial and operational issues affecting the trust at this forum. However, no clinically focussed NEDs sit on the committee and this was accepted as a weakness by the chair of the committee. While, there was a formal process for quality impact assessments, this took place outside the committee, and there was no NED challenge on the adequacy of those assessments.

Interviewees from across the executive teams set out that the ownership for delivery of the cost improvement plans (CIPs) sat within the divisions and with clinical and operational staff. This was echoed at senior divisional level; divisional directors of operations and divisional directors of clinical services had a good understanding of the financial constraints the trust was operating under and their role in developing and delivering CIPs while maintaining quality.

However, this was not fully embedded at middle management level, with feedback from interviewees suggesting that the process and their role in business planning was not fully understood. At divisional level the quality of the support and challenge that the divisions receive from the PMO team was seen as variable. This was partly due to the process being new and the relative roles and responsibilities taking time to embed.

We were assured the trust CEO and chairman understood the unique qualities and needs of their team. They were also aware of the number of concerns we had regarding the leadership team related to skills, experience, knowledge and capacity, and actions were being taken to address these. There was an ongoing work to review leadership capacity and portfolios, and development programme had been put in place.

We reviewed the last two sets of trust board papers. Each board paper was prefaced by a comprehensive front sheet which included an executive summary. These were linked to the board assurance framework (BAF) and strategic objectives. BAF is part of the trust risk management strategy and accountability framework which aims to identify and manage internal and external strategic risks. We found the reports from chairs and board subcommittees to be concise, highlighting key points and clearly detailing level of assurance. Most of the executive team told us they had reasonable challenge from the non-executive directors. We observed a board meeting which showed varied level of engagement from NEDs. We saw some good levels of constructive challenge; however, this was inconsistent and NEDs did not always offer scrutiny and seek the high level of assurance from executive directors. We noted there was a tendency to rely on reassurance from executive directors rather than evidence to provide assurance to the board.
In July 2017 the trust had reorganised their operational structure from five clinical business units to three clinical divisions, which were:

- Medical and urgent care
- Surgery and cancer
- Women’s, children’s and clinical support services.

Each division was led by a clinical divisional director, a divisional director of operations and a divisional head of nursing or midwifery. The divisional triumvirates were jointly responsible and accountable for patient care, outcomes, staff and the divisional budget and reported to the chief operating officer and medical director. We found the divisional leadership teams to be knowledgeable, willing, capable and robust in leading and managing their areas of activity.

The trust was looking to appoint the head of allied health professions (AHPs) to give them a “Bigger voice” as the trust had recognised there was a gap in terms of AHPs representation and leadership. We also noted there was a gap in representation of children services at the board level. The trust had set up children’s board but there had been no meeting for almost a year. Also, there seemed to be some confusion amongst executive directors as to who the lead for children was.

Staff commented on the challenges they had experienced with the many changes at the executive level and a large number of interim staff. However, they were positive about the current executive team. Most senior staff told us the CEO, finance director and director of nursing and midwifery were the most visible, supportive and accessible members of the board. Divisional directors stated they were impressed the finance director read clinical papers to help review business cases and the focus was on quality and not just finance. Also, staff within departments commented about positive changes to the executive team since the last CQC inspection in September 2016. They said the current executive team was more engaged and patient focused. Everyone we spoke with were very optimistic about the current CEO. They felt “Lucky to have Maria”, were “Confident in her judgement”, integrity, responsiveness and knowledge. They said, “She was moving the trust forward” and they felt positive about her ability to drive improvement.

We found limited evidence of succession planning and a talent management system within the trust. A well-aligned talent strategy allows board members to support the recruitment, development and retention of a future agile workforce. This approach would enable them to meet not only current needs of the trust, but also to align staff appointments to the vision and strategy. We found some elements of succession planning and talent management, for example the trust had an improvement program to identify training and development needs and establish mentoring programme. However, access to development opportunity was a concern raised by staff survey. Also, we did not see any evidence of an active and deliberate talent management approach with the focus on future leaders.

The trust told us NEDs had a programme of visits scheduled across the organisation where they “Discussed the key challenges, priorities and good work with staff working in clinical areas”. We saw that between March 2017 and March 2018 four NEDs visited clinical and admin areas five to six times a year, with one NED visiting clinical areas 10 times. According to the data provided by the trust the remaining three NEDs did not do hospital walkabouts in that period. Divisional management reported improved visibility of NEDs and recognised their input. Recent examples were of a NED who had helped staff with arranging redecoration of wards, or another NED who organised tea parties and school kids visits to elderly wards. However, we were told not all NEDs were as engaged and proactive and that it was still "Work in progress". Some staff were not clear
over the purpose and quality of NEDs’ walkabouts and thought the visits had limited impact on improvement and change.

The trust had a Fit and Proper Persons policy and we were satisfied with the pre-employment checking processes and that the on-going fitness checks were in line with the trust policy. All executive and non-executive director appointments are subject to the Fit and Proper Persons Test (FPPT) as required by Regulation 5 of the Health and Social Care Act 2008 which came into force in November 2014.

We reviewed eight pre-employment checks and personnel files for the executive and non-executive directors and found the process to be mostly robust and effective. Files and checks were complete and comprehensive including identification and the Disclosure and Barring Service checks, references check, occupational health clearance, qualification and professional body checks (where appropriate) and employment history recorded. The FPPT self-declarations and annual appraisal had been completed annually by directors, as required by the trust’s policy.

Pharmacy was integrated into the governance structure of the trust and played an active role. The medicines management committee (MMC), monitored medicines optimisation within the trust and reported to the trust executive board. The medicines safety committee provided quarterly reports to the MMC. Medicines optimisation was also a standing agenda item on the clinical women’s, children’s and clinical support services divisional governance board, and the nursing, midwifery and allied health professionals committee. The chief pharmacist was line managed by a divisional general manager and professionally accountable to the medical director, to allow communication directly to the board.

**Vision and strategy**

The trust had a clear vision and set of values, it was: ‘to provide outstanding care for local people’. The trust’s values promoted positive behaviours and encouraged staff to be ‘caring, helpful, open, honest, and encouraged teamwork.

The trust had embedded values across the organisation in many ways. For example, by introducing monthly ‘staff stars’ and annual staff awards or monthly ‘Schwartz rounds’ which facilitated sharing of ideas and reflection upon the emotional aspects of work. The trust created values and behaviours frameworks for senior leaders, heads of department/ward managers and all staff. Trust vision and values were incorporated in selection assessments, inductions, staff professional development and appraisals. The trust had values based recruitment, which meant that staff were made aware of trust values through adverts, job descriptions, during the recruitment and selection process. In addition, the trust had several values based materials such as lanyards and posters.

The trust strategic priorities were:

- Excellent outcomes for patients
- Excellent experience for patients and staff
- Excellent value for money.

We reviewed documents which made references to strategic objectives such as board assurance framework, board papers, annual reports, policies, improvement programmes, communications to staff or internal and external presentations.

At the time of the inspection the trust did not have a long-term strategy. The trust was in a process of refreshing its service strategy as the one in place was very out of date. The last version was from 2014 when it was formulated to support its foundation trust application. The trust was
exploring options for future partnership with another NHS trust. At the time of the inspection, the trust was formulating a ‘case for change’. In the past two years there had been a great deal of uncertainty amongst staff regarding the future of the trust. Staff told us they did not feel well informed and consulted. The CEO seemed to understand the importance of consultation and engagement and planned to improve staffs’ involvement in developing plans for the future. They stated due diligence was necessary when making decision on any business case and future strategy. Board level and divisional directors stated they needed to reassess what would benefit the local population before making any decisions.

The consultation on the case for change was done within the context of the sustainability and transformation partnership (STP) designed around the needs of the local area and wider health economy. The trust leaders told us that they wanted high-quality and sustainability (in terms of finance and care provision) to be at the forefront of their strategy. The trust wanted their strategy to be aligned with local health and social care plans to ensure their services met population’s needs. However, at the time of the inspection, the trust was still in the consultation stages therefore it was not possible for the CQC to assess how robust, realistic and achievable their strategy was. The trust planned to engage staff, patients, residents, community groups, commissioning bodies and any other stakeholders by holding a number of different engagement events and workshops. The consultation was going to focus on current demands of the health and care sector with an emphasis on medium and long term strategic problems. The trust wanted to take a one to five-year view rather than focusing on current operational issues facing services. The trust had a deadline to complete the consultation phase which was to be followed by a series of ‘You said, We did’ sessions with staff and briefing sessions with stakeholders. The final proposal was to be presented at the trust board meeting in October 2018.

The trust priorities for 2018/19 were:

- Improving governance structure, system and processes
- Safely achieving standards
- Delivering financial plan
- Improving recruitment and retention
- Developing organisational culture and improving staff morale.

In August 2017, the trust took the decision to become a clinical partner of another NHS trust. This partnership aimed at supporting clinical excellence, reducing unwarranted variation in practice and outcomes, and providing access to training resources and quality improvement practice. Staff of different seniority were all positive and enthusiastic about this collaboration. They told us the clinical partnership was about embedding quality and improvement by tapping into their partner’s experience. They were also proud to emphasise that the relationship was mutual. The trust was setting directions for their clinical partner and NMUH clinicians were leading on a number of clinical pathways.

The leadership team understood the trust’s medicines optimisation strategy needed to ensure the right people received the right medicines at the right time and people were empowered to take their medicines. The chief pharmacist (CP) told us the medicines optimisation strategy and vision were shared widely through the trust divisional governance meetings with the emphasis that this was cascaded downwards. The pharmacy team was also involved in the education and training of healthcare professionals including nurses and doctors. The CP told us staff understood how they contributed to medicine optimisation although there was not a formal way of measuring this.

**Culture**
The trust recognised historically there had been serious concerns regarding bullying and harassment, which had significantly impacted on the culture of the organisation. Senior staff and leaders said improving the culture and staff satisfaction was very important to them. The leadership team told us they wanted to focus on promoting good stories and celebrating success. They said past difficulties within the trust created a “Culture of people not speaking well of themselves” and at times a “Culture of low aspirations”.

We found staff to be passionate about delivering good care. Staff told us about improved communication and feeling motivated to drive improvement. We heard several positive examples of kindness, team work, and supportive and appreciative relationships among staff. For example, we were told about three instances when clinicians voluntarily agreed to share gaps in medical rota or share their colleague’s workload to support them.

The trust told us they had taken positive action to deal with bullying and harassment. They introduced a ‘Bullying and Harassment Resolution Pathway’, which outlined a range of steps and routes staff could follow to challenge inappropriate behaviour while being supported by the trust. We noted that many cultural issues and significant concerns of harassment and bullying identified by the CQC inspection in September 2016 had been addressed. These in particular related to ED, maternity and critical care departments.

Most of staff across divisions told us they felt supported by the divisional managers and described them as visible and approachable. We did not hear about systemic cultural concerns as we did during the 2016 inspection and staff were largely positive about the culture within the trust. However, before and during the current inspection staff from different areas of the trust still had raised some concerns of harassment and bullying as well as allegations of discrimination and nepotism.

Some staff reported a lack of transparency during recruitment and said the recruitment policy and processes were not consistently applied. The leadership team were aware of the allegations, and told us they investigated claims of nepotism that were highlighted to them. The CEO stated that two cases were directly brought to their attention. Following the investigation, they found no evidence of bias in the recruitment process. The trust leaders recognised there were issues with an unprofessional and inappropriate “management style” amongst some managers of different seniority and recognised a need for training in performance management. They also recognised that there was “A long way to go in ensuring recruitment of managers is done in line with trust policies”. Despite acknowledgements from the leadership team of the above concerns we did not see evidence there was a plan or that work was underway to address the issues apart from training staff on what bullying and harassment looks like.

The trust leadership team took many steps to increase their visibility and positively engage with staff which was welcomed and appreciated by staff we spoke with. For example, all staff could attend ‘staff conversation’ events to raise issues and discuss concerns with executive team. There was a weekly ‘tea and talk’ sessions for all staff to talk to executive team members. The CEO arranged for one to one meetings with consultants to consider their views and learn about the day-to-day service delivery. They planned to meet all the consultants; at the time of the inspection the CEO had met with approximately 25% of them.

In addition, there was a chief executive hotline which gave staff additional avenue to share their concerns directly with the CEO. Executive directors attended various meetings with an aim to increase visibility and approachability. Members of the human resources team told us trust staff were given time to attend these various meetings, however, some staff we spoke to told us the
opposite. They found it difficult to attend trust meetings due to staff shortages, the need to focus on their daily responsibilities and work pressures.

The lack of stable, reliable and well-resourced HR team in the past two years meant a number of areas were ineffectively managed. For example, slow and lengthy recruitment process, disciplinary proceedings that lasted too long (sometimes as long as a year or more before being completed), or lack of internal mediation as there were not enough business partners to support the process. The trust told us they had recently trained staff support officers in mediation. The trust had also employed a permanent director of HR which staff hoped would offer stability and consistency.

The executive team and senior divisional leadership was clear that they believed that the delivery of CIPs sits firmly within the divisions and the operational staff, with appropriate support and challenge from the key functions of finance and HR. However, this was not fully embedded and this message was not echoed across divisions.

While the trust understands the importance of the financial challenge, interviewees did not always articulate how they set out triangulating between finance and quality. Rather in many cases, these were discussed separately. However, it was noted that there is strong challenge on CIPs from a quality perspective through the QIA process.

Staff told us about weak mechanisms for providing staff with professional development opportunities, including high-quality appraisal and career development. Some staff felt appraisal had been fragmented and ineffective while career development opportunities were unequal. We were also told it was not always clear what criteria staff needed to fulfil to get promoted.

The requirement for NHS trusts to have a freedom to speak up guardian in post had been in place since October 2016. The role of the guardian is to foster a culture of safety and learning and to encourage staff to raise any issues of patient care quality or safety. The trust had appointed a freedom to speak up guardian in July 2016. Given the number of concerns we had heard during the inspection, it appeared that a low number of staff chose to contact the guardian regarding their concerns. In the first year of the role from July 2016 to July 2017 six members staff contacted the guardian. From July 2017 to January 2018 a further three staff members met to discuss concerns.

Of the nine concerns raised, none had been direct concerns about patient safety which might also indicate staff were not clear about the guardian’s role. Some staff we spoke with were not positive about the role and felt the guardian was not accessible and approachable. Others felt the person nominated was too senior and that not every staff member would feel confident to approach the guardian. Just before the inspection the trust told us they had appointed a second guardian at a less senior level to extend the role’s scope and reach.

We were not assured the leadership team had a good awareness of concerns expressed to us by staff around equality and diversity within the trust. Certain staff groups felt they were being discriminated by their managers because of their race, gender or pay grade. They gave us examples when staff were being treated differently “Depending on their skin colour”. Moreover, staff reported the trust’s understanding of equality and diversity was limited to race and ethnicity while they ignored other protected characteristics such as disability or age. Staff told us there was an equality and diversity policy, however, they felt this was not being implemented.

Of all staff overall 91% answered questions identifying their ethnicity. The largest two ethnic groups for medical staff at the trust were white and asian. The largest ethnic group amongst nursing staff identified as black, followed by white.
<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical staff (%</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>39.9%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.8%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Asian</td>
<td>34.4%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Black</td>
<td>6.3%</td>
<td>38.7%</td>
</tr>
<tr>
<td>Chinese</td>
<td>2.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>13.3%</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity)

In 2017, just under 1% of the trust’s staff disclosed that they had a disability (against average of 3% across the NHS) and 26% chose not to disclose it. The trust recognised this might be result of the needs of some disabled staff not being fully met. The trust also recognised the percentage of staff with a disability was not representative of people’s working age in Enfield and Haringey (18% and 16% respectively). In 2017 black and minority ethnic (BME) staff accounted for 49% of the 3,197 staff employed by the trust. Staff in job bands 1 to 4 accounted for 54%, 51% in band 5 to 6 and 41% of medical staff. The percentage was significantly lower in job bands 8b to 9 where BME staff made up 27% of staff.

The trust had BME staff network that was launched around two years ago and met monthly. The aim of the network was to provide a support and discussion platform for BME staff in a neutral space. The group had around 67 members which means around 4.2% of BME staff employed by the trust were members.

The below table shows NHS Staff Survey 2017 results which were better than average of acute trusts. The trust had six key findings that were better than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.99</td>
<td>3.91</td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>92</td>
<td>90</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>4.01</td>
<td>3.92</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>71</td>
<td>70</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>3.32</td>
<td>3.10</td>
</tr>
<tr>
<td>KF 13. Quality of non-mandatory training, learning or development</td>
<td>4.13</td>
<td>4.05</td>
</tr>
</tbody>
</table>
The below table shows NHS Staff Survey 2017 results that were worse than average of acute trusts. The trust had 24 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.56</td>
<td>3.75</td>
</tr>
<tr>
<td>KF 5. Recognition and value of staff by managers and the organisation</td>
<td>3.33</td>
<td>3.45</td>
</tr>
<tr>
<td>KF 8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.87</td>
<td>3.91</td>
</tr>
<tr>
<td>KF 9. Effective team working</td>
<td>3.69</td>
<td>3.72</td>
</tr>
<tr>
<td>KF 10. Support from immediate managers</td>
<td>3.62</td>
<td>3.74</td>
</tr>
<tr>
<td>KF 11. Percentage of staff appraised in last 12 months</td>
<td>77</td>
<td>86</td>
</tr>
<tr>
<td>KF 14. Staff satisfaction with resourcing and support</td>
<td>3.25</td>
<td>3.31</td>
</tr>
<tr>
<td>KF 15. Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>44</td>
<td>51</td>
</tr>
<tr>
<td>KF 16. Percentage of staff working extra hours</td>
<td>73</td>
<td>72</td>
</tr>
<tr>
<td>KF 17. Percentage of staff feeling unwell due to work related stress in last 12 months</td>
<td>46</td>
<td>36</td>
</tr>
<tr>
<td>KF 18. % attending work in last 3 months despite feeling pressure</td>
<td>55</td>
<td>52</td>
</tr>
<tr>
<td>KF 19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.45</td>
<td>3.62</td>
</tr>
<tr>
<td>KF 20. % experiencing discrimination at work in last 12 months</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>KF 21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>69</td>
<td>85</td>
</tr>
<tr>
<td>KF 22. % experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>KF 23. Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>KF 24. % reporting most recent experience of violence</td>
<td>63</td>
<td>66</td>
</tr>
<tr>
<td>KF 25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>35</td>
<td>28</td>
</tr>
<tr>
<td>KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>35</td>
<td>25</td>
</tr>
<tr>
<td>KF 28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>40</td>
<td>31</td>
</tr>
<tr>
<td>KF 29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>89</td>
<td>90</td>
</tr>
<tr>
<td>KF 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.65</td>
<td>3.73</td>
</tr>
</tbody>
</table>
For two other questions the trust performance was similar to the national average.

(Source: NHS Staff Survey 2017)

In April 2018, the trust launched ‘listening into action’ programme to obtain more up to date and timely views from staff about working in the trust. Staff were encouraged to complete a ‘pulse check’ survey. The response rate and results were more positive than the results of NHS Staff Survey 2017. The response rate within three weeks of the survey was 51% (in comparison to 41% response to NHS Staff Survey 2017). Fourteen out of 15 questions scored above the average in comparison to other 90 trusts that had been through the programme nationally. The top three best scoring questions/statements related to:

- understanding how staff’s role contributed to the wider organisational vision (68%)
- feeling that the quality and safety of patients was the organisation’s top priority (60%)
- believing staff were providing high quality services to the patients/service users (57%)

The three lowest scoring results, which were still better than other trusts, related to:

- communication between senior management and staff feeling it was effective (37%)
- the work environment, facilities and systems that enabled staff to do their job (36%)
- day-to-day issues and frustration that got in the way was quickly identified and resolved (29%)

The trust planned to share the results with staff and each department and speciality were going to be asked to make a series of quick improvements in response. This work had not commenced at the time of the inspection.

The chief pharmacist was able to outline the procedures in place to ensure all staff knew how to report medicine related issues and incidents which were reviewed by the medicines safety officer (MSO) and how they were discussed at monthly governance meetings. There was an initiative within the trust to reduce omitted and delayed doses.

There was an open and honest no blame culture in the trust which promotes learning culture. Learning was shared through the governance structure and cascaded via each divisional directorate. Also, the trust published medicines newsletter which was circulated to frontline staff via email. Pharmacy staff had regular annual appraisals (98%) completed for this year. Patients were supported at discharge by nursing staff and pharmacist non-medical providers on the ward.

The below table shows workforce race equality standard 2017. The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for key findings 25, 26, and 21, split between white and BME staff, as required for the workforce race equality standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key finding and question numbers have changed since 2014.

To preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.
Of the four questions above, two questions showed a statistically significant difference in score between white and BME staff. These were:

- KF21 – Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
- Q17b – In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored similar to the England average for recommending the trust as a place to receive care from December 2016 to August 2017. From September 2017 to March 2018 trust performance was worse than the England average.
The trust’s sickness absence levels from February to December 2017 were better than the England average except for July where they were similar to the England average.

(Source: Friends and Family Test)

(Source: NHS Digital)
In the 2017 General Medical Council National Training Scheme Survey the trust performed worse than expected for two areas (teamwork and feedback) and the same as expected for the remaining 15 indicators.

(Source: General Medical Council National Training Scheme Survey)

**Governance**

The board had overall responsibility for the activity, integrity and strategy of the trust. Their role was to monitor performance and ensure corrective action. The board was supported by six sub-board committees which met regularly and reported back to them. These included: audit remuneration, clinical quality and patient safety, patient and staff experience committee, charitable funds, and finance, performance and investment committees. The trust accepted that the quality, length and content of papers discussed at the board meetings still required improvement and development although these were getting better. For example, some papers needed to be more succinct so that the board could focus on the most important strategic issues and less operational which should be discussed by the relevant committees and divisional groups. They were also working on standardising papers.

The trust had three divisions: medical and urgent care, surgery and cancer, and women’s, children’s and clinical support services. The divisions were led by a clinical divisional director, a divisional director of operations and a divisional head of nursing or midwifery and this structure had been in place since July 2017. Each division had a board which managed the quality and governance of its service. Since April 2018 the trust board started to receive monthly divisional presentations outlining the operational issues, risks, challenges and areas they were most proud of, which the board found useful. The three divisions had governance meetings across individual specialities within it and for the division as a whole. During the governance meetings key themes were discussed and escalated through to patient safety and outcomes committee, clinical quality and patient safety committee and trust board. The divisions also had monthly performance meetings which were chaired by the executive director. To support the various meetings and inform about the current trust performance the trust produced integrated performance reports, which included information on quality and safety indicators as well as performance metrics. We saw these being used by the trust committees and trust board to support analysis and inform decision making.

Although we found several positive elements within the trust’s governance processes, we found at times these lacked clarity, consistency and robustness. The trust leadership team also recognised that a number of areas in their governance structure and their approach to clinical and corporate governance required improvement and these were on their ‘worry list’. For example, for some time the divisions were largely unsupported in their role as there was no dedicated governance team aligned to each division. Insufficient governance support led to a backlog of serious incidents investigations. Another example was a gap in the oversight of the management of patients presenting with an acute gastrointestinal bleed which should have been identified and acted on if there were effective governance processes in place.

To address the number of issues with their approach to governance the trust planned to introduce the Governance and Risk Improvement Programme (GRIP). The programme aimed to achieve cohesion and to embed sustainable improvements. The GRIP identified three primary drivers of improvement: people, processes and strategy; these were established into three workstreams. Each of the workstreams had between three to five themes with associated tasks. Each task had ‘an owner’ assigned to them and a timeframe to complete each task. The workstream meetings were going to be chaired by an executive director whose role was to provide independent scrutiny.
and advice to the workstream leads. At the time of the inspection the GRIP was in the final stages of planning.

A board assurance framework (BAF) is a method of setting out the most important risks facing the organisation. The trust approved their current BAF in November 2017. The framework tracked risks to the governing objectives and recorded the control measures, assurance and any gaps. Corrective actions were recorded to address the gaps. Gaps in controls or assurances also featured on the significant risk register (corporate risk) if they presented a current risk which required mitigation. BAF risks were assigned to committees for additional scrutiny. At the time of the inspection there were ten risks on the BAF (for full list of the risks see ‘Management of risk, issues and performance’ section, the table showing ‘significant risk register and board assurance framework’). We examined the framework to see the extent to which it provided a clear and complete understanding of the most important risks faced by the organisation. The highest risk on the BAF related to meeting the annual financial control total agreed with NHSI (risk score 20). A control total is an annual financial target that must be achieved to ‘unlock’ access to national funding and other financial benefits. All NHS providers are offered a control total that they can accept or reject.

There were five risks with the next highest score of 16. These related to governance arrangements, reliance on locum and agency staff, trust reputation, improving clinical outcomes or creating efficiencies, and achieving the targets within the Single Oversight Framework (SOF). The SOF sets out how NHS Improvement (NHSI) oversee NHS trusts and NHS foundation trusts. It helps NHSI to determine the type and level of support trust might need to meet required standards related to, for example, quality of care, operational performance, or leadership and improvement capability. We reviewed board papers between November 2017 and June 2018 and saw how the BAF progressed and improved from month to month, however, we noted it required further development. Although the BAF was a live document and was meant to be reviewed each month, we noted most of the risks remained static throughout the past months. It was not always clear who had done what and what the next steps were. We also noted that two risks depended on the newly established divisional triumvirate making an impact; risks related to staff retention and culture referred to an outdated staff survey which was carried out under the old management and progress against some risks was overdue. In addition, no new risks were added since November 2017. A number of board level directors felt the risk management and BAF still required development and further work. Some said the BAF lacked proportionality by, for example, assigning higher than necessary risk scores to certain risks, and that it was an automatic process rather than a dynamic tool to manage most important risks.

The trust said that from September 2018 the board meetings would alternate with board development sessions. The plan was to identify gaps and developmental needs of the board, such as how to utilise BAF.

In March 2018, the trust introduced an executive assurance forum. This was another platform for the executive team to, for example, ensure any incomplete serious incident investigations, or outstanding audit actions were addressed. Also, the forum looked at any quality indicators which were of concern and ensured these had robust systems of governance, risk management and internal control. The forum was chaired by the CEO and was facilitated by the board secretary with support from the associate director of risk and governance. Review of the board papers between March and June 2018 showed the forum committed, or was tasked with reviewing a number of risk areas. For example, the forum was to review the significant risk register in order to standardise their rating and check the associate action plan, monitor the risk management strategy and associated policy and processes, review actions following unexpected deaths audit or review the
BAF. The forum gave increased attention by the executive team to a number of risks and outstanding actions; however, we could not assess the impact as the group was newly formed and was too early to evaluate the outcomes.

The pharmacy team was integrated into the trust governance structure and evidence of the reporting structure between different committees was seen. The chief pharmacist was accountable to the medical director. Senior pharmacists oversaw new NICE guidance implementation, alerts and reports. This task was shared by medicines safety officers (MSO) and the medicines management committee (MMC) that decided what guidance was relevant and needed to be implemented. The guidance would then be shared via the divisional governance meetings. Medicines related incidents were reported via the trusts’ electronic incidents reporting system, investigated and reviewed by a member of the pharmacy team or MSO. These were also discussed at medicines safety committees, and patient safety group meetings and shared with the departmental senior managements.

**Management of risk, issues and performance**

The trust’s revised risk management strategy was approved for ratification by the board around the time of our inspection. The trust said the previous risk management strategy was not aligned to the organisational governance structures. We noted that trust’s risk management processes were ineffective, lacked timeliness, accountability and challenge, and was often reactive. We noted that medical representation at some of the divisional risk and governance meetings was low. In December 2017 there was no medical representation on surgery and cancer division risk and governance meeting.

The clinical governance summary reports highlighted areas of focus, and risks for escalation. However, we saw progress on identified risks was slow. For example, gaps in out of hours emergency endoscopy rota for patients presenting with acute upper gastrointestinal (GI) bleeding were identified over a year ago following patient’s death. At the time of the inspection, there was still confusion who to contact if such intervention was required and rota was not cover. We also saw, actions related to NEWS scoring and escalation processes for day case procedures was discussed in December 2017 as there were concerns about staff compliance with WHO checklist. The process was still ongoing in April 2018. There were no action plans to identify what actions were required to be taken in response to risks. It was not clear who was responsible for each action, progress was not monitored and no timescales were identified. Minutes for the monthly divisional board meetings for January and March 2018 indicated there were low numbers of clinical leads at both of those meetings. The meeting highlighted that rapid reviews for incidents were not being completed. Clinical engagement regarding clinical guidelines and governance was reported as an issue.

The trust’s risk management strategy was last updated and distributed in 2016. The strategy was formulated for the period 2014 – 2018, with a review date scheduled for March 2017. An implementation plan for the revised strategy was in the development stage. The plan was to pass the risk management policy and processes (still in development) via targeted communications to the leads responsible for risk management. They were then responsible for cascading these messages within their areas. The strategy described how risk and governance department maintained the significant risk register (these were risks to the trust’s strategic objectives and risks identified at committees and sub-committees). Divisional risk registers were maintained by each of the three divisions and included risks that affected the achievement of objectives and/or the local service operation. We saw that there was a risk register but it did not include all risks. Staff told us it was written “from a clinical perspective” and did not consider other risks. The revised risk management strategy explained that all staff were responsible for reporting risks and incidents and
for following the trust policy and procedures. It was unclear how this was to be measured and monitored.

The trust introduced a daily incident review meeting chaired by the director of nursing and midwifery or medical director. The meeting aimed to ensure the executive team had oversight of all safety incidents reported across the organisation. In addition, the trust said it offered a rapid response to safety concerns and allowed them to identify themes and trends of incidents. In addition, the trust was working on streamlining their serious incident (SI) review process. To date, the executive led weekly SI panel reviewed incidents and either declared these as SIs or not. However, the trust recognised that the process was overly complicated and potentially caused further delays in their response to SIs. At the time of the inspection, the draft proposal of the new process was completed and was soon to be trialled.

The Governance and Risk Improvement Programme (GRIP) was established to improve and direct, amongst other things, the trust’s management of risk. The GRIP group planned to audit the quality of local risk management to assess whether risks and controls were clearly articulated, had effective mitigations, risks were correctly calibrated and reviewed and, when appropriate, levels of risk were reduced. The programme was still in the planning phase at the time of the inspection, therefore, we could not assess its impact.

The 2017/18 financial year was another challenging year for the trust which saw a deterioration in their financial position. In the year ending 31 March 2018, the trust was unable to meet its control total (an annual financial target that must be achieved to unlock access to national funding and other financial benefits) and reported a retained income and expenditure deficit of £28.9m. Some of the contributing factors identified by the trust were continued pressures on the emergency services and significant agency costs resulting from ongoing challenges in recruitment and retention of staff.

In 2017/18, the trust participated in the NHS Improvement's Financial Improvement Programme (FIP) which resulted in the achievement of £12.3m efficiency savings. The FIP aimed to support trusts to tackle the more difficult savings that previous cost improvement programmes have been unable to reach. The total capital expenditure (an amount spent to acquire or upgrade physical assets such as buildings, machinery and equipment) for the 2017/18 financial year was £5.38m. This included investment in the refurbishment of the education centre and was funded from the profits of the sale of the hospital land in 2016. In addition, £1.4m was spent in the replacement of ageing medical equipment, including x-ray and theatre equipment.

In June 2018 the trust had agreed a control total of £18.95m deficit. The trust board discussed disappointing cost improvement programme (CIP) delivery in ‘month 1’. CIP is a programme which aims to identify schemes to increase efficiency and/or reduce expenditure. The CIP was at 71% of the planned value, and with a 5% planning gap still unresolved. This meant the trust had achieved CIP of £407k against a plan of £568k in ‘month 1’, a shortfall of £162k (29%). The board noted this was putting achieving the control total at risk. The trust was aware they had a challenging CIP programme however the finance director was positive about the trust’s ability to meet the control total. The trust employed a director of transformation to lead on CIP. They worked with executive directors and divisions on how to create a financially sustainable organisation.

The divisional directors told us that the quality impact assessment (QIA) assessors were rigorous in assessing all CIPs which were initially rejected as did not have sufficient information to assess impact on patient safety. The trust told us the QIA were becoming better and that they wanted to make sure staff understood the importance of these assessments. They did not want the process to be “About bureaucracy but about improving quality”. Also, divisional directors felt confident
about their role to review CIP and responsibility to manage budget. They said they would challenge decisions that might impact on patient safety. We were reassured to see and hear from staff that clinical and finance teams work together to achieve CIP and to drive improvements. Staff emphasised the trust was driven by quality, safety and patient experience rather than just finance as it was in the previous years.

The trust performance was reviewed monthly during clinical divisions’ performance meetings chaired by an executive director. To provide adequate control of risks and performance the trust had also established a number of management groups and sub-committees. It included: executive led weekly serious incidents (SIs) panel, mortality review group, divisional performance meetings, serious incident learning and assurance group, daily incident meeting, and executive assurance forum, amongst others. We noted some of the meetings were not always robust and effective. For example, as mentioned before, the trust was in the process of reviewing the SI panel meeting and questioned its effectiveness. We also noted there was little input from clinicians during the SI panel meetings and we observed a lack of challenge when actions were delayed. Divisional performance meetings did not have a standardised agenda. The daily incident meeting was a good initiative, however, it offered little insight into the incidents and had no input from the clinicians. Some staff attending the meetings did not have the relevant skills and knowledge to correctly code incidents. Also, two of the incidents discussed were several months old.

In 2017/18 the trust met 12 of 18 key national standards, the A&E four-hour target being the most challenging. The trust achieved 80.94% against the national target of 95% for seeing, treating and discharging patients within four hours. In April 2018, the four-hour target was 83.1% which was just below the locally agreed monthly trajectory of 84%. The trust told us they focused on landing their trajectory to meet the 90% target by September 2018. The trust did not meet the cancer target in two categories: 62 days from urgent GP referral to first treatment (79.20% against 85% target) and 62 days from NHS cancer screening service referral (88.89% against 90%). The trust exceeded a number of national standards and these include the 18-week referral to treatment (RTT) standard for patients, seeing 94% of them in the required time, compared to a target of 92%. They also exceeded on maternity bookings within 13 weeks with referrals received within 13 weeks where they achieved 89.26% against 80% target.

The trust provided the below summary of their financial performance.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£249.8m</td>
<td>£293.6m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£8.3m)</td>
<td>(£25.1m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£258.0m</td>
<td>£318.7m</td>
</tr>
<tr>
<td>Budget (deficit)</td>
<td>£0.0m</td>
<td>(£17.5m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview)

The trust risks were included in the board assurance framework (BAF) and significant risk register (corporate risk register). These were reviewed monthly by the board in addition to a monthly
review by the relevant board committee. The top risks as of April 2018 with a score 20 or above are outlined below.

BAF risks:

- If the trust fails to meet the annual financial control total agreed with NHSI then it will be unable to deliver its strategic objectives and improve the quality of its services (score 25).
- If established trust-wide clinical staffing levels cannot be achieved, then the Trust will remain heavily reliant on non-contracted staff which may in turn compromise patient care (score 25).
- If the trust does not embed clear governance arrangements then there will be unacceptable variability in the implementation of standards and quality of care (score 20).
- If the trust fails to understand and act upon the explicit expectations and needs of patients then the trust will not improve the experience of our patients leading to a negative reputation of the trust (score 20).

Significant risk register risks:

- Failure to maintain consistent achievement of good operational performance adversely impacts on patient care, outcomes and our reputation (score 20).
- The trust fails to control its use of and spend on temporary staff which could result in financial overspend, deterioration in quality due to use of non-substantive staff (score 20).
- Failure to agree winter plan and funding with commissioners leading to failure to plan appropriately and contain costs, resulting in significant pressure on the trust’s financial plan (score 20).
- If the trust fails to implement the improvement plans identified following the CQC inspection and report, there is a risk that the trust will fail to achieve a rating of 'Good'. This may result in damage to the trust’s reputation (score 20).

The pharmacy team regularly monitored performance and quality of pharmacy service via comments and feedback from stakeholders. The chief pharmacist managed the pharmacy risk register, which also hosted corporate medicines risks. Divisional specific medicines risks were recorded on the relevant local risk register. The medicines safety group reviewed national safety alerts relating to medicines and managed the implementation of any actions related to those alerts.

**Information management**

The quality of the data and reporting which informs decision making was easy to understand and appropriately signposted key risks to both the Executive team and the NEDs.

A good level of financial information is available at board level, with a clear statement of the financial position of the trust. Interviewees felt that the financial and CIP reporting highlighted key risks and appropriately set out the current position, which allowed a good conversation at board and sub-committees on mitigations and future delivery.

In addition, the reporting provided at board level is the same as that provided at divisional level, allowing for appropriate granularity. Accordingly, all interviewees noted that the quality of information was appropriate at all levels of the organisation.

The trust informed us they had more than 100 IT applications that had been produced by informatics and finance. Some examples included: a live A&E and bed state dashboard to show the current picture of how the hospital was running; a workforce dashboard containing statutory
and mandatory training, appraisals and sickness absence data from across trust down to wards, departments and individual members of staff; budget reports to allow managers to see where efficiencies could be made. The trust incorporated all this information into an integrated performance report. The report summarised the trust’s performance against key national, local performance targets and other milestones, for example, quality of care (included indicators such as complaints rate per 1,000 contacts, mixed sex accommodation breaches, venous thromboembolism risk assessments, or infection rates, amongst others), finance and use of resources (capital service capacity, distance from financial plan, or agency spend), operational performance (referral to treatment, cancer standards, or dementia assessments) or leadership and improvement capability (staff sickness, staff turnover, or staff survey results). This information was shared with divisional leaders and discussed at the monthly clinical divisions’ performance meetings and shared with the trust board.

The trust used external hospital benchmarking tools, including CHKS and Model Hospital. CHKS is a hospital benchmarking service and the trust used its benchmarking application to monitor: patients’ mortality and hospital re-admission rates, in hospital length of stay, new outpatient appointments to follow up appointments ratios, outpatients and elective surgery ‘did not attend’ rates amongst other quality indicators. They also used CHKS’ programme that allowed the trust to monitor local and wider market trends across specialties, CCGs and GP practice-level. In addition, the trust used Model Hospital (NHS Improvement tool) to track and improve their productivity and efficiency.

We found many issues with the repository and accessibility of clinical guidelines, policies and standard operating procedures. The documents were not always easy to find, we saw a number of policies published on the trust’s intranet, ready for staff to obtain guidance from, before there were being ratified, some were out of date. We found different versions of the same policy and inconsistent naming conventions. The trust was aware of this issue. They told us work was underway to rectify the problem and to update the process of maintaining the documents and its repository. We were told that approximately 80% of the documents were already updated.

As outlined above, the trust had access to a range of information and had information technology systems to support this, however, we felt some systems and data were not always fully and effectively utilised. The trust gathered and held a great deal of information and intelligence but these were often not efficiently used making the trust’s approach reactive. The trust did not always proactively use quantitative analysis from incidents, complaints and patient feedback to understand trends and risks in safety and quality. We saw some staff lacked skills and training to extract and make the best use of information. For example, the trust told us they had a business intelligence (BI) analytics tool accessible to all staff which allowed them to produce performance dashboards and presented live data. However, we saw that information held on the trust’s BI data system was underutilised and many staff did not know how to use it. We saw the trust did not make the full use of the electronic incidents reporting system’s functionality. Also, we noted the senior staff did not always use the data to look at trends and impact when hospital was under pressure. A review of divisional and trust board meeting minutes indicated information was mainly used to seek assurance rather than to drive improvement.

The trust introduced a new electronic audit application which was a nursing audit that allowed staff to review qualitative information about the care patients receive. The application was used on inpatient wards, emergency department and critical care unit. Four audits were carried out each week by a ward manager, head of nursing or a matron. The audit allowed the staff to review quality data more quickly. Some of the qualitative information was based on questioning patients or members of staff, it was not clear how objective the selection criteria that used across the
hospital to select participants of the survey. There was a risk of partiality and possibility of staff avoiding patients who were less happy or those who complained.

The chief pharmacist told us the information management systems in the trust were “Frustrating” as the trust had no electronic prescribing, or any automation in the dispensary. There was an internal audit programme. These included medicines logistics audits for example: security of medicines, controlled drug, missed or delayed medicines audit.

The trust had recently secured “Global Digital Exemplar (GDE) – Fast Follower Programme” funding. GDE was developed in response to ‘The NHS Five Year Forward View’, originally published in 2014, and aimed to support the growth of digitalisation amongst NHS providers. The trust hoped it would help to transform their current clinical IT infrastructure and replace paper-based processes with safer, user-friendly and efficient systems. The three-year programme was to build on existing systems and add other systems such as electronic prescribing, clinical notes, nurse documentation and systems used for improved team communication. In addition, the trust planned to standardise interfaces between the trust systems and primary care as well as emerging sustainability and transformation partnership (STP) wide systems.

Engagement

Staff of different seniority were positive about current changes to the way trust engaged with them. Most staff we spoke with felt the trust wanted to listen to their views and the trust was more transparent about introducing changes. In April 2018, the trust launched the ‘listening into action’ initiative which is a staff engagement programme to provide an opportunity for all staff to share their views on how the trust was doing as well as suggest improvements. The programme engaged staff by asking their views on a series of questions and listing three things they would like to change at work that would improve things for patients and for staff. The response rate within three weeks of the survey was 51% and the trust planned to share the results with all staff (for further details about the survey results see ‘Culture’ section above).

The trust held a monthly staff briefing and, question and answer sessions, known as ‘executives question time’ (EQT) in which staff had the opportunity to hear about corporate priorities and to put questions to members of the executive and other senior leaders. The trust reported that the sessions were attended by between 50 and 100 staff. More recently, the trust introduced ‘staff conversations’, a forum which replaced EQT and was designed to encourage more open discussion about key issues and concerns.

The trust proactively engaged and worked with a number of external partners. We found the relationship to be positive and collaborative. The trust was willing to build a shared understanding of challenges to the wider healthcare system and needs of the population they serve. For example, they worked closely with Health Education England and the General Medical Council to improve the supervision and training experience of trainee doctors in emergency department. The trust also worked with the local Healthwatch who regularly visited the hospital and actively contributed their views during trust’s board meetings. The trust had co-commissioned a report with the local commissioning groups (CCGs) into patient usage of their emergency department. This work had been undertaken by Healthwatch Enfield. A meeting between the trust and NHS Haringey CCG, NHS Enfield CCG and two local Healthwatch stakeholders (Enfield and Haringey) was arranged to develop an action plan to address the report’s findings.

Trust patient’s experience group met bi-monthly, chaired by the director of nursing and midwifery. The trust noted the patient experience strategy needed to be refreshed and this review was due to be completed by July 2018. The strategy was being co-produced with Enfield Healthwatch and was using ‘always events’ as a methodology to implement the strategy. Always events are those
aspects of the patient's experience that should occur when patients, service users, their family members and carers, interact with health care professionals and the health care delivery system. The trust had two patient's experience improvement plans, including plans for the emergency department and the maternity, while an improvement plan for outpatient services was due to be completed in July 2018.

The trust used a range of feedback channels to learn about patients' experiences of care including: through compliments and complaints, by contacting the patient advice and liaison service (PALS), the Friends and Family Test (FFT). The NHS Friends and Family Test (FFT) is a quick and anonymous way for patients to give their views on the service they have received. The trust also reviewed comments posted on social media, including NHS Choices/Care Opinion website, and social media. The information was shared with the trust board and individual divisions and their teams so that they could consider what was important to patients.

The trust’s monthly FFT results in outpatients, inpatients, and A&E are shown below.

**Friends and Family Test results – outpatients**

The outpatients department's FFT results were consistently below the England average of 94% between June 2017 and May 2018.

<table>
<thead>
<tr>
<th></th>
<th>Recommend</th>
<th>Would Not Recommend</th>
<th>Response Rate</th>
<th>EnglandRecommended average</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-18</td>
<td>75%</td>
<td>15%</td>
<td>9%</td>
<td>94%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>89%</td>
<td>6%</td>
<td>2%</td>
<td>94%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>89%</td>
<td>5%</td>
<td>5%</td>
<td>94%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>85%</td>
<td>8%</td>
<td>6%</td>
<td>94%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>86%</td>
<td>8%</td>
<td>3%</td>
<td>94%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>86%</td>
<td>8%</td>
<td>4%</td>
<td>94%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>88%</td>
<td>6%</td>
<td>5%</td>
<td>94%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>83%</td>
<td>10%</td>
<td>4%</td>
<td>94%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>87%</td>
<td>7%</td>
<td>4%</td>
<td>94%</td>
</tr>
<tr>
<td>Aug-17</td>
<td>85%</td>
<td>8%</td>
<td>4%</td>
<td>94%</td>
</tr>
<tr>
<td>Jul-17</td>
<td>85%</td>
<td>9%</td>
<td>5%</td>
<td>94%</td>
</tr>
<tr>
<td>Jun-17</td>
<td>85%</td>
<td>8%</td>
<td>4%</td>
<td>94%</td>
</tr>
</tbody>
</table>

**Friends and Family Test results – inpatients**

Throughout 2017/18 performance on the inpatient FFT had been close to the London average of 93.7%. On four occasions the inpatients department’s FFT results met or exceeded the England average of 96%.
<table>
<thead>
<tr>
<th>Inpatients</th>
<th>Response Rate</th>
<th>Recommend</th>
<th>Not Recommended</th>
<th>England Recommended average</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-18</td>
<td>11.4%</td>
<td>85%</td>
<td>6%</td>
<td>96%</td>
</tr>
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<td>Apr-18</td>
<td>15.4%</td>
<td>96%</td>
<td>1%</td>
<td>96%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>18.4%</td>
<td>94%</td>
<td>2%</td>
<td>96%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>19.2%</td>
<td>94%</td>
<td>3%</td>
<td>96%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>19.9%</td>
<td>90%</td>
<td>7%</td>
<td>96%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>15.5%</td>
<td>91%</td>
<td>5%</td>
<td>96%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>18.3%</td>
<td>92%</td>
<td>5%</td>
<td>96%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>20.6%</td>
<td>94%</td>
<td>3%</td>
<td>96%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>19.4%</td>
<td>92%</td>
<td>4%</td>
<td>96%</td>
</tr>
<tr>
<td>Aug-17</td>
<td>18.9%</td>
<td>96%</td>
<td>1%</td>
<td>96%</td>
</tr>
<tr>
<td>Jul-17</td>
<td>17.0%</td>
<td>96%</td>
<td>2%</td>
<td>96%</td>
</tr>
<tr>
<td>Jun-17</td>
<td>19.0%</td>
<td>97%</td>
<td>2%</td>
<td>96%</td>
</tr>
</tbody>
</table>

Friends and Family Test results – A&E

The A&E department's FFT results saw steady improvement over the past year. The percentage of those recommending the service increased from 46% in April 2017 to 66% in March 2018, with a slight dip in April and May 2018 (60%), although the results were below the England average of 84-88%.

<table>
<thead>
<tr>
<th>A&amp;E</th>
<th>Response Rate</th>
<th>Recommend</th>
<th>Not Recommended</th>
<th>England Recommended average</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-18</td>
<td>6.0%</td>
<td>60%</td>
<td>28%</td>
<td>87%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>6.7%</td>
<td>60%</td>
<td>30%</td>
<td>87%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>10.9%</td>
<td>66%</td>
<td>22%</td>
<td>84%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>69.7%</td>
<td>69%</td>
<td>12%</td>
<td>85%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>17.3%</td>
<td>67%</td>
<td>17%</td>
<td>86%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>27.0%</td>
<td>63%</td>
<td>23%</td>
<td>85%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>30.5%</td>
<td>66%</td>
<td>18%</td>
<td>87%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>19.4%</td>
<td>58%</td>
<td>26%</td>
<td>87%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>14.6%</td>
<td>59%</td>
<td>27%</td>
<td>87%</td>
</tr>
<tr>
<td>Aug-17</td>
<td>23.6%</td>
<td>51%</td>
<td>29%</td>
<td>88%</td>
</tr>
<tr>
<td>Jul-17</td>
<td>19.3%</td>
<td>46%</td>
<td>31%</td>
<td>86%</td>
</tr>
<tr>
<td>Jun-17</td>
<td>16.7%</td>
<td>48%</td>
<td>32%</td>
<td>88%</td>
</tr>
</tbody>
</table>
The trust had not undertaken any public consultations in the last 12 months prior to the inspection. An initial ‘case for change’ public stakeholder engagement workshops were planned for July 2018 to provide and obtain public views on the future of the trust.

The chief pharmacist felt that the engagement with the wider trust had been good and improving, as well as with the wider local health economy and networks. The trust pharmacy team worked with the pharmacy teams in adjacent trusts through local networking groups including medicines safety officer network, chief pharmacist network and local area prescribing committees.

**Learning, continuous improvement and innovation**

Information on serious incidents (SIs), complaints and deaths was fed through to senior managers. Electronic reporting system were used to collect data and themes were reported to senior managers. A monthly patient safety report was shared with the patient safety and outcomes group and then onto the clinical quality and patient safety committee which then fed this information to the trust board.

The trust had a backlog of SIs and rapid incidents reviews. There was a limited capacity within the divisions and the central governance team to address this backlog. This meant the trust was not always able to promptly analyse incidents, complaints and patients’ feedback to fully understand trends and risks in safety and quality.

Between April 2017 and March 2018, the number of incidents reported varied between 700 to 900 every month. The medicine and urgent care division reported 45% of the overall incidents. There was a high ratio of low and no harm incidents reported which could demonstrate a positive patient safety culture. However, we found that not all staff we spoke to had sufficient skills and knowledge in categorising levels of harm and sometimes relied on initial incident review to confirm the category. Senior member of staff told us that managers often categorised incidents as serious and then were hoping to lower the category or de-escalate should the initial review found it did not fit this category. This potentially caused a backlog in carrying out rapid reviews and SIs investigations due to lack of capacity. This also delayed learning implementation identified during those reviews.

The top five incident categories reported through the trust’s electronic incidents reporting system in 2017/18 were related to: admission and discharge, infrastructure, patient falls, maternity incidents and patient documentation.

The trust was the seventh highest reporter of never events (NEs) in London. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. We observed a two-fold increase in the number of never events with six of them reported in 2017. With two retained foreign object post-surgery, three incidents categorised as wrong site surgery and one unintentional connecting of a patient requiring oxygen to an air flowmeter instead. Root cause analysis (RCA) investigations had been or were in the process of being completed to identify learning and action plans. In May 2018 the trust held its first ‘learning from never events’ open forum for staff to share learning and good practice. The trust identified that human factors were the contributory factors in several SI and NEs. In response the trust started a ‘human factors’ training, however at the time of the inspection only four clinicians were undergoing the training programme. The human factors approach focusses on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment.
The serious incident framework states that “serious incidents must be reported by the provider to the commissioner without delay, and no later than two working days after the incident is identified”. Thirty-five percent of the SIs reported by the trust were reported more than two days after identification in 2017/2018. The trust also did not meet “the timeliness of submission of reports” KPI as 100% of the reports submitted were submitted after the 60 days deadline prescribed by the NHS’s framework.

The trust had plans to improve patient safety and these included “patient safety work streams”, for deteriorating patients, sepsis and surgical safety. Those were forums where relevant incidents were reviewed and learning from them disseminated.

The work on National Safety Standards for Invasive Procedures (NatSSIPs) and development of Local Safety Standards for Invasive Procedures (LocSSIPs) was put on hold due to limited resources and capacity. At the time of the inspection, the trust was in the process of recruiting a lead for NatSSIPs with a view to improve safety for interventional procedures. NHS provider organisations are required to develop local procedures based on national best practice examples. The LocSSIPs are meant to build on the existing World Health Organisation’s surgical checklist and promote the effective performance of the five steps to safer surgery guidance. In May 2018 the trust held its first ‘learning from never events’ open forum as means of sharing learning and good practice. The event was attended by over 110 staff from multi-professional teams and included personal testimony from a clinician involved in the never event, highlighting the impact of such events on staff and patients alike, and the practical measures put in place to prevent re-occurrence. Another practitioner highlighted the emotional impact of a never event on their team.

The trust had developed an overarching action plan for falls and was in the process of implementing it across the trust. The implementation and outcomes from it was monitored at the patient safety and outcomes committee since April 2018 with an aim to ensure better triangulation against serious and low harm incidents.

Learning from SIs was also shared at Serious Incident Action and Learning Group (SIALG), which was attended by representatives from all divisions who shared learning back within their clinical areas. Following the SIALG meeting, the trust distributed a newsletter to all staff which included the key learning point from each serious incident investigation. The trust also produced a quarterly ‘safety matters’ newsletter which included feedback from incidents, complaints and mortality reviews along with training events and key patient safety initiatives. The trust’s lead for deaths’ reviews also prepared a trust wide newsletter, which aimed to share key learning points identified during deaths reviews. These were distributed electronically amongst trust’s staff. However, the trust did not develop systems and processes for monitoring learning actions at the divisional level. We identified gaps in who was taking responsibility and was accountable for ensuring actions and learning was shared in each of the three divisions.

The chief pharmacist explained that continuous learning, improvement and innovation was sustained by the pharmacy team by providing medicines management training to staff as needed and non-medical prescribers on all general medical and surgical wards. An audit of prescribing errors for discharge medicines (known as TTAs) showed that the introduction pharmacist non-medical prescribers had reduced prescribing errors from 48% to 0.5%. Clinical governance meeting in every clinical area. Serious incidents and learning from such incidents were discussed in divisional and medicines safety committee, which the chief pharmacist attended.

The trust reported a total of 90 incidents through the Strategic Executive Information System (STEIS) in period between March 2017 to February 2018. Most common category of incident was slips trips and falls, diagnostic incident and surgical/ invasive procedure.
<table>
<thead>
<tr>
<th>Nature of Incident</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>20</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>12</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>12</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>8</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>8</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>8</td>
</tr>
<tr>
<td>Confidential information leak/information governance breach meeting SI criteria</td>
<td>5</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>4</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother only</td>
<td>3</td>
</tr>
<tr>
<td>Pending review</td>
<td>3</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)</td>
<td>2</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
</tr>
<tr>
<td>Blood product/ transfusion incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Major incident/ emergency preparedness, resilience and response/ suspension of services</td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>90</td>
</tr>
</tbody>
</table>

We saw that alongside the incident reporting system a number of departments used a ‘learning from excellence’ reporting system. This system enables examples of good practice to be reported, analysed and shared with other staff.

As part of our inspection, we undertook a detailed examination into how well the trust investigated and learned from unanticipated deaths. This involved reviewing investigation reports and speaking to key trust staff. All trusts are expected to develop their practice following the NHS National Quality Board guidance on Learning from Deaths, 2017 and the 2016 CQC report ‘Learning, candour and accountability’ which requires NHS trusts to produce and publish an updated policy on learning from death.

From April 2017 onwards, the trust was required to collect quarterly information on deaths, reviews, investigations and resulting quality improvement. This data was to include the total number of the trust’s in-patient deaths (including emergency department deaths) and those deaths that the trust had subjected to case record review. Of these deaths subjected to review, the trust was required to provide estimates of how many were judged more likely, than not, to have been due to problems in care. The trust had some difficulties in collating the information as required data was not captured using the existing incidents reporting system. They planned to implement a new way of reviewing mortality from April 2018 but this had not been implemented and trust’s leaders were not clear when problems with data collection would be resolved.

There were a hospital wide mortality review meeting taking place and divisional governance meetings were deaths were discussed. Mortality review meetings were not always minuted. This meant we were unable to evidence any learning or actions from these meetings.

We saw a document submitted to the mortality review group in March 2018 which indicated there were 604 overdue death reviews as at end of February 2018. Of these, almost 400 deaths occurred between April 2017 and Dec 2017. Eleven cases had been reported as SIs so those had
been reviewed or were to be reviewed under the SI investigation framework. The document noted that each speciality should have conducted a full review on at least 25% of those 604 cases during specialities’ mortality and morbidity (M&M) meetings. Non-executive directors were not aware of the issue and the board was not involved in the decision-making process. Since the M&M meetings were often not minuted to inform learnings we were not assured the current process offered sufficient assurance to the learning from deaths requirement. In addition, the document from March 2018 highlighted records were not available for an estimated 100 deaths reported across the trust, as they had been sent to storage.

The trust recognised the governance team was unable to support death review process as they were short staffed and did not have capacity to overview it. New process was being implemented at the time of the inspection, where all deaths would be categorised twice a week by a doctor visiting the mortuary where relevant current records of deceased patients were kept.

We reviewed four serious incidents where substandard care could potentially be a contributory factor to patients’ deaths. Mortality reports in two cases were incomplete and not finalised within one year. Rapid reviews which were to be undertaken within two days to identify initial learning and prevent further occurrences took many months to complete. Senior leaders told us that those incidents were discussed during staff meetings and divisional governance meetings and despite the reports taking a long time to produce initial learning was identified and implemented. However, we did not find sufficient evidence of the effectiveness and oversight of governance and safety systems to support learning from deaths and incidents.

We reviewed how trust responded to seven formal complaints; this included four complaints made in August 2017. One was not completed until January 2018. The other three took three months to resolve. Although, the trust did not meet its target to respond to formal complaints, we noted overall improvement in timeliness when compared with previous years. Complaints officers told us divisions did not promptly investigate or proactively provide information which would allow them to respond to complaints within set timescales. The trust focused on educating staff within individual divisions to help them understand their responsibility to respond to formal complaints and request for information from the complaint officers. We saw evidence of communication with complainants to agree extensions as needed. Quality of responses to complaints made was good and written communication with patients and/or their carers and families was considerate, individualised and information provided in letters was comprehensive.

The below table shows trust targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 days</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>80%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>50</td>
<td>80%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>2,403</td>
<td>January 2017 to December 2017</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview)
The below table shows a number of complaints made to the trust. The trust received 447 complaints from January 2017 to December 2017.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of Complaints</th>
<th>Average Time to close (working days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>117</td>
<td>42</td>
</tr>
<tr>
<td>Surgery</td>
<td>116</td>
<td>35</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>59</td>
<td>33</td>
</tr>
<tr>
<td>Other</td>
<td>49</td>
<td>37</td>
</tr>
<tr>
<td>Maternity</td>
<td>35</td>
<td>36</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>26</td>
<td>34</td>
</tr>
<tr>
<td>Outpatients</td>
<td>21</td>
<td>32</td>
</tr>
<tr>
<td>End of life care</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>5</td>
<td>41</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>447</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints)

The below table show number of compliments received by core service. The trust received 116 compliments from January to December 2017. A breakdown by core service is below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of Compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>37</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>26</td>
</tr>
<tr>
<td>Outpatients</td>
<td>24</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
</tr>
<tr>
<td>Surgery</td>
<td>5</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>2</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>2</td>
</tr>
<tr>
<td>Maternity</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)

We reviewed how the trust engaged with families and carers in reviews and investigations of deaths and serious incidents. From the serious incidents reviews we noted there was no single named person to handle liaison and communication with families. Patients and/or their families were contacted by governance team members, doctors, managers or senior nurses at various stages of the investigation. There was no evidence of support to families and carers involved in the incident investigation process. It was not always clear if they were involved in setting out terms of reference and key lines of enquiries for the investigation.

We saw letters sent to families informing them of an investigation taking place and of the set timescales for investigating incidents. Those letters were personalised and, where necessary, a formal apology that an incident took place was issued at that stage. Those letters were sent out while the incident was still being investigated, at the same time patients and their families or carers were offered an opportunity to meet with a person overseeing the investigation. We did not see
formal correspondence or records of such meetings taking place post investigations. This would allow to debrief people concerned and formally apologise if it was found the care and treatment provided by the hospital staff was substandard.

The trust took longer than expected to investigate serious incidents with many incidents taking over a year to complete an investigation. For example, we noted that there were 26 overdue rapid incident reviews shown on the agenda from SI panel meeting of 20 June 2018. Such reviews should take place within 48 hours from the incident taking place. We noted that in one case the 48 hours review took nearly 12 months to complete. This meant the trust was unable to promptly comply with their responsibilities set out under the duty of candour (DoC) regulation as they were unable to assess if the regulations would apply without carrying out full investigations. 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.

DoC training was covered at induction for all doctors and offered as a e-learning module the General Medical Council (GMC). GMC provided had also provided training to staff in relation to DoC at the hospital with two sessions taking place in 2018.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited. No accreditation data has been supplied by the trust. They stated that they sought re-certification in Endoscopy in 2018.

(Source: Routine Provider Information Request (RPIR) – Accreditations)

In the last 12 months prior to the inspection, the trust’s staff had won several awards. These included:

- ‘Nurse Leader of the Year’ awarded to a critical care matron by the ‘Nursing Times’ for their work in addressing cultural conflict on ITU.
- Bereavement midwife, won ‘Best Hospital Bereavement Service’ in Butterfly Baby Loss Awards. They were also runner up in the British Journal of Midwifery Midwife of the Year.
- Education supervisor of the year was awarded to consultant paediatrician by the Royal College of Paediatrics
- Paediatric department was awarded Paediatric Awards for Training Achievements best training award.

In 2017/18 the trust achieved a 72% flu vaccination rate among staff during the winter flu season. This was the highest rate achieved in any given year to date and an increase of 24% from the previous year.

The trust awarded funding to 15 projects put forward by staff to improve patient care in a ‘Dragons’ Den’ style competition. All staff were invited to present their ideas for spending of £200,000 made available by the trust’s charity to spend on improvements to patient care. The funding was awarded to a range of projects ranging from new TVs for patients in podium 1, acute stroke unit and tower 4 wards, more chair-beds for the maternity delivery suite, new digital signage for the emergency department, or refurbishment of the physiotherapy department.
In 2017, the trust formed a clinical partnership with another NHS trust. This enabled the trust to share best practice and experiences and ensure they had consistent approaches to designing and delivering care based on evidence and best practice. Staff we spoke with were very positive about the partnership and opportunities this created.

**Acute services**

**Urgent and Emergency Care**

**Facts and data about this service**

All emergency department (ED) facilities are located at the North Middlesex University Hospital. The department comprises of an ED majors area which includes an assessment and treatment area (known as the fast initial treatment zone), as well as cubicles, a resuscitation area and an observation ward. There is also a children’s emergency department and an urgent care centre.

There were 167,067 attendances from April 2016 to March 2017 at North Middlesex University Hospital NHS Trust as indicated in the chart below. Updated information from the trust showed there was a total of 175,099 attendances between May 2017 and April 2018, of which 130,321 were adults and 44,778 were children.

**Total number of urgent and emergency care attendances at North Middlesex University Hospital NHS Trust compared to all acute trusts in England.**
Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission remained similar from 2015/16 to 2016/17. In 2016/17, rates were the lower than the England average. (Source: NHS England)

Urgent and Emergency Care attendances by disposal method

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory Training
There was a room recently converted into an education room within the department. It had eight computer terminals for staff use as well as reference materials. Nursing staff told us they were encouraged to maintain their mandatory training levels and when a shift was quiet, the shift leader released them to use the education room for a period of time. In addition, they received e-
mails to remind them of training which was soon to expire and training sessions were arranged as a rolling programme to ensure they were able to attend.

We were told that education about the recognition and management of sepsis was part of the induction programme for all doctors and nurses. Further education was provided via the departmental teaching programme using patient stories to illustrate the key priorities. Ad hoc education around sepsis was provided during bedside teaching. We saw that staff were reminded about the importance of prompt management of sepsis at the morning handover and in safety briefings.

Trust board minutes for April 2018 noted that there were concerns around compliance with mandatory training, in particular Mental Capacity Act and Deprivation of Liberties Safeguarding (DoLS). It was felt that there had not been a robust training programme around DoLS. The minutes recorded that more could be done to support and enable staff to complete their training in a timely way. Staff were frequently taken off training to cover staff shortages. Access to the training had been expanded to include weekends, evenings and e-learning.

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to February 2018 for nursing/midwifery staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>137</td>
<td>123</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>137</td>
<td>119</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>137</td>
<td>119</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>137</td>
<td>118</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>26</td>
<td>19</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>136</td>
<td>91</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 83% which did not meet the trust target of 90%.

The trust subsequently submitted data below which showed nursing compliance at the end of April 2018 was 86%. The trust did not submit numbers of eligible staff or number of staff trained.

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Intermediate Life Support (ILS)</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric intermediate life support (IPLS)</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
The table below reflects mandatory training completion rates for medical staff at the end of April 2018. The trust did not submit numbers of eligible staff or number of staff trained. The overall completion rate for medical staff was 86% which did not meet the trust target of 90%.

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Advanced Life Support (ALS)</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Advanced Paediatric Life Support (APLS)</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Safeguarding
Staff and security members said that patients with challenging behaviour were sometimes given rapid tranquilisation medicine, especially in the emergency department. We saw four incidents which recorded staff gave rapid tranquilisation medicine to a patient during the previous 12 months. However, the incident reporting policy did not specifically mention logging episodes of rapid tranquilisation medicine as an incident.

Safeguarding Adult Level 2 training was provided as face to face training for relevant groups of staff. Female Genital Mutilation (FGM) and Modern Slavery was part of the mandatory face to face induction for all new clinical staff. Local stakeholders told CQC the trust was seen as an area of good practice with the development and implementation of its FGM policy, risk assessment tool, FGM clinic and a specialist Midwife for FGM to support the clinic. Levels 2 and 3 safeguarding training included the requirement for mandatory reporting of a person under the age of 18 years where FGM was undertaken.

The Counter Terrorism and Security Act 2015 introduced the Prevent duty, the aim of which was to help stop vulnerable people from being exploited and drawn into terrorism. Forty four per cent of medical staff and 24% of nursing staff had completed their Prevent HealthWrap training at the time of this inspection; the trust aim was to achieve 85% compliance by the end of July.

Staff told us they referred adults who attended the ED with injuries that may be as a result of domestic violence to safeguarding team. Where these adults had children, then the children were also referred to safeguarding on the basis that they were a witness to domestic violence within the family. The local authority placed youth workers in the ED in response to concerns about gang violence and child sexual exploitation.

The table below reflects safeguarding training completion rates for April 2017 to February 2018.

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>70</td>
<td>64</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>119</td>
<td>103</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
The data below was submitted to CQC following the inspection and showed the overall safeguarding training completion rate for nursing staff. Managers told us where the trust target was not met, this related to recent staff turnover.

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>87%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The data below was submitted to CQC following the inspection and showed the overall safeguarding training completion rate for medical staff.

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Between May 2017 and April 2018, there were 306 safeguarding concerns raised by emergency department staff.

The multidisciplinary ED safety checklist included a section which noted relevant referrals including adult safeguarding referrals; child cause for concern referral; domestic or sexual violence referral and alcohol and drug nurse specialist referral.

**Cleanliness, infection control and hygiene**

The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment (PPE) such as gloves and aprons, and management of the spillage of body fluids.

Following the CQC inspection in September 2016, we told the trust that it must improve hand hygiene levels especially amongst medical staff. However, we observed instances of poor hand hygiene during this inspection. For example, staff did not routinely clean their hands before and after patient contact. We observed staff in the resuscitation area and whilst all wore appropriate PPE, there were just two out of 21 occasions when staff washed their hands as they entered and exited a bay which represented 9.5% of available opportunities for good hand hygiene.

We performed a similar exercise in the FIT zone; there were just five out of 26 occasions when staff washed their hands as they entered and exited a bay which represented 19.2% of available opportunities for good hand hygiene.

The trust compliance standard with hand hygiene was 95%. Data submitted following this inspection showed that the average compliance with hand hygiene between November 2017 and March 2018 was 80%; varying each month between 63% in November and 90% in March.
There were housekeeping staff for cleaning all areas of the emergency department and we found most areas were maintained to a good standard of cleanliness. Most areas we visited were tidy, clean and uncluttered. Disposable curtains hung around examination beds were clean and included a replacement date. The plaster room was visibly clean and fit for purpose.

There was easy access to personal protective equipment (PPE) such as aprons and gloves in all areas we inspected and all staff used PPE as required. There was also sufficient access to hand gel dispensers, handwashing and drying facilities. Hand washing basins had a sufficient supply of soap and paper towels. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice.

Clinical waste management practices, including those for contaminated and hazardous waste were safe and in line with national standards. There was a colour-coded system for disposal of waste, and clear segregation of clean and dirty equipment. The main ED dirty utility room where used equipment was stored to reduce the risk of infection and cross-contamination was generally tidy and clean.

All items were stored off the floor and on shelving, all areas were visibly clean. Patients and relatives told us they were satisfied with the level of cleanliness in the department. We saw sharps bins available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) (d). This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on most sharps bins had signatures of staff, which indicated the date it was constructed and by whom. Temporary closure mechanisms were engaged on most bins.

There were objects on the floor of the paediatric ED and cleaning agents were not secured in a locked cabinet. We raised this with staff and this was immediately.

**Environment and equipment**

The emergency department had 13 patient cubicles in the majors area. In addition, there were three assessment cubicles and four further cubicles in which health care assistants could carry out observations. There was a new assessment and treatment area (FIT zone) in the emergency department introduced in February 2018. This had a ‘fit to sit’ and a ‘sit to treat area’. We were told that the current environment was still a work in progress; doctors and nurses acknowledged that it was a very open space with patients seated close to each other. There were low lying drip stands dangling from the ceiling in the FIT zone and we saw staff hitting their heads off them on a number of occasions and patients being guided away from them by nursing staff. There was an observation ward which had five beds and six chairs. This area was separated to facilitate male and female patients to ensure there were no mixed sex breaches.

The main waiting area had a good supply of fixed seating and was visibly clean. There were two large screens which were meant to show the waiting time, but neither was in working order. The receptionists displayed the waiting on a hand written notice which they updated every two or three hours. Patients told us they were able to discuss their personal details without being overheard. However, many told us that it was difficult to hear when their name was announced by the streaming nurse; one patient told us they missed their slot as they did not hear their name and experienced a slight delay as a result. We sat in the waiting area when it was busy and found it very difficult to hear patient names when called by nursing staff or GPs.

There was a separate waiting area for children in paediatric ED (PED). Entrance was by secure access and adults were challenged upon entry. The overall environment was child friendly with murals on the walls and was well maintained. There were two large screens being installed during the inspection which would be used to display health education information and waiting times. There was a small play room which had minimal equipment and a separate feeding room. All consultation rooms had visual distraction in the form of a light projection effect.
Whilst there were two toilets in the PED, one of which was disabled accessible, there was no commode or nappy changing facility and parents had to take their children to the main ED facilities. Some parents told us they were surprised that a children’s emergency department did not have a dedicated changing area and they found it inconvenient to leave the department to go to the main area.

The emergency department had a mental health assessment room which followed national guidance. The room was clean, had two doors with viewing panels and staff had access to appropriate emergency alarms. Staff said that patients were supervised when using the toilet facilities.

In the paediatric emergency department, staff used a side room to nurse children and adolescents who required support for their mental health conditions. Staff minimised ligature risks and used one to one support to ensure child patient safety.

We checked the resuscitation trolley in the adult majors area which was secured with a plastic snap lock so it was clear if someone had accessed the resuscitation equipment. We snapped the lock on the adult resuscitation trolley with permission and saw that all equipment was present, including equipment for smaller or paediatric patients. We saw there were no gaps in the twice daily checks. Fluids and single use equipment expiry dates were highlighted. The defibrillator machine was safety tested and within the required timescales.

We checked the contents of the paediatric resuscitation trolley; there was no defibrillator and there were no signs to direct staff to the nearest one. We noted that daily checks were not always carried out; for example, there were five gaps in the previous three weeks.

We received a spreadsheet of all the equipment in the department, along with the next service schedule date. Most service review of items of equipment in the department were up-to-date with the exception of one defibrillator, two pulse oximeters and three vital signs monitors which were between three and six months overdue.

**Assessing and responding to patient risk**

Patients who self-presented to the department were booked in at reception. Once booked, the four hour target time started, in line with the Department of Health’s standard for emergency departments that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

At the time of the previous CQC inspection, in September 2016, the department introduced an early senior assessment and treatment model (ESAT). This was a nurse led clinical assessment and ambulance triage process. This model was amended in February 2018 and the principle was to change from a single stream model to one with multiple parallel streams. The emphasis was not necessarily to address the four hour target but to improve how flow through the department was managed and enhance patient safety and their overall experience when in the department.

Aims included early senior doctor input, maximisation of capacity in ED, reduction in unnecessary investigations, earlier referral to specialty and clearly defined staff responsibilities. This was known as the fast initial treatment (FIT) zone which was consultant led from 8:00am to 8:00pm and included three nurses one of whom was an advanced assessment nurse, and two healthcare assistants.

Patients who arrived at reception were initially assessed by a nurse and streamed to the most appropriate area. A brief history and basic observations including calculation of early warning scores were taken by the assessment nurse. We confirmed these were calculated correctly on all of the patient records we reviewed.

The department followed guidelines for streaming of patients to ensure they were sent to the...
correct area of the department which best met their needs which included the urgent care centre, staffed by emergency nurse practitioners and GPs. Patients who re-presented within 48 hours of discharge; those with abnormal observations or chest pains were taken by the streaming nurse and handed directly over to the FIT zone consultant.

Ambulance crew logged in at an ambulance reception desk before proceeding to the ED majors area. They then handed their patient over to the consultant in a designated area in ED majors who took the decision about where the patient should be directed to. When a patient was not well enough to sit, they were moved to an assessment cubicle. The ‘fit to sit’ and ‘sit to treat’ zones were two chaired areas separated by a screen. The ambulance reception desk was not staffed after 10:00pm; patients were logged in at the main reception area and then returned to majors; some crew members described this process as time consuming.

We observed the handover of three patients from ambulance crews. A consultant assessed two patients whose condition gave cause for concern and oversaw the assessment of the third patient. We saw the focus was to ensure patient safety; the patients were taken directly to cubicles and two had an ECG within 10 minutes of arrival. For each patient, pain levels were managed and where relevant, their social circumstances were discussed.

This model was new but staff told us it had a positive impact on patient care and the general efficiency of the department. There was no formal risk assessment of the area but there were two band 6 and above nurses allocated at all times. In addition, chairs were on wheels so that in the eventuality of patient collapse, the chair could be tipped back and the patient wheeled to a cubicle or resuscitation.

There were necessary changes to facilitate the new rota for the FIT zone but such was the commitment to this system that these were initiated rapidly and with general willingness. Early indicators showed improvements in performance; for example, patients who arrived by ambulance were seen within 18 minutes where it was 22 minutes before the new FIT model was introduced.

We observed a nurse as they assessed and prioritised a patient in the ‘fit to sit’ area who complained of chest pain. They had an ECG done, as well as observations within ten minutes, during which there was a discussion with the consultant about the most appropriate area to transfer them to. Junior doctors told us they were encouraged to escalate any concerns to the consultant in the department.

Paediatric patients were streamed in the paediatric ED. This was done by band 6 or senior band 5 nurses. It was done electronically and mandatory fields included paediatric early warning scores (PEWS), weight, observations and sepsis 6.

The ED used a system of national early warning scores (NEWS for adults and PEWS for children) to alert staff to the deteriorating patient. We were told a multidisciplinary ED safety checklist was introduced since the previous inspection in September 2016 and saw copies were retained in patient paper records. Tasks to be completed each hour over a four hour period included vital signs, NEWS and pain scores. The checklist also included a falls risk assessment for patients over 65 years of age; sepsis screening if indicated and a pressure area screen for older patients as well as those with conditions likely to increase the risk of pressure ulcers.

We are unable to comment on results of any audits of early warning scores or appropriate completion of safety checklists since the trust did not submit this data.

There was a sepsis screening tool in place as part of the NEWS record and actions were escalated as appropriate. However, we reviewed 24 patient records and found that sepsis screening was not recorded on eight out of 24.
The paediatric resuscitation bay was in the majors resuscitation area, accessed through an adjoining door. We observed two handovers of paediatric patients who came in on blue light ambulances. For the first patient, there was no consultant present and it was not apparent to us who was in charge; there was no request for consultant support or review. There were no paediatric early warning scores calculated up until the time we left the department 45 minutes later. There were no bloods or cultures done or antibiotics administered and just two out of six steps of the sepsis 6 bundle were completed.

The second patient handover was well organised; it was apparent who was in charge and there was consultant overview of the process. A nurse was assigned to support the parents and there was a systematic primary survey carried out of the child, which included breathing, airways and circulation. There was consultant overview and a concise handover from team leader to the consultant. There was clear stepdown of staff by the team leader to ensure minimum impact in the main department.

We attended a safety huddle which identified that all five cubicles in the resuscitation area were occupied. A plan was devised which identified two patients who were well enough to ‘step down’ in order to create capacity.

On one inspection day, we saw two patients aged 69 and 74 on trollies, both of whom were in the department for longer than 12 hours. Trust policy states that a patient should be transferred from a hospital trolley to a bed if in the department for longer than four hours. We drew this to the attention of a member of staff and it was escalated to one of the management team to address.

Patients who presented to the emergency department after attempting suicide were not always kept safe. There were a high number of absconders from the emergency department. There was no written protocol or policy for staff to follow in order to prevent patients at risk of suicide from leaving the emergency department before they were assessed and treated. There were two security staff members within the emergency department at all times, however these security staff members were not all trained in the mental health act.

We observed an episode of staff administering rapid tranquilisation medicine, and saw that vital sign readings (such as heart rate, respiration rate, and blood pressure) were taken once during the next hour. This was not in line with NICE guidance which states that staff should take vital signs every 15 minutes during the first hour after a rapid tranquilisation medicine is administered. This meant that there was a risk to patients who were given this medicine as the trust did not ensure that this was done safely.

There was confusion about how and when staff members could prevent patients from leaving the emergency department. There had been two serious incidents resulting in the death of patients who had absconded from the emergency department, an incident where a patient had absconded and then returned with serious self-harm injuries, and an incident where a patient presenting after taking an overdose of medication, was able to take a further overdose while in the emergency department. We observed a patient assessed as high risk of suicide, who absconded three times from the emergency department during the two days we were on site.

The trust’s scored “worse than” other trusts for three questions and “about the same” as other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you</td>
<td>5.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td>RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>first spoke to a nurse or doctor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>7.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.1</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The median time from arrival to initial assessment was worse than the overall England median in the entire period from February 2017 to January 2018. The trust showed a gradual decline from November 2017 onwards, never getting within two minutes of England average at any time.

We reviewed trust data for the national target for ambulances to handover within 15 minutes. Data showed that the average percentage time to assessment within 15 minutes for patients who arrived by ambulance between May 2017 and April 2018 was 58% for paediatric patients and 39% for adult patients.

Ambulance – Time to initial assessment from February 2017 and January 2018 at North Middlesex University Hospital NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

From March 2017 to February 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at North Middlesex University Hospital NHS Trust. Throughout the entire reporting period, the trust fluctuated from 68% to 76% of all ambulance journeys having a turnaround time over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes - North Middlesex University Hospital NHS Trust
Ambulance: Percentage of journeys with turnaround times over 30 minutes - North Middlesex University Hospital NHS Trust

(Source: National Ambulance Information Group)

From March 2017 to February 2018 there was a decline in performance in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at the trust. This decline was most noticeable from November 2017, after a short period of improvement of performance.

A black breach occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From February 2017 to January 2018 the trust reported 219 black breaches, 95 of which were recorded in January 2018 and 36 in December 2017.

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)
Nurse staffing
The trust reported their registered nursing staff numbers as below as of January 2018.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and Emergency Care</td>
<td>161.5</td>
<td>145.97</td>
<td>90%</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018, the trust reported a vacancy rate of 13.6% in urgent and emergency care; this was worse than the trust standard of 7.5% and worse than at the time of the last inspection when it varied between 2% and 12%. Shortages were experienced across adult and paediatric nursing. The turnover rate of 12.1% from February 2017 to January 2018 was better than the trust standard of 15%. The trust reported a sickness rate of 4% in urgent and emergency care for the same time period, which was worse than the trust standard of 3.5%. The current paediatric emergency department vacancy rate was 34%.

Bank and agency staff were used to maintain numbers and an appropriate skill mix of nursing staff in the department. We saw there was a robust induction for agency staff, which the senior nurse on duty went through and signed off before they went on the floor.

Senior leaders told us staffing levels across the hospital were assessed twice a day at ‘safecare’ meetings which were chaired by the divisional representative of the day and attended by staff from the emergency department. When staffing concerns were raised at this meeting, as they impacted on patient safety, agreement was reached that available staff would be redeployed to the ED. Staffing levels were based on Royal College of Nursing guidelines which included two nurses to one patient in the resuscitation area and one nurse to four patients in ED majors. Nursing staff we spoke with told us that there was sufficient staff on duty to ensure patient safety. They said when there were unexpected shortages on shift, the matron and the deputy head of nursing stepped in to support the shift. There was a process to deal with occasional nursing shortages in the FIT zone where a nurse from ED majors would move across to cover the shortage.

The trust reported that the emergency department was one of the five areas with the highest use of bank and agency staff. The table below was submitted by the trust following the inspection. It shows that between May 2017 and April 2018 the average bank usage was 60% and agency was 23%. The unfilled shift rate was 17% for the same period.

The trust did not currently monitor the numbers or percentage of shifts which did not have a nurse with paediatric life support (PLS) training in line with RCEM guidance. However, we were told that the paediatric ED was always staffed by paediatric nurses with PLS training as part of their training requirement and appraisal.

The trust did not employ qualified mental health nurses (RMNs). When a RMN was required, the charge nurse requested one from the NHS bank staff. Staff said that they could get an RMN within one hour.
Medical staffing
The trust reported their medical staffing numbers below as of January 2018.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and Emergency Care</td>
<td>64.2</td>
<td>50.25</td>
<td>78%</td>
</tr>
</tbody>
</table>

There were seven consultants in substantive posts although the budgeted establishment was for 14 whole time equivalent (WTE). The other seven posts were covered by locum consultants on fixed term contracts. There was 15 hours weekday consultant cover between 8:00am and 11:00pm. Consultants told us that whilst the roster did not go up until midnight, they were always in the department until then, and used the hour between 11:00pm and midnight for handover. Three consultants covered 15-hour shifts on Saturday and Sunday (9:00am – 4:00pm; 13:00 – 8:00pm; 4:00 – 11:00pm on-call). Consultant cover was not in accordance with the Royal College of Emergency Medicine recommendation to provide consultant presence in the ED, 16 hours a day seven days per week as a minimum in all emergency departments.

There were 16 middle grade doctors in substantive posts although the budgeted establishment was for 21 whole time equivalent (WTE).

Paediatric emergency department staff told us there was a full clinical rota which included two paediatric emergency consultants who worked eight-hour shifts Monday to Friday. The additional cover was met by an ED consultant and middle grade doctors.

Staff we spoke with told us there was a sufficient number of medical staff. Those who were around at the time of the previous CQC inspection in September told us staffing levels had improved, especially at night. There were usually four middle grade doctors and five junior
doctors in the department at night-time, with one middle grade doctor in the paediatric emergency department at all times. We were told there was a general willingness from senior staff to cover extra shifts at times of shortage.

We were told that the allocation of medical staff on the shop floor took into account the skill mix, grade and training needs. One doctor told us they were recently allocated to the FIT zone, which gave them valuable experience in triage. Others told us they were placed in the resuscitation area where they were monitored by more experienced doctors as well as in the paediatric ED.

The clinical director told us they considered staffing to be one of their top priorities, in particular, the recruitment of consultants to substantive roles. In the meantime, there will be a new rota introduced in June 2018 which they expect to underpin the safety of the department.

We observed a medical handover which was punctual and well attended. There was a discussion about patient safety, capacity in the department and bed availability in the rest of the hospital. Staff were allocated to different areas of the department at the end of the handover.

From February 2017 to January 2018, the trust reported a vacancy rate of 13.1% which was worse than the trust standard of 7.5%. The turnover rate was 49% against the trust standard of 15%. The sickness rate was 1.7% which was better than the trust standard of 3.5%.

The trust reported that A&E medical staff were one of the highest uses of bank and locum staff in the trust. We were told that no locum doctors were booked to cover night duty unless they were competent in advanced paediatric life support (APLS).

During December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 40-whole time equivalent staff working in Urgent and Emergency Care at North Middlesex University Hospital NHS Trust:**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>26%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>36%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (STr) 1-6
* Junior = Foundation Year 1-2 on

(Source: NHS Digital Workforce Statistics)

**Records**

Records were a mix of electronic and paper. We reviewed 20 paediatric patient records which were held in booklet format to ensure that essential information was kept in the same place. It
included mandatory fields which included paediatric early warning scores (PEWS for children) to alert staff to the deteriorating patient; sepsis 6; weight and observation. Some areas were not consistently captured; for example, there were no allergies, discharge details or safeguarding information recorded on five out of 20 records. Time of medication prescribed was missing on two records.

We reviewed 24 patient records in the adult emergency department and found that there was inconsistent recording of information. For example, early warning scores were not recorded on five out of 24 notes and pain scores were not recorded on seven. Sepsis screening was not recorded on eight out of 24. There was also inconsistent complete of the multidisciplinary ED safety checklist. This was retained in patient paper records and included a list of tasks to be completed each hour over a four-hour period. However, allergies were noted on all records as well as skin and falls assessments where relevant.

We also did a review of 12 further patient records focussed on patient discharge and advice given on discharge. We found that seven were signed off by the discharging doctor. There were three records where advice was relevant and we saw that each of the three were given ‘worsening advice’ where they were told to contact GP or return to the department if they experienced certain symptoms. However, the ward transfer checklist was not completed on the five patients who were admitted to a ward.

Patients who presented to the emergency department in a mental health crisis were not always assessed and treated in a safe manner. We reviewed care notes for five patients who had mental health issues, four of whom were at risk of suicide. Staff did not fill in the safeguarding prompt on the care records and three of the care records did not have a mental health assessment or record of observations.

We looked at clinical records inspection reports for March, April and May 2018, which looked at five random patient records and were electronically recorded. Completion rates varied with 94% completion in March, 65% in April and 62% in May. There were significant variations noted in what was recorded; for example, accurate calculation and escalation of National Early Warning Scores (NEWS) was 100% in March, 80% in April and 33% in May. Comfort rounds were recorded 80% on the time in March and April and 40% in May. Where dementia screening was applicable, this occurred 100% of the time in March but 0% of the time in April and May. Appropriate recording of drug charts was 75% in March and 100% in April and May. Appropriate cannula care recording was 40% in March, 25% in April and 27% in May. We spoke with the interim assistant head of nursing who told us one of their priorities was to improve the accuracy of record keeping.

We noted that poor documentation by doctors was highlighted in a local audit (acute Kidney injury) In February 2018. Their findings noted there was no standardised structure and layout followed and discharge time was not documented in 92% of patient records.

**Medicines**

During the previous CQC inspection in September 2016 we told the trust they must ensure that all medicines and instruments associated with resuscitation were disposed of safely after use. During this inspection we found that this was no longer a concern; staff ensured they disposed of medicines and instruments safely after use.

Administered medicines were electronically recorded and evidenced the medicine and dose given, as well as the name and registration number of the nurse who administered it.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs and their storage and dispensing are regulated by legislation. Controlled drugs should be kept in a separate locked cupboard with those keys kept separately from the main cupboard keys;
counted twice daily and when dispensed, signed by two members of staff in a separate controlled
drugs register. We checked controlled drugs and confirmed that this procedure was followed in
accordance with safety guidelines.

Intravenous fluids were stored safely, off the floor and were in date. Water and saline for
injections were in 10ml vials and stored safely. There was a plentiful supply of purple enteral
syringes in varying sizes; these are vital when administering accurate amounts of liquid
medication.

Fridges in all areas were recorded daily and the log showed they remained within safe
temperature range.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers
follow national guidance on how to prevent them. Each never event type has the potential to
cause serious patient harm or death but neither need have happened for an incident to be a
never event. There were no incidents classified as a never event between March 2017 to
February 2018.

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents
(SIs) in urgent and emergency care which met the reporting criteria set by NHS England from
March 2017 to February 2018. Of these, the most common types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results)
  with nine (47% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with four (21% of total
  incidents)
- Apparent/actual/suspected self-inflicted harm meeting SI criteria with two (11% of total
  incidents)
- Treatment delay meeting SI criteria with two (11% of total incidents)
- Slips/trips/falls meeting SI criteria with one (5% of total incidents)
- All other categories with one (5% of total incidents)

(Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

Following the CQC inspection in September 2016, the trust was told it must ensure that learning
from incidents was shared with all staff. Since then, learning was shared in the A&E meetings
with all staff. It is also discussed at the trust wide serious incident assurance & learning group.
We saw that a newsletter which listed learning from serious incidents was produced by the
associate medical director of patient safety and sent to all staff. Root cause analyses of serious
incidents were carried out and included future learning and ways in which learning should be
shared.
There were 1710 incidents recorded on the electronic incident reporting system between May 2017 and April 2018. Of these, 1443 were no harm; 299 low harm; 28 moderate harm; five death (due to the incident rather than to natural course of patient's illness or underlying condition) and five severe.

The incidents related to death included all specialties failure to diagnosis/delay in diagnosis; failure of follow-up arrangements; incidents in community from absconded/discharged patients and wrong diagnosis made.

The severe harm incidents included missed diagnosis; wrong diagnosis; fall; unscheduled transfer and all specialties failure to diagnosis/delay in diagnosis

The most frequently occurring moderate harm incidents included six delayed treatment incidents; three all specialty delay or failure to diagnose and three admission and discharge incidents.

We spoke with a wide range of staff, many of whom were present at the last inspection. The general consensus was that there was increased emphasis on incident reporting and feedback from incidents. There was a clinical governance whiteboard in the seminar room on which were displayed complaints, themes and learning. Handovers for nursing and medical staff were held in the seminar room and the governance board was referred to at handovers. Staff said the fact that it was so visible and current meant that there was on-going awareness and discussion of incidents.

Information about incidents was shared with staff at safety huddles which were held during the day; as well as at staff meeting and handovers. Learning from incidents was shared in a number of ways including in safety huddles.

Each member of staff we spoke with told us they were encouraged to report incidents even if they were not sure whether it constituted an incident. They said there was no sense of blame attached and there was emphasis placed on seeing each incident as a learning experience. Senior members of staff told us they encouraged staff to report incidents as there was always something to be learnt from them.

Staff spoke with confidence about how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations. For example, one nurse told us of an incident they reported related to a pressure ulcer. They received feedback, and an increased emphasis on pressure ulcer avoidance was included in handovers for a period of time.

Most staff we spoke with were familiar with the current serious incidents in the department. They told us of the impact lessons learnt had on the way they managed patients; one of which related to a diagnostic incident including delay of treatment. They told us that all ‘risky’ patients must have an ECG within 15 minutes of arrival and the results must be shown to a consultant for interpretation. Other learning included the checking of blood results prior to patient discharge.

The trust submitted data following the inspection for time to ECG between January and May 2018. Average response times over 14 weeks showed that 31% of patients had an ECG in less than 15 minutes; 25% between 15 and 30 minutes; 22% in 30 to 60 minutes and 25% in more than 60 minutes.

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of
suggested data collection date. Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from February 2017 to February 2018 within urgent and emergency care.

Is the service effective?

Evidence-based care and treatment
The emergency 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 that was provided.

At the previous CQC inspection in September 2016, we told the trust it should develop a chest pain pathway and a frailty pathway. A chest pain pathway was subsequently introduced; however we were told the frailty pathway was not yet developed.

A range of other clinical care pathways and proforma had been developed in accordance with national guidelines. These included treatments of deep vein thrombosis, cellulitis, sepsis, urinary tract infection, stroke, low risk chest pain and low risk pulmonary embolism. A paediatric fracture pathway was also developed since the time of the last CQC inspection. We found pathways were understood by staff and were being used effectively to manage patients’ care.

The policies, care and treatment pathways, and clinical protocols we reviewed were based upon recognised guidance, including that of the National Institute of Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM). However, the way in which they were stored was inconsistent; those that were on the trust intranet were generally out of date and the clinical lead told us they had no control over updating them.

In order to mitigate the risk of ED staff accessing out of date guidelines, ED specific clinical policies were updated and stored on a separate computer drive, accessed using a different computer log-in and password. These included policies on the use of antibiotics, chest infections and venous thromboembolism; as well as head injury and jaundice. We were told that new staff were shown how to access this drive. We found there was mixed understanding amongst new and longer-term staff about where and how to access the most up to date policies. We asked five staff of different grades to show us policies and three of these accessed the trust site, with the out of date policies. Those that went to the correct computer drive told us it was often inaccessible or off line. We had a discussion with the clinician responsible for this area who told us they would ensure that staff were made aware of the most reliable way to access up to date policies.

There was a range of audits carried out locally. We saw the results of the most recent monthly audit of patient records in the paediatric emergency department which showed that each area scored above 90% apart from correct completion of drug charts which scored 76%. In another local audit carried out in February 2018 (acute kidney injury), findings noted there was no standardised structure and layout followed and discharge time was not documented in 92% of patient records. The recommendation was that discharge advice, safety netting and follow-up must be documented and doctors should be made aware of the consequences of poor record keeping. This standard will be re-audited in August 2018.

The department was currently participating in the fractured neck of femur and management of pain in children national audits. There were four quality, innovation, productivity and prevention initiatives (QIPPs) underway in the department. The integrated urgent care QIPP was initiated in October 2016 in conjunction with local clinical commissioning groups. It proposed to bring together and enhance current urgent care services which are outside of hospital, in order to create a single, unified integrated urgent care service for patients. The ED front door streaming
and redirection QIPP was initiated in July 2017 the aim of which was to ensure that patients received the most appropriate care in the most appropriate setting and unnecessary long waiting times in ED were reduced or avoided.

Other proposed QIPPs included reducing non-elective admissions for children and frequent attendees. The frequent attendees QIPP proposed to improve frequent user management to enhance clinical quality and reduce system demand; generate multidisciplinary care plans to assist clinicians and the patient access the right care at the right time in the right place; promote the sharing of information to support clinical assessment, safety, health and well-being of the patient; identify and prioritise frequent health and social care system users who would receive the greatest benefit from the process.

**Nutrition and hydration**

In the CQC Emergency Department Survey, the trust scored 5.4 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was worse than other trusts.

Following the CQC inspection in September 2016, we told the trust that it should improve the provision of snacks to patients who have been in the ED department for long periods of time. During this inspection, we observed a member of the housekeeping staff regularly offer hot or cold drinks to patients. They told us they gave food to patients who were in the department for longer than four hours.

Patients we spoke with were satisfied with the level of fluids they were offered. The housekeeper worked from 8:00am to 5:00pm after which it was the responsibility of either the nurse or healthcare assistant to ensure patients had sufficient food and drink. We returned for an unannounced evening visit to the emergency department on one of the inspection days. We observed nursing and healthcare staff serving food and drink to patients, despite the general busyness of the department at that time.

**Pain relief**

In the CQC Emergency Department Survey, the trust scored 4.3 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was worse than other trusts.

The trust scored 6.8 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was worse than other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>4.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>6.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>5.4</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

Our review of patient records showed there was inconsistent recording of pain scores. Pain scores were not recorded on seven out of 24 adult records reviewed.

**Patient outcomes**

In the 2016/17 Moderate and Acute Severe Asthma report, the trust failed to meet any of the standards.

The hospital was in the upper UK quartile for two standards:

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and
recorded on arrival at the ED. Hospital: 41.7%; UK: 26%.

- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). Hospital: 37.5%; UK: 19%.
  - Standard 5b (fundamental): within 4 hours (moderate). Hospital: 66%; UK: 28%.

The hospital was in the lower UK quartile for two standards:

- Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. Hospital: 6.7%; UK: 19%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 11.7%; UK: 25%.

The hospital’s results for the remaining three metrics were all between the upper and lower UK quartiles. In response to this, changes were introduced to improve oxygen delivery and early bronchodilator delivery. We saw that ED Casualty cards were amended to include oxygen prescription and peak flow chart. There was no re-audit done to measure improvements in this standard at the time of this inspection.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Consultant sign-off audit, the trust failed to meet any of the standards.

The hospital was in the lower UK quartile for three standards:

- Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Hospital: 3.3%; England: 11%. ST4 Reviewed Hospital: 26.7% England: 43%
- Standard 2: Consultant reviewed – fever in children under 1 year of age 100%. Hospital: 0.0%; England: 8%. ST4 Reviewed Hospital: 10.0% England: 48%
- Standard 4: Consultant reviewed - abdominal pain in patients aged 70 years and over 100%. Hospital: 0.0%; England: 10%. ST4 Reviewed Hospital: 60.0% England: 40%

The hospital did not report data for the remaining standard relating to patients making an unscheduled return to the ED with the same condition within 72 hours of discharge.

In response to these poor results, the trust told us there was increased consultant cover during afternoons, evenings and at weekends, as well as 24 hours a day seven days a week increased middle grade cover. There was no further re-audit to measure the effects of this increase in medical cover.

In the 2016/17 Severe sepsis and septic shock audit, the trust was in the upper UK quartile for four standards:

- Standard 4: Serum lactate measured within one hour of arrival. Hospital: 77.2%; UK: 60%.
- Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 63.8%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 66.3%; UK: 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. Hospital: 70%; UK: 44.4%.

The hospital was in the lower UK quartile for one standard:
• Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 51.3%; UK: 64.6%

The hospital’s results for the remaining three metrics were all between the upper and lower UK quartiles.

The National CQUIN on Sepsis was included in the local commissioning contract for 2017/19. Local audit results showed improvements for 12 weeks between January and May 2018.

• There was 100% compliance on the screening requirements
• 100% of blood cultures were achieved within one hour
• 75% of antibiotics administered within one hour of arrival

In the 2015/16 Vital signs in children audit, the trust failed to meet any of the standards.

The hospital was in the upper England quartile for one fundamental standard and one developmental standard:

• Standard 1 All children attending the emergency department with a medical illness should have a set of vital signs consisting of: Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. The hospital score was 56% against the England median of 37.6%.
• Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). The hospital score was 91.4% against the England median of 69.7%.

The hospital was in the lower England quartile for two developmental standards:

• Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. The hospital score was: 0% against the England median of 4.4%.
• Standard 5 (developmental). Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). The hospital score was 0% against the England score of 60%.

The hospital’s results for the remaining two metrics were all between the upper and lower England quartiles. We were told that measures were introduced to improve on these results which included increased consultant cover during afternoons, evenings and at weekends, as well as 24 hours a day seven days a week increased middle grade cover. Paediatric ED casualty cards were updated to ensure that essential information was captured. We saw they were designed as a booklet to contain information in one location. There was no further re-audit to measure the effects of these changes.

In the 2015/16 Procedural sedation in adults audit, the trust failed to meet any of the audit standards (which were all 100%). The hospital was in the upper England quartile for two fundamental standards:

• Standard 1 (fundamental): Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
Standard 1a ASA grading. Standard 1b. Prediction of difficulty in airway management. Standard 1c Pre-procedural fasting status
The hospital score was 35.5% against the England score of 7.6%.

- Standard 5 (fundamental): Monitoring during procedural sedation must be documented to have included all of the below:
  Standard 5a Non-invasive blood pressure. Standard 5b Pulse oximetry. Standard 5c Capnography. Standard 5d ECG
  The hospital score was 67.7% against the England score of 23.9%.

The hospital was in the lower England quartile for one developmental standard:

- Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. The hospital score was 0% against the England score of 41%.

The hospital’s results for the remaining four metrics were all between the upper and lower England quartiles. This was scheduled for re-audit during 2018.

The trust did not take part in RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16.

**Unplanned re-attendance rate within 7 days - North Middlesex University Hospital NHS Trust**

![Graph showing unplanned re-attendance rate](image)

(Source: NHS Digital - A&E quality)

From February 2017 to January 2018, the trust’s unplanned re-attendance rate to ED within seven days was worse than the national standard of 5% and also worse than the England average. There was a notable improvement in the trust’s performance in October 2017, where the performance was below the England average but dropped in November 2017. The average performance between January and April 2018 was 7.4%.

**Competent staff**

There was protected training time for all doctors each week and we were told it was of a high standard. Doctors told us there was a good culture of teaching and learning in the department. Training was consultant led, pre-planned and tailored to the needs of the emergency department. They also said their training was seen by all as a priority and they were always supported to attend, no matter how busy the department was.

We spoke with the educational lead who was a consultant with protected time to develop and
maintain a properly evaluated education programme for medical staff. The programme was initiated in September 2017 and teaching was delivered in a variety of ways, including simulation based training and peer to peer learning for consultants.

There were programmes developed to meet the on-going learning needs of all doctor grades. There was a weekly rolling programme for junior doctors which included sessions delivered by other specialities within the hospital. On the day of our inspection, we spoke with a cardiologist who had just delivered training. They told us they were booked to run a session at various times throughout the year as part of this more formalised teaching programme.

The education lead developed a two-year programme for middle grade doctors who previously were not included in any structured teaching. This two-year programme was based on the acute care common stem core training programme (ACCS), which provided a knowledge base to work in emergency medicine. Every middle grade was supported to access the Royal College of Emergency Medicine training and hold a portfolio. In this way, their competencies could be checked and maintained.

The ED department currently supported doctors who wished to become emergency medicine practitioners, but had not previously trained in emergency medicine, to study for the certificate of eligibility for specialist registration (CESR). This represented a significant level of commitment by the participating doctor and their mentor.

There was also a ‘you said we listened’ slot at the end of the junior doctor session where they could raise concerns and issues in confidence with the teaching consultant, out of which joint projects were planned to address these issues. Junior doctors spoke positively of the teaching and said the opportunity to express their concerns in a safe space was very valuable and supportive.

We observed consultants supporting junior medical staff to review patient notes and results. This was followed by a joint discussion about probable diagnosis and a mutually agreed treatment plan.

Medical and nursing staff told us the new FIT zone provided a valuable training opportunity for triage and rapid assessment of patient healthcare needs. Health care assistants told us they were supported to develop within their roles and had been trained to take bloods, dress wounds, cannulate, take observations and do ECGs.

We were told training for nurses had improved and been more formalised over the past two years although it was difficult to release staff on occasion due to shortages.

Nurses in the paediatric emergency department (PED) told us they were on an 18-month rotation programme between the wards and the PED which was effective in maintaining their paediatric nursing skills. Student nurses told us there was a positive learning environment throughout the department.

Emergency nurse practitioners in the urgent care centre spoke positively of the encouragement they were given to take an advanced nurse practitioner course. Other nurses told us they had been asked to consider doing a leadership course.

From February 2017 to January 2018, 83% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the table below:
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<thead>
<tr>
<th>Staff Group</th>
<th>Number of individuals required</th>
<th>Number completed</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
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</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>23</td>
<td>21</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>152</td>
<td>124</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Staff - Hospital</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
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</tbody>
</table>

The trust submitted data following the inspection which showed that the nursing appraisal rate was 79% and 100% for doctors at the end of April 2018.

The trust did not provide mental health act (MHA) training to staff as a separate module and staff told us that they had not received MHA training. They told us that they were frustrated by their lack of knowledge around the MHA because they often cared for patients who had mental illness. Trust data showed that 49 patients attended the hospital after attempted suicide during the previous year, four of them in the week leading up to this inspection. We observed security staff members supporting patients with mental health needs who displayed challenging behaviour in the emergency department. We confirmed that nine of the 14 security staff members did not have mental health training.

**Multidisciplinary working**

CQC commented at the previous inspection in September 2016 that there was poor multidisciplinary working (MDT) amongst nursing and medical staff in the department, particularly with the consultant body. There were also areas of weaknesses with MDT working with other departments within the hospital.

During this inspection, we were told by doctors and nurses alike that MDT working within the department was now an embedded part of their work. Nurses, healthcare assistants and doctors spoke of teamwork and joint working and the way in which it enhanced good working relations as well as improved patient safety.

A consultant told us that MDT working with other specialties had greatly improved since the last inspection, though it remained a work in progress. There was a definite improvement in how other departments understood the need to be responsive to the emergency department in order that their patients had a good experience and flow was increased. For example, specialties attended the ED more rapidly and more frequently to review patients, which led to quicker decisions about their care and appropriate pathway. However, they said that there still needed to be more work done to increase patient discharges throughout the hospital in order to move patients out of ED and onto wards more quickly.

We were told that doctors from other specialties which included gastrology, endocrinology and care for the elderly recently worked alongside ED staff on the shop floor. This served a dual propose; ED staff learnt from these specialisms and the visiting doctors gained a better understanding of the challenges which ED staff faced on a daily basis.

Many staff spoke positively about the creation of the division of medicine and emergency care. They said it meant that there was increased sharing of information and better communication with specialties throughout the hospital, as well as the potential for pooling resources.

**Seven-day services**

There was 24 hours a day seven days a week access to diagnostics, x-ray, computer tomography (CT) and endoscopy in the emergency department. There was also access to the rapid assessment, interface and discharge (RAID) psychiatric liaison service as well as child and adolescent mental health service (CAMHS) team.
There was access to the admission avoidance team, discharge co-ordinators and the alcohol liaison service. Pharmacy was available until 2:00pm on Saturdays and Sundays.

**Health Promotion**

There was a variety of leaflets to promote good health within the department. Health care assistants told us they discussed healthy eating with patients, particularly those with diabetes or a heart condition.

Doctors spoke of the importance of educating the general public to encourage them to consider options other than attending the A&E in the first instance.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

The trust did not provide Mental Capacity Act (MCA) training as a separate module for staff. Instead, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training was included in Safeguarding Adult Level 2 training which is provided as face to face training. We were told that the framework for Mental Capacity Act and Deprivation of Liberty Safeguards was included in the trust training strategy and the levels of training required by each staff group was identified. The safeguarding lead nurse planned to provide additional specific MCA & DoLs training during May and June 2018.

Staff we spoke with said that they did not have MCA training, and if they had questions regarding a patient’s capacity, they would ask the psychiatric liaison team to assist them and to carry out a MCA assessment if necessary. The psychiatric liaison team told us that it was not within their remit to carry out MCA assessments though they were frequently asked them to do so. The trust policy stated that clinicians responsible for the patient’s care should carry out a MCA assessment using the MCA template which is available.

We observed an episode of potential restraint with two security officers and a police officer ready to restrain a patient with challenging behaviour in the emergency department which staff said was a regular occurrence. However, episodes of restraint were not raised as an incident on the internal incident reporting system; and the security staff members did not fill in an incident form themselves.

The trust did not keep numbers of episodes of restraint or monitor its use. The incident reporting policy did not specifically mention logging episodes of restraint as an incident, although staff said this should happen. This meant that the trust did not have oversight of the use of restraint.

Staff understood the importance of obtaining consent; we observed doctors and nurses introducing themselves as they engaged with patients. They confirmed that patients understood any treatment and asked consent before the examination was progressed.

**Is the service caring?**

**Compassionate care**

The way in which the new fast initial treatment (FIT) zone in the majors area of the department was configured made it difficult at times to maintain patient privacy and confidentiality. We were able to overhear the conversations between staff and patients in this area. There were six chairs in the ‘sit to treat’ area, which was separated from the sitting area by a temporary screen. When all six chairs were occupied, it meant that patients were in close proximity to each other.

Nurses told us it was a challenge at times to speak in confidence with a patient and the screen which divided the treatment area from the sitting area did not act as a sound barrier. They did say that if the procedure required was likely to compromise patient dignity, for example when doing an ECG, they would help the patient to move to a cubicle. They acknowledged that at times it
was not always possible to move the patient to a cubicle and they discussed with the patient whether they were comfortable to go ahead with the treatment in the FIT zone.

We spoke with several patients who were seated in the FIT zone during the course of the inspection, none of whom felt their privacy or dignity was compromised. One told us, “there is nothing the staff are doing that makes me feel embarrassed; I'm just glad that I am being seen so quickly.”

We heard doctors and nurses introduce themselves to patients and carers and explain what their role was. Patients told us they appreciated this, “it makes them [staff] seem more approachable.”

We saw when staff assisted a patient to the bathroom; they first made sure their hospital gown was long enough to fully cover them. They respected the patient’s strong desire to walk rather than use a wheelchair, despite the length of time it took them away from the area when they accompanied the patient.

We observed a nurse interact with a patient who chose to sit in the general waiting area in their hospital gown until transport arrived to transfer them to another hospital. They gave them frequent updates on the expected arrival time of the ambulance and invited them back into the emergency care area to wait. At one point, the nurse sat with the patient to ask whether there was any other person they wished to contact.

Parents whose child was in the resuscitation area were supported by a nurse throughout the whole resuscitation area. We heard how the nurse explained to them what was happening and when possible, the doctors involved also came to speak with them.

The 2017 NHS patient survey results showed that 68% of patients said they received the right amount of information about their condition or treatment. 72% said they were given enough privacy when being examined or treated.

The trusts urgent and emergency care Friends and Family Test (FFT) performance which reports on the percentage of patients who would recommend the department to family and friends was generally worse than the England average from January 2017 to December 2017. It was 67.4% in January 2018 which was worse than the London average (82.5%). However, this shows a steady improvement since July 2017 when the scores were below 50% for the previous seven months.

Data submitted following this inspection showed the February result was 69%; March 66% and April 95%. Actions taken to improve response rates included new FFT terminals which were recently installed. The terminals were easy to use and included a variety of languages. In addition, ED staff had access to hand held devices which they could give to patients to complete the FFT survey.

Emotional support
Emotional support was provided to patients and relatives. There was a relative’s room in ED where family members could go to when their relative was gravely ill or had died. This enabled them to have confidential discussions with the medical and nursing team away from the general busyness of the department.

Staff told us there was usually a team debrief whenever there was a traumatic death in the department. This was done with the whole team involved and lead by senior doctors.

Understanding and involvement of patients and those close to them
Staff had access to communication aids to help patients better understand their care and treatment. This included easy read versions of information leaflets and communication booklets with pictorial and sign language graphics.
Most patients and their relatives received regular communications and were kept informed about their care, treatment and condition. Staff made sure patients and relatives understood the assessments being done and the likely diagnosis and treatment plan. Patients and relatives were given opportunities to ask questions and staff gave them time to do this.

One patient told us staff took the time to explain to them what any planned procedure involved. We observed nurses in the UCC carefully explain to patients the type and dosage of their take home medication.

The results of the CQC Emergency Department Survey 2016 showed that the trust scored worse than other trusts in eight of the 24 questions relevant to caring. The remaining 16 questions were about the same as other trusts.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>6.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to</td>
<td>7.2</td>
<td>About the...</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>be in decisions about your care and treatment?</td>
<td></td>
<td>same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>3.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>3.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>4.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
Is the service responsive?

Service delivery to meet the needs of local people
There was a sufficient amount of seating in the general waiting area. Patients registered at reception, then waited to be called by a streaming nurse. In the reception area staff were seated behind a glassed desk area with two heights, which meant people who used wheelchairs were able to speak comfortable with a receptionist. 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.

At ‘risk’ or complex patients, which included those living with dementia and learning-disabled patients were ‘fast tracked’ from the time they booked into reception. The streaming nurse was made aware of their presence when in the waiting area and they were removed from the queue for more rapid assessment. Patients without hearing or sight were given a coloured card to hold when in the waiting area; this made them identifiable to the assessment nurse who collected them from the waiting area. We saw this in operation and a patient subsequently told us they appreciated the extra care taken to ensure they did not miss their assessment slot.

Some patients who were deemed frequent attenders had an alert on their electronic record, although there is no other guidance or information about what to do when they next attended the emergency department. We were told there were no current advance plans for these individual patients although there was a recently initiated quality, innovation, productivity and prevention initiative (QIPP) to look at how best to manage frequent attenders.

There was an urgent care centre (UCC) at North Middlesex University hospital which included one assessment room, two streaming rooms, three GP rooms and a sitting area for four patients. It was led by emergency nurse practitioners (ENP). It was a 24-hour, seven day a week service staffed by GPs start from 9am (three GPs overlapping) with the last GP finishing at 12 midnight. There were four ENPs who covered staggered shifts between 8:00am to 12 midnight and one ENP from midnight to 8:00am. There was GP cover between 9:00am and midnight. Staff from the ED majors supported the ENP after midnight and there was one middle grade doctor identified as being responsible to respond to requests for assistance.

Meeting people’s individual needs
There was a separate paediatric emergency department (PED) which treated children up to 16 years of age. Children aged 16 – 19 were seen in the main emergency department, unless they were in transition from paediatric to adult services. We noted that there was limited play provision; there was one part-time play therapist who worked across the paediatric wards and paediatric assessment unit.

The trust recognised there was on average two children per month going into emergency foster care directly from the hospital. In many instances, these children had no essential items to take to foster care. In response to this, there were age and sex specific backpacks of essential items provided for these children. The backpacks include pyjamas, pants, socks, toothbrush, toothpaste, felt tip pens, bubbles, superhero capes and masks, activities and a soft toy. Grab bags were provided for older children at risk of child sexual exploitation or gang membership. These included sanitary products and toiletries; as well as information on potential risks such as child sexual exploitation and gang culture. We were told that seven backpacks had been distributed since their introduction at the end of February.

From August 2016, all organisations that provide NHS care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to
identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

There was a trust wide Accessible Information Standard (AIS) Task & Finish Group which was attended by representatives from the ED. The purpose of the group was to progress the implementation of the AIS in local areas and had met twice to date.

Nursing and healthcare staff told us they received dementia training and patients with dementia were flagged on the electronic patient record. They were able to demonstrate to us some of the tools held in the department to aid communication with patients with a learning disability or communication difficulties. There were pictorial illustrations and pain scores were included, represented by a range of facial expressions and a numerical score.

The British sign language alphabet and Makaton symbols (a language programme which uses signs and symbols to help people to communicate) were also included in the tool kit. Receptionists had a leaflet which contained basic British sign language which they could refer to.

We spoke with a patient who was registered blind. They told us they had not been offered additional assistance to go to the bathroom. We subsequently reviewed their notes and there was no reference to their visual impairment in the communication needs assessment.

There was a flag on the electronic patient record to identify patients with a learning disability to staff. The alert signposted staff to the patient local learning disability specialist service and prompted them to ask for the patient hospital passport or purple folder. The passport recorded key information about the patient including their treatment and any medication they were on. Their preferred method of communication was recorded, as well as triggers for what made them feel happy or unhappy.

In order to further improve the service to patients with a learning disability, the trust recently acquired the local authority learning disability register and work was underway to upload that information onto the patient electronic medical record. It was hoped that this would capture all patients known to have a learning disability.

We were told that learning disability awareness training was delivered to ED nursing and healthcare assistant staff. This was delivered on scheduled training days and further sessions as requested. These were delivered during the staff team handover and education programme. There was an acknowledgement that further training was required for the medical team and an electronic learning training package was being explored.

The electronic patient record system automatically notified the trust learning disability liaison nurse when a patient was admitted. Staff told us they could access the learning disability liaison nurse for additional support; those that had done so told us they benefitted from the advice.

When there was a patient in ED who had dementia, staff told us they checked to see whether they came in with a care plan or asked the family member or carer about the patient. They told us interventions were done in the patient’s best interest; at times they consulted with the trust dementia nurse specialist to assist with the assessment. There was a dementia champion in the ED who also offered support and advice.
Receptionists showed us the patient booking in form which had some key questions written in the eight most common languages spoken by the local population. In addition, the department accessed an interpreting and translation service for those whose first language was not English.

The trust scored “worse than” other trusts for one question and “about the same” as other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.4</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Access and flow

All emergencies brought in by ambulance on a blue light were pre-alerted to the ED and taken straight to the resuscitation area. Other patients who arrived by ambulance were taken to the fast initial treatment (FIT) zone in the majors area and handed over by ambulance crew to the consultant in charge of the FIT zone. Patients were streamed at this point by a consultant and those patients fit enough to sit remained in the FIT zone and had bloods and vital signs taken. Where a patient was unable to sit, they were taken to a cubicle for their assessment.

Doctors and nurses told us there was a strong commitment to admission avoidance where it was possible to facilitate safe patient discharge. One way which this was achieved was to move patients from ED majors to the observation unit, which was staffed by one doctor (8:00am until midnight), two nurses and a healthcare assistant. The unit was for patients who did not require hospital admission but were not ready for discharge for up to 24 hours. Patients deemed to be frequent fallers were seen by the discharge intervention team. This was a multidisciplinary team comprised of a nurse, physiotherapist and occupational therapist. They often linked in with social services to ensure a safe discharge.

There was a five-bedded area in the unit as well as an area with six chairs for those patients who were assessed as fit to sit and were waiting for blood test or scan results. In addition, there were three side rooms with ensuite facilities. These side rooms were used where a patient was thought to be infectious or to avoid placing male and female patients in the same area.

There was an emergency department escalation policy the goal of which was to plan, coordinate, escalate, respond and recover from any surge activity and overcrowding to ensure patient safety. The policy described the escalation level criteria and risks which reflected the capacity of the ED and the process to be followed in the event of there being more patients than could be safely cared for. There was no record of the numbers of time it was triggered by ED. A senior nurse triggered the escalation policy during this inspection. We saw there was contact with a senior manager and there was an intense period of discussion about staffing requirements. More staff were allocated to the ED by the time we left the department.

The trust had a service level agreement with the local mental health trust and their psychiatric liaison team supported the trust to assess patients suffering from mental illness. The trust target was for these patients to be seen 95% of the time within one hour. The psychiatric liaison team said that they did not meet this target, and a review of minutes of meetings between the psychiatric liaison team and the trust over the last year showed that this target had not been met.
We were told this was due to resource constraints.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard across the entire 12-month period from February 2017 to January 2018, and averaged 70% during this period. Performance against this standard showed a gradual decline.

**Ambulance – Time to treatment from February 2017 to January 2018 at North Middlesex University Hospital NHS Trust**

![Graph showing time to treatment data](image)

(Source: Source: NHS Digital - A&E quality indicators)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust did not meet this standard on any occasion between February 2017 and January 2018. Data showed that this standard was achieved for 79% of patients between January and April 2018.

Departmental leaders told us their focus was to achieve the 90% target by September 2018. One of the ways in which they expected to achieve this was the initiation of the ‘Red2Green’ process in order to help with patient flow within the hospital. The ‘Red2Green’ approach is a visual management system to assist in the identification of wasted time in a patient’s journey. Patients were reviewed to establish whether anything was holding up their discharge. Increased patient discharge from the wards would have a positive impact on the transfer patients from the ED.

The trust breached the standard 12 times from February 2017 to January 2018 and performance against this metric showed a trend of decline. Data for February 2018 showed the trust performance improved and was 83% against the 4-hour target which was the highest ranking in over two years when compared with other trusts. It dropped down to 76% for March and rose to 84% in April.

The performance for the urgent care centre averaged 92% between January and April 2018. The performance for paediatric emergency department averaged 95% for this same time period.

From February 2017 to January 2018 North Middlesex University Hospital NHS Trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted showed some variance against the England average.
The trust submitted data which showed that 13% of patients waited longer than four hours to be admitted from decision to admit between May 2017 and April 2018. The highest percentages occurred in December (23%); January (17%); February (17%) and March (22%).

Over the 12 months from February 2017 and January 2018, two patients waited more than 12 hours from the decision to admit until being admitted. Both of these occurred in September 2017. We were told that in both of these cases, the patients were not stable enough to move to the ward.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb-17</td>
<td>218</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>243</td>
<td>0</td>
</tr>
<tr>
<td>Month</td>
<td>Number of patients between 4 and 12 hours</td>
<td>Number of patients over 12 hours</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Apr-17</td>
<td>237</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>269</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>299</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>262</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>243</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>158</td>
<td>2</td>
</tr>
<tr>
<td>Oct-17</td>
<td>206</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>225</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>616</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>447</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

Staff told us at times when the department was at full capacity, the escalation policy was initiated and medical and surgical teams came to the emergency department to assist and admit patients to the wards where appropriate. There was no data collected to show how often this escalation occurred.

From February 2017 to January 2018, the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average. From February 2017 to November 2017, performance against this metric showed a trend of gradual decline. The rapid drop to 0% in November 2017 may indicate a failure in data collection or reporting.

From February 2017 to January 2018, the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was higher than the England average. Data for December 2017 to April 2018 showed improvements from 8.5% of patients leaving without being seen in December to 5.9% of patients in April.

**Percentage of patients that left the trust without being seen - North Middlesex University Hospital NHS Trust**

From February 2017 to January 2018 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Trust performance showed minor variation in performance.
Learning from complaints and concerns
From January 2017 to December 2017, there were 59 complaints about urgent and emergency care services. The trust took an average of 33 working days to investigate and close complaints. Data submitted following this inspection evidenced there were 30 complaints between November 2017 and March 2018. Of these, just 57% were investigated and closed in line with the trust complaints policy, which states complaints should be resolved within 30 working days.

The general themes related to poor care and staff attitude. Improvement measures initiated included targeted training and feedback to individual members of staff in relation to their care and attitude following complaints made. We spoke with a senior member of staff about the sensitivities in relation to this. They told us it was made very clear to the individual members of staff that the exercise was not a punitive one. It gave them a chance to reflect and consider how they would respond differently to patients since patient care was the top priority for the department.

Is the service well-led?

Leadership
The emergency department was part of the medicine and emergency division. The management structure included a divisional director, clinical lead, deputy head of nursing and business manager.

Most staff told us members of the divisional leadership team were visible and approachable. One person said they felt listened to and cited the example of communicating by social media to notify of a broken fridge in the staff room. This was replaced within one week of the post being placed.

Managers told us they placed a high importance on empowering staff to feel confident to contribute to the on-going improvement of the department. They did this by seeking views and working alongside staff to develop a relationship of trust. One manager told us they felt roles needed to be more clearly defined; with those doctors and nurses in charge of a shift acting as role models of good clinical practice and quality patient interaction.

The ED matron held a regular ‘surgery time’ for nurses and healthcare assistants to address any
concerns they might have. There was evidence of senior nurse presence on the shop floor throughout the inspection. They monitored capacity and escalated as appropriate. For example, on one occasion there were five medical patients waiting to be admitted, this was escalated to the site manager and their admission was expedited.

**Vision and Strategy**

Most staff were aware of the trust values (caring; helpful; open and honest; teamwork) and the vision of providing excellent patient care. They told us they believed the department almost always provided good care and frequently provided excellent care.

The medicine and urgent care divisional business strategy 2018-19 aimed to achieve 90% compliance by September 2018 with the Department of Health’s standard for emergency departments that 95% of patients should be admitted transferred or discharged within four hours of arrival in the ED. The business strategy aimed to reach the national performance standard of 95% from March 2019. In addition, seven day working to support emergency flow and the hospital at night was also in the strategy.

Ways in which the standard of 95% was expected to be achieved included the efficiency of the recently introduced fast initial treatment (FIT) zone as well as recruitment and retention of medical staff in particular. Most staff we spoke with were aware of this ambition and said it met with their own expectations of the service. However, they were cautious when asked whether they thought the initial 90% standard and subsequent 95% were achievable within the time frame.

**Culture**

Staff told us they experienced the trust to be employee friendly and non-discriminatory. Doctors and nurses described the culture within the department as dynamic with a genuine sense of teamwork amongst the whole staff body. We were told that the cultural diversity amongst staff reflected the local population which helped to give a better understanding of culturally specific norms and their potential impact on the patient.

Many doctors and nurses who had worked in the trust for some years said the culture in the department had altered significantly, for the better. Teamwork was very evident and there was a general sense of doctors and nurses wanting to support each other. There was a general sense of positivism throughout the department. We were told that the emergency department team won the star team of the month award for March which they believed was testimony to this.

They said they felt re-energised by recent changes which included the introduction of the fast initial treatment (FIT) zone. They also said there was a flexible approach to their work pattern which helped to support a good work/life balance.

Health care assistants told us they were encouraged to develop their careers though some told us they would like the opportunity to progress to a higher band (band 4) which was not part of the current grade band at the North Middlesex hospital. Emergency nurse practitioners in the urgent care centre were encouraged to take an advanced clinical practitioner course and others were doing a leadership course.

Doctors and nurses told us how previously the trust leadership team placed most emphasis on savings, to the detriment of other areas, some of which impacted on patient safety and staff education. This had now shifted and there was emphasis on improving patient flow, as well as patient safety and education. This was evident in the support given to the development of the FIT zone, as well as giving a consultant the responsibility of developing a learning environment and robust teaching programme for all medical staff.

We were also told how local managers reminded staff that good performance was about patient safety, good care and patient experience and not all about breaches and performance. They reminded staff that breaches were often inevitable when acting in the patient’s best interest; for
example, not moving a patient from ED when they were too unstable or close to death, despite causing a breach for length of time in the ED.

There were appropriate security arrangements to keep staff and others safe and protected from aggression and violence. Medical and nursing staff told us the security guards were very quick to respond to their call for assistance at any time of the day or night throughout the week.

**Governance**

The leadership team, which comprised of a clinical director, deputy head of nursing and business manager met each week, chaired by the clinical director.

The current clinical governance lead was recently appointed to the role and it was their first time leading on governance. They acknowledged that there was a significant amount of work to be done in order to establish a robust governance structure but they told us they had the support of the wider department with this.

The clinical lead maintained the clinical governance whiteboard which was very visible in the staff seminar room. It was kept up to date with governance information which included trends in incidents and was used at handovers. Staff were reminded of serious incidents, current themes from incidents, as well as the top risks, daily staffing information and performance data. Staff we spoke with were able to reflect these risks, the current ones being staff shortages, pressure ulcers and long waiting times.

However, some staff told us the governance of the department was still a work in progress. We were told that learning from incidents was not always identified and shared and the department was often more reactive than proactive. The challenge was to develop a way in which learning from incidents was shared in a timely manner with all staff in the department and for this learning to become embedded. We spoke with the governance lead about this and they acknowledged there were inconsistencies with identifying learning and then sharing that learning; however, they were optimistic they had the support of colleagues and the leadership team to initiate good methodology and good practice around this.

Senior managers of the medicine and emergency care division contributed to the monthly trust level patient safety and outcomes committee. There was a four week rolling meeting programme at divisional level which considered risks, incidents and complaints; human resources and audit; risks, incidents and complaints.

However, the department did not currently have morbidity and mortality (M&M) meetings as part of this governance structure. These meetings review patient deaths and are recognised as an essential part of professional learning. They give assurance that patients are not dying as a consequence of unsafe clinical practices. We were told M&M meetings were in the process of being reinstated.

There was a daily incident meeting at which all electronically recorded incidents from across the medicine and emergency care division were reviewed. We observed one and noted the discussion was around which category the incident should be and staff who presented the incidents gave an outline of actions taken following the incident.

The governance of the paediatric emergency department came under the children and young people division.

There was a medicine and urgent care division ‘governance hotspots’ newsletter issued to all staff each month. This was a quick reference which highlighted top risks and responses; learning from recent incidents and safeguarding; learning from feedback; learning from quality improvement and audit. For example, the April newsletters listed staff vacancies, four-hour target and poor record keeping as the top risks. Learning from a serious incident related to non-escalation of a deteriorating patient included more rigorous safety huddle and patient handover.
Management of risk, issues and performance

The departmental risk register was reviewed monthly. There were eight current risks, the highest of which was the risk of non-compliance with the four-hour standard which was on the risk register since 2013. Controls put in place included daily review of performance; three daily bed meetings; two hourly escalation board rounds; band 7 patient flow coordinators; strengthened streaming process and the embedding of the fit zone. Increased movement of patients to the observation ward was also seen as a way to increase flow in the department. The second highest risk was training for middle grade doctors, on the register since 2016. The concern was this lack of training could compromise the quality of emergency care. A training needs analysis was undertaken and our discussions with the education lead assured us that this was being acted on. Other risks included non-compliance with the 15 minutes to initial assessment, which has been on the register since 2016, and time taken to handover patient from ambulance also on the register since 2016. These risks reflected what we found, what staff told us and we did not identify any risks that were not on the trust's risk register.

There were three further risks awaiting approval to go onto the risk register. One was listed as the inadequate medical staffing model in paediatric ED. The details noted the current model did not meet the demands of the service. In addition, there was a lack of continuity which meant that a new doctor was allocated to the paediatric emergency department each week, with limited opportunity to develop skills and competencies in paediatric emergency medicine. Requirements were put in place by the General Medical Council to ensure these doctors were adequately supervised. This meant there was one middle grade doctor allocated to the paediatric ED overnight. The detail of this risk stated that this put pressure on current resources and there was heavy reliance on locum doctors to provide support overnight.

Another risk awaiting approval was the introduction of the fast initial treatment (FIT) zone. The identified risk was that the change to the flow model to incorporate a new FIT Zone may lead to a reduction in patient flow. This could cause confusion over patient locations within the department which may result in a reduction to patient safety and patient experience. Controls in place included continued patient monitoring using the existing patient safety checklist and continued departmental monitoring using the existing departmental escalation board rounds.

The third risk waiting for approval was lack of capacity and unsuitability of environment in paediatric emergency department. Concerns raised stated that the space was not sufficient for the census of children seen (45,000) in accordance with the intercollegiate standards for paediatric emergency medicine. Other comments referred to the lack of confidentiality when discussing or referring cases, with no space to undertake consultations via telephonic language interpretation services. There was no separate area for young people or those with mental health, behavioural or learning difficulties. Our inspection of the paediatric department corroborated these points; we observed the department to be very crowded on occasion and there was no separate space for a parent to withdraw to with their child who had a learning difficulty.

Senior leaders told us their top risks included staffing and clinical governance. Staffing issues related to the lack of consultants in substantive posts. Recruitment to these posts was on-going and the hope was that most if not all posts would be filled within the next six months. In the meantime, current consultants and middle grade doctors were to be mentored to develop their leadership skills with regards to managing the department when on duty.

There was a management plan to ensure safe staffing by assessing acuity and need, and the trust RAG rated this each day. We saw plans to mitigate staffing risks as far as possible, and there had been some success in recruiting more permanent staff. Nonetheless, there were regular staff shortfalls even though as many shifts as possible were covered by bank and agency nursing and medical staff.

We found that clinical and nursing staff we spoke with were aware of the top departmental risks as listed by the leadership team. Performance was reviewed at daily bed meetings; other aspects of the department were also discussed including patients awaiting admission; staffing levels and infectious patients. Staff were
asked to list the current departmental main worries; the status of two patients with mental health issues was raised at the board round we attended. Plans for the night were discussed, including ways in which other areas of the hospital would offer support to ED as required.

**Information Management**
The department was able to monitor performance of accident and emergency performance against the four-hour standard throughout the day. This information was shared during bed management meetings. Clinical staff told us they focused on providing safe care first rather than trying to meet standards which they did not feel they had the capacity to meet.

Some staff expressed frustration at the frequency with which computers broke down. They acknowledged that the IT team responded quickly but they had to return to the department frequently.

The system in use was simple to operate and provided a good overview of patients in the department including their current status which made it easy for the doctor in charge to prioritise individual patients. Records were a mix of paper and electronic.

**Engagement**
The emergency department introduced a daily handover for medical staff since the last CQC inspection in September 2016. All handovers were held in the seminar room. This ensured patient confidentiality and staff could observe the governance board see the current themes, risks and learning, as well as staffing status.

We observed a medical handover which was punctual and well attended. There was a discussion about patient safety, capacity in the department and bed availability in the rest of the hospital. Staff were allocated to different areas of the department at the end of the handover. The nursing handover was structured in a similar way.

The clinical director acknowledged that whilst there had been some work to engage the adult population through meetings with the clinical commissioning groups and patient representatives, there was much work to be done around engagement with the 16 and 17-year-old patient group.

There was a trust wide action plan developed in response to the 2016 staff survey. Some ED staff told us they recognised measures put in place in response to concerns as they applied to ED. This included a heightened openness and honesty around incident reporting and a flexible approach to working patterns.

There was a monthly ED administration newsletter which updated staff on new staff and those who left as well as mandatory training and sickness levels. Staff used the trust social media group to communicate across the trust. Leaflets around the department encouraged patients and relatives to participate in the friends and family test. Patients could also complete the friends and family test via a hand-held device in the ED department.

**Learning, continuous improvement and innovation**
The trust was supported by the NHS Improvement Emergency Care Improvement Programme Team (ECIP); the main focus of which was improvement at the front of the hospital. A member of the ECIP team told us a new concordat was recently agreed between the trust, local clinical commissioning group, ambulance provider and ECIP. The concordat set out the next set of priorities which should be adapted in order to continue to improve patient outcomes and achieve greater efficiency.

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. This programme was still active and had two planned outcomes and 12 associated actions. The outcomes were improved timely patient journey through ED and increased ‘pull’ from specialties
which in essence meant increased engagement with other specialties to enhance multidisciplinary team work. The identified actions were all logged with start and projected finish time frames. Most staff we spoke with were aware of the actions and understood that the success of most involved depended on whole department commitment.

The medicine and urgent care division business plan 2018/2019 objectives included an increase in ED performance to 90% by Sept 2018 and 95% from March 2019; seven day working to be extended to support emergency flow and the hospital at night; introduction of nurse consultant role. The major areas of focus to achieve this were identified as the establishment of a robust workforce to give the board assurance that there is sufficient skill and numbers of nurses and doctors in the ED at all times; and the implementation of an innovative team approach to initial assessment and ambulance handover to improve patient safety and flow.

The workforce strategies included identification of exact numbers of doctors and nurses required per area and a rota to reflect that; ensure shifts and patterns aligned the medical and nursing staff as one functional team. Once actual staff numbers were agreed, the focus would be to maintain sustained recruitment into substantive posts in order to reduce agency staff usage. This would increase clinical safety and reduce financial spend. It was also acknowledged that the high sickness rate and associated financial cost of agency staff needed to be addressed.

We were told there was general support from the trust to introduce innovative ways of improving the functioning of the ED and cited the fast initial treatment (FIT) zone. Most staff we spoke with described a general sense of commitment to continued improvement. It was widely acknowledged that improvements were still required, around performance in particular but those whom we spoke with were optimistic that these would happen.

The ED gave grab bags to older children; these included information on local services as part of an initiative to educate children about child sexual exploitation, gang activity and missing children. Back packs with age appropriate supplies were given to children who went into foster care directly from the ED.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at the trust provides care and treatment for specialties including acute medicine, cardiology, elderly and frailty care, diabetes and endocrinology, renal medicine, respiratory and stroke. There are 288 inpatient beds spread across 23 wards. The site also has one community ward.

(Source: Routine Provider Information Request - Acute-Sites)

The trust had 28,531 medical admissions from December 2016 to November 2017. Emergency admissions accounted for 12,978 (45.5%), 287 (1%) were elective, and the remaining 15,266 (53.5%) were day case.

Admissions for the top three medical specialties were:

- General Medicine with 8,199 admissions
- Gastroenterology with 6,279 admissions
- Clinical Oncology with 5,638 admissions

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to February 2018 for medical and nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Nursing Staff</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained – YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>305</td>
<td>258</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>284</td>
<td>239</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>257</td>
<td>210</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>305</td>
<td>245</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>303</td>
<td>232</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>307</td>
<td>202</td>
<td>66%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 79% which did not meet the trust target of 90%. There was a lack of compliance in all courses, with the trust target not being met in any of the training course.
Medical Staff

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical staff was 84% which did not meet the trust target of 90%. Medical staff performed slightly better, with two of their courses showing 100% training completion. The trust reported very low staffing numbers for their mandatory training, they provided no explanation when prompted for it this indicated doctors mandatory training was not monitored.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2016 to February 2017 for medical and nursing staff in medicine is shown below:

Nursing Staff

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained – YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>269</td>
<td>244</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>293</td>
<td>238</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 86%, which did not meet the trust target of 90%. The target was met for the safeguarding adults level 2 course.

Medical Staff

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained – YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for medical staff was 100%, which was better than the trust target of 90%. Medical staff have only one course entered and the trust reported very low staffing numbers for their safeguarding training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff knew how to access the safeguarding team for advice and guidance when required and had access to the trust’s safeguarding policy via the trust intranet. They spoke about scenarios where they identified potential signs of abuse and how they responded to concerns, for example, reporting them to the nurse in charge or making a referral to the safeguarding team.
Cleanliness, infection control and hygiene

Cleaning audits were undertaken by the contractor responsible for maintaining the environment. We noted that results were displayed on individual ward’s notice boards and the scores indicated good level of cleanliness on wards visited by us. In general, we observed a good level of cleanliness, however, on Charles Coward Ward we noted an unpleasant smell of ammonia which we pointed out to a senior member of staff. Patients and their relatives told us that they found wards clean and that “staff kept on top of it [cleaning]”.

Ward managers undertook infection prevention and control audits monthly. Those audits were comprehensive and focused on various aspects of preventing infections and promoting cleanliness and good hygiene. For example, staff checked availability of sanitisers, whether staff cleaned their hands in line with the trust’s policy, used protective equipment or correctly disposed of waste.

The table below indicates results of the infection prevention and control audits as provided by the trust in May 2018.

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>January 2018</th>
<th>February 2018</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>T4</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>T5</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>AAU</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>T6</td>
<td>95%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>T7</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>T8</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td>AMU</td>
<td>93%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>Haematology unit (Podium 1)</td>
<td>92%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>Stroke unit (Podium 2)</td>
<td>91%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The trust reported one incident of Methicillin-resistant staphylococcus aureus (MRSA) and 23 cases of incidents of Clostridium Difficile (C Diff) for the period March 2017 to March 2018 related to the medicine and medical speciality wards. The trust did not collect MRSA screening data for individual medical wards.

In the last report we raised concerns with the cleanliness and upkeep of the environment within the endoscopy unit. We noted then that several surfaces in treatment areas and waiting rooms were visibly dusty and dirty. The endoscopy unit had now completed its refurbishment and issues related to cleanliness were resolved. We noted the environment was well maintained and clean with rare dust observed at high levels, for example the top of wall mounted equipment.

Environment and equipment

The hospital participated in the patient-led assessments of the care environment (PLACE) in 2017. This assessment focuses on the care environment. Where shortcomings were identified these were addressed through an action plan. We noted that the action plan disputed many of the findings of the assessment without giving any reasoning. The action plan noted that on many occasions ‘design was difficult to change’, or that findings were not accurate and estate and facilities department found it to be inaccurate. In some cases, it was not clear if any action would be taken in response to findings and who was responsible. For example, in numerous cases where actions were needed it was only noted that the ward was informed of findings.

Equipment inspected by us was serviced and tested with labels indicating when the next test was due or last test carried out. This included clinical equipment, fire extinguishers and medical gas cylinders as well as other electronic equipment such as kitchen or office equipment. Staff reported that they had no issues with maintaining equipment and the team responsible for repairs responded promptly. In our report of 2016 we commented on lack of staff knowledge around
pressure relieving equipment, we have noted staff now felt confident using the equipment as they had been provided with suitable training.

Resuscitation equipment was easily available on all wards visited. Staff checked it daily and kept record of checks to confirm readiness to use.

All patients used a standard pressure relieving mattress without a pump (static), and a pump could be attached for higher risk patients. The static mattress was judged by the staff to be suitable for patients with a grade 2 pressure ulcer or less. When they required pressure relieving mattress pump, if the ward did not have a spare one they requested it from the equipment library. However, staff told us they often did not have any in the library and they had to obtain one from another ward or move another patient off one to free it up. Staff reported that they could wait up to 24 hours for a pump.

**Assessing and responding to patient risk**

The trust did not carry out sepsis audits specific to individual medical wards. They collected standard data as required by the Commissioning for Quality and Innovation (CQUIN) focusing on incentivising the screening for sepsis for prompt recognition and initiation of treatments for patients arriving at hospitals via emergency department. Medical and nursing staff we spoke to were aware of how to identify, escalate and treat sepsis in accordance with the best practice should there be a need.

Patient’s risk was assessed using nationally validated tools. For example, we saw the risk of falls and the risk of pressure damage was assessed using standardised tools. We observed risks were mostly updated with appropriate risk management actions.

Staff used national early warning scoring system (NEWS) to detect and initiate response to clinical deterioration in patients and improve patient outcomes. They used it for recording physiological parameters such as: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. We reviewed a sample of scoring cards on elderly care wards, stroke unit, respiratory medicine ward and general medicine ward. Cards were calculated correctly and when escalation was required staff followed the correct procedure.

Ward managers carried out quarterly audits to monitor NEWS compliance and to check whether staff took appropriate escalation actions. The audits provided by the trust indicated 100% accuracy in recording all parameters and appropriateness of escalation in January to March 2018, however, this audit did not indicate how individual wards were performing or the size of the sample used.

Urgent or un-planned medical admissions were seen and assessed by a relevant consultant within 12 hours of admission on the acute medical unit. There was an on-site access to level 2 and 3 critical care beds that could provide full ventilator support. There was a clinical protocol in place for managing and responding to acutely unwell patients. Staff knew if patient’s early warning scores were high to inform the nurse in charge or the critical care outreach team. Staff told us that they found the support from the team helpful. The critical care outreach team provided services 24-hours, seven days a week.

Adult basic life support level 1 and 2 formed part of the mandatory training programme and was updated annually. However, staff compliance with the training was low at 66%. This was below the trust’s target of 90%.

**Nurse staffing**

The numbers of staff planned, and on duty were displayed at wards entrance. Staff on medical wards used a standardised tool to confirm if staffing allocation was appropriate when considering patients’ acute needs. On the wards we visited we observed staffing levels were frequently below
planned staffing levels. This potentially caused risk to patients and impacted on their experience as nurses were busy and care seemed rushed.

On Charles Coward Ward to minimise patients falls patients at higher risk were placed in one area which should be permanently staffed with a healthcare support worker. However, this was not always staffed as required. Records indicated that 16 out of 20 days checked in April 2018 the ward was short of staff. Similarly, in May 2018 out of 22 days there were 18 days were staffing levels did not meet the staffing establishment. The daily staff allocation for the ward was five registered nurses and three healthcare assistants, records indicated that on a number of occasions the ward was short of one nurse and two healthcare assistants. The acuity tool review indicated that there was only two days from 1 March to 18 May 2018 were the ward had sufficient staffing to meet patients’ needs.

Staff on other wards we visited also reported that they were frequently understaffed. For example, on the day we visited the acute medical unit they were short of two nurses, out of nine, and one healthcare support worker, out of five. Records indicated that the unit was usually short of two nurses in February to May 2018 with 37 day and 10-night nurses’ shifts uncovered in March, 49 day and five-night shifts in April and 24 day and 10-night shifts in May 2018 (until 23 May 2018). Staff told us that they were often asked to work in other units to ensure they were safely staffed.

Respiratory ward’s nurses said they frequently worked with temporary staff who did not have full set of skills required, they said they were short of staff most of days. This had put additional pressure on permanent members of staff.

The stroke unit was short of one healthcare support worker on one day we visited (out of four) and fully staffed on another day.

The National Cancer Patient Experience Survey 2017 (NCPES), designed to monitor national progress on cancer care, indicated that only 54% of patients felt always / nearly always enough nurses on duty this was worse that the England average of 67%.

The trust has reported their staffing numbers below as at January 2018 for medicine.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>493.98</td>
<td>441.76</td>
<td>89%</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018, the trust reported a nursing vacancy rate of 14.1% in medicine; this is worse than the trust target vacancy rate of 7.5%

From February 2017 to January 2018, the trust reported a nursing turnover rate of 16.1% in medicine; higher than the trust target turnover rate of 15%

From February 2017 to January 2018, the trust reported a nursing sickness rate of 4.6% in medicine; higher than the trust target rate of 3.5%.

The trust has identified the following wards to be the highest users of bank and agency staff in medicine:
- T4 Medical
- Pymmes Zero
- The Acute Assessment Unit

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Senior leaders told us recruitment was continuously underway with new recruitment strategies
being implemented by the trust to draw the right quality of candidates. They also focused on improving staff culture and development opportunities hoping for staff retention improvement.

**Medical staffing**
The trust has reported their staffing numbers below as at January 2018 for medicine.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>69.29</td>
<td>66.7</td>
<td>96%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From February 2017 to January 2018, the trust reported a medical staff vacancy rate of 7.7% in medicine; slightly higher than the trust target rate of 7.5%.

From February 2017 to January 2018, the trust reported a turnover rate of 14.2% in medicine; better than the trust target rate of 15%.

From February 2017 to January 2018, the trust reported a sickness rate of 1.3% in medicine; better than the trust target rate of 3.5%.

The trust was unable to provide a full cover for an out of hours rota to cover gastroenterology due to vacant consultant’s posts. This meant patients were at risk of delay to treatment should they experience upper gastrointestinal bleed during out of hours. The trust told us that approximately 20% of the May and June out of hours on-call rota for gastroenterologists was unfilled. Shortly after the inspection the trust told us gastroenterologists agreed to cover all on-call shifts in 2018 and they provided us with a rota to confirm it.

In December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 147-whole time equivalent staff working in medicine at North Middlesex University Hospital NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>39%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>34%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (SIR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce statistics (01/12/2017 - 31/12/2017)
The trust reported that there were nine physician assistants employed across medicine who provided support to the junior doctor trainees. The assistants had been introduced following feedback from junior trainees regarding their high workload. The assistants supported the handover meetings and updated the electronic patient list; they also took bloods and undertook a lot of the administration work on the wards.

Medical wards had a daily consultant ward rounds Monday to Friday with junior doctor ward teams working alongside the specialist teams. Out of hours cover was provided by the on-call consultant. The acute medical unit and acute assessment unit had daily consultant ward rounds seven days per week.

**Records**

Records quality audits were undertaken by ward managers monthly. The trust reported 96% compliance on medical wards with the good clinical record keeping standards in February 2018. They noted 97% in March and April 2018.

We reviewed five endoscopy patients’ records and noted in three cases patients had undergone procedure under sedation but staff failed to ask them to sign a disclaimer form to confirm they understood risks related to it and that they should arrange to be escorted after the procedure. Although the safety checks were completed for each patient, prior and after the procedure, the checklist form was not always signed by the endoscopist as required and nurses signature was not legible.

Records quality in the day hospital was variable. We reviewed five standard assessment forms used by the unit. Patient’s name and address, GP’s address and some other baseline observations were recorded, however, staff omitted some other parts of the assessment form. Missing information included body assessment on admission, patient’s understanding related to their diagnosis and information related to their spiritual needs or mobility. Where patient attended with their own mobility device there was no information on how to safely support them with use of it.

Dementia status was not always recorded and staff told us there was no need to formally assess patient for dementia as they could tell if they had dementia or not. There were no care plans implemented to support patients with falls or dementia. For example, it was noted that one patient had mobility issues and experienced two falls but staff did not undertake any specific falls risk assessment. In another case there was no information in relation to how to support a patient with their mobility support device (walking frame). Staff told us that there was no need to record if additional support was needed and how to support this patient safely as they “all knew the patient”.

Ten records reviewed on elderly care wards were of variable quality. Some records, such as body maps, not dated, others such as care plans incomplete. For example, a peripheral cannula record had no removal date or batch number recorded or patients repositioning records were not complete in two cases nutritional assessment was not completed. In one case record wrongly indicated that episode of care took place at the same time patient was actually sleeping.

During the last inspection we found large numbers of unsecured patient records within the endoscopy unit. This time we noted records were stored securely on lockable trolleys. We observed no records being left unattended.

**Medicines**

Medicines were stored securely. Treatment rooms, medicine cupboards and medicine trolleys were locked. Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained. We saw evidence of regular daily checks, and the stock balances we checked were correct. Fridge temperatures were recorded daily; however, we saw
medical wards did not have any record of room temperature monitoring. The trust’s medicines policy stated that medicines should be stored at the manufacturer’s recommended storage temperature, however, staff on wards were unable to confirm this requirement was fulfilled.

Emergency medicines were readily available on emergency trolleys, which were secure, sealed and checked regularly.

Nursing staff told us that pharmacists visited wards daily, and medicines were received when requested. Pharmacy technicians also provided regular top ups to ensure that stock did not run out. Pharmacy staff provided an on-call service out of normal opening hours. Emergency stocks were accessed by authorised staff and a ‘drug locator’ was available via the trust intranet.

We looked at 10 prescription charts on Charles Coward Ward; four patients were receiving oxygen. Not all patients had their reconciled medicines prescribed on the drug chart. We saw that one patient admitted four days before the inspection had not had their eye drops prescribed on the drug chart therefore administered doses were not recorded. We brought this to the attention of the ward manager and a doctor and these were prescribed immediately. One of the patients receiving oxygen did not have this prescribed. The rest were prescribed as should be the case but administration records were not signed by the nursing staff responsible. We saw patient’s allergies were documented in patients’ medical records so they could be considered when medicines were prescribed.

The trust employed a team of pharmacist non-medical prescribers on medical wards, they prescribed medicines once a patient was fit for discharge. These were dispensed promptly as there was no need to wait for a doctor. Staff on the ward told us that this had significantly improved patients’ experience and the admission and discharge flow as discharges could be planned better and patients were getting home quicker.

Medicines information was available to clinical staff via the intranet and was easily accessible.

**Incidents**

From March 2017 to February 2018, the trust reported two incidents classified as never events for medicine. One of these events was the retention of a foreign body post procedure, the other related to a patient being connected to an oxygen flowmeter incorrectly. Managers reassured us that lessons had been learnt to prevent similar occurrences.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

*Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)*

We reviewed an incident from May 2017 related to patient’s death where the trust found one of the contributory factors was a lack of on-call support to respond to upper gastrointestinal bleed. We were concerned that the lack of appropriate and effective arrangements was putting patients at risk and that the trust had not responded promptly to prevent further incidents as per recommendations from the internal incidents review carried out in response. We asked the trust to make significant improvements in relation to the provision of this out of hours service by 11 June 2018.

In accordance with the Serious Incident Framework 2015, the trust reported 32 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from March 2017 to February 2018.
Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with 14 (44% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with seven (22% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with three (9% of total incidents).
- Treatment delay meeting SI criteria with three (9% of total incidents).
- All other categories with three (9% of total incidents).
- HCAI/Infection control incident meeting SI criteria with two (6% of total incidents).

(Source: Strategic Executive Information System (STEIS))

During our previous inspection in 2016 we noted action points or lessons learnt were not always identified during patients’ death’s reviews. At this inspection we were unable to fully assess whether mortality and morbidity reviews fed into service improvement. Although doctors and senior leaders told us these were undertaken monthly for individual specialities they were not minuted and we could not assess if lessons learned from reviewed cases at divisional or speciality level.

Staff we spoke to knew how to report an incident using trust’s electronic system. They provided examples were feedback was given after incident was investigated and spoke of lessons learnt. Incidents were discussed at staff meetings to prevent occurrence and key issues related to serious incidents were noted on ‘governance boards’ used by staff to share information.

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 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. Staff we spoke to 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. They spoke of examples where they followed the principles of openness and transparency in situations where care and treatment were not delivered in line with expectations or when errors were made.

Safety Thermometer
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 26 new pressure ulcers, six falls with harm and 16 new catheter urinary tract infections from February 2017 to February 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at North Middlesex University Hospital NHS Trust

(Source: Safety Thermometer)

The trust established weekly ‘harm free panel’ meetings in May 2017 to reduce pressure ulcers and improve overall safety awareness amongst staff. Each pressure ulcer occurrence reported through the trust’s electronic incident reporting system was discussed during the meeting. The panel also reviewed documentation, such as care bundles to identify any gaps and learning points and analysed initial root cause analyses. Staff reported that the panel had been received well and seen as a supportive and an educational forum. It was co-chaired by the tissue viability specialist nurse and the deputy director of nursing and attended by senior sisters or matrons from individual wards where pressure ulcers were reported. However, some staff had reported that they were unable to attend panel due to staff shortages. The trust reported 57% reduction of hospital acquired pressure ulcers (grade 3 and above) since the panel was established.

Records we examined indicated that wound assessments were undertaken irregularly, repositioning records were not always completed and in some cases, we have seen that the pressure ulcer prevention care plans were not completed. On one of the elderly care wards a senior member of staff told us the frequency of repositioning depended on staffing levels. Staff
aimed to reposition patients at risk of developing pressure ulcers every two hours, however, they admitted it was not always possible when they were short of staff.

The trust employed a falls lead who provided staff with falls prevention advice and could support with assessing patient’s risk of falls, and delivering care to manage the risk. However, due to staff shortages staff were not always able to follow the advice and monitor risk appropriately. We noted on Charles Coward Ward managers were frequently unable to provide staff to monitor patients at risk of falls. Those patients were admitted to the same bay area, as advised by the falls lead, to minimise the impact on staffing and allow increased supervision. The area supposed to have a member of staff always present within it. We observed that the area was at times left unstaffed during the day. Rotas indicated that it was not always possible to book sufficient staff numbers to ensure patients safety and adequate falls prevention.

**Is the service effective?**

**Evidence-based care and treatment**

We found a lack of compliance with recommendations issued by the National Patient Safety Agency, Royal College of Physicians and the British Society of Gastroenterology (BSG) related to out of hours endoscopy provision. This outlined nine service standards including one that specifies that ‘for patients who require more urgent intervention either for endoscopy, interventional radiology or surgery, formal 24/7 arrangements must be available.’ The trust told us they were aware there is an insufficient provision of the out of hours endoscopy and it was something they had identified as a risk over two years ago. During our visit, the trust told us that gastroenterologist provided cover on a “good will basis “. The trust reviewed arrangement shortly after our inspection and had implemented a fully covered out of hours rota for 2018.

Trust provided list of audits document, however, all audits related to medicine were listed as "awaiting audit report", "not available” or “in progress". Clinical audits were carried out to check how the trust performed against national guidelines or to confirm compliance with them. Audits were carried out within individual specialities or by individual doctors and learning was not always shared or evident. The trust made us aware of 85 clinical audits, carried out March 2016 to May 2018, which were related to medical specialities. Only in 20 cases outcomes report was created (23%) and in 18 cases there was an action plan prepared in response. Fourteen audits were awaiting finalisation as they were still in progress and one was abandoned. In 45 cases no outcomes report or action plan was created (45%) which meant senior leaders and people responsible for monitoring performance and implementing changes were not aware of its findings.

The trust participated in all mandated external audits recommended by the National Clinical Audit and Patient Outcomes Programme (NCAPOP). They participated in total of 31 national audits including the national audit of cardiac rehabilitation, pulmonary hypertension, cardiac arrest audit or comparative audit of transfusion associated circulatory overload amongst others. They submitted data quarterly for myocardial ischaemia national audit project and for the national heart failure audit, outcomes of which are reported below in the ‘patients outcomes’ section of this report.

Staff used a national early warning score (NEWS) to identify deteriorating patients to ensure they were escalated to the medical team or critical care outreach team in line with National Institute of Health and Care Excellence (NICE) Guideline - CG50 -that covers recognising and responding to deteriorating patients. Clinical policies and guidance were available on the trust intranet and staff were able to access these easily.

The endoscopy unit was ‘Joint Advisory Group’ (JAG) accredited at the time of our inspection. They sought recertification in Endoscopy in 2018 and were listed by the JAG as at level 3, which
meant 5% reduction’ in best practice tariff status as the service had been assessed either by peer visit or annual report card, but did not meet the JAG accreditation standards within the maximum time allowed to address the issues identified.

**Nutrition and hydration**

The trust used malnutrition universal screening tool (MUST) to identify adults, who were malnourished, at risk of malnutrition (undernutrition), or obese. The tool included management guidelines which could be used to develop a care plan.

Ward managers undertook MUST completion audits monthly. They reported that MUST assessments were completed on medical wards in 100% of cases in February 2018, 97% in March and 98% in April 2018. In two out of seven records reviewed at Pymmes Zero ward nutritional assessment were not completed. We also noted the accuracy of food intake charts completed by nursing staff was poor with food not recorded regularly and some of the fluid charts not being calculated correctly.

On wards visited we observed patients at all times had access to water or other drinks and within their reach. Staff clearly indicated if patient required additional support with eating or followed any special diet and could accommodate their dietary needs accordingly.

Catering staff on the wards were given daily lists of patients’ dietary needs and any restrictions and were able to cater for verity of diets including: high energy, soft, gluten free, high fibre, vegetarian, and halal amongst others. Patients selected their food choices from prepared menus that provided a choice of foods.

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.

**Pain relief**

The pain management service was available. They provide advice and assistance with acute pain, and chronic non-malignant pain conditions and consisted of two pain nurses and two pain nurse specialists (Level 6 qualifications in pain management) and two consultants.

The hospital carried out a pain assessment audit in 2017 to check if they were meeting the core standards for acute pain management services as recommended by the Faculty of Pain Medicine. This audit found that although no patients were identified with inappropriate regular analgesia prescriptions 23% of patients (out of 153) needed option of ‘when necessary’ analgesia but none had been prescribed. Only 41% of patients in significant pain were reassessed after an appropriate interval. Only 10% of regular pain assessments, for patients with severe or moderate pain, were recorded accurately with further 24% of records with ‘under-recorded’ results and vital signs. For people with mild pain in 86% of cases regular pain assessment was not undertaken at all. The audit did not assess whether patients were always referred in a timely fashion.

It also found that acute pain management was adequately supervised by consultants and specialist nurses with appropriate training and competencies. All patients with complex pain were already known to the pain team and no additional patients with complex pain were identified during the audit.

The team prepared an action plan in response to the audit which focused on developing clinical skills amongst the ward teams through formal training sessions and shadowing nurses. They also reviewed available support literature and records, such as early warning score cards, to prompt staff to complete pain assessments for patients.
The National Cancer Patient Experience Survey 2017 (NCPES), designed to monitor national progress on cancer care, indicated that only 64% of patients felt hospital staff did everything to help control pain this was worse than the England average of 84%.

**Patient outcomes**
The National Cancer Patient Experience Survey 2017 (NCPES), designed to monitor national progress on cancer care, indicated that only 67% of patients had confidence and trust in all doctors treating them which was worse that the England average of 82%. Similarly, patient had lower confidence and trust in all ward nurses (54% compared with the average of 74%). The trust had 434 eligible patients that were sent questionnaires with 216 of those patients responding, which gave the trust an overall response rate of 54% against the average response rate of 67%.

Overall, the trust had scored worse than expected in this survey with only 15, out of 59, responses similar to the England average and 44 worse than expected. Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.3 which was the same result as the previous year but worse than the average of 8.7.

The trust prepared an action plan with a view to address shortcomings in care indicated through this survey, however, actions were agreed only in January 2018, seven months after findings of the survey were published. Twenty-nine out of 35 deadlines for actions were not indicated on the plan and it was not clear how potential improvements would be monitored.

From November 2016 to October 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and similar to expected risk of readmission for non-elective admissions when compared to the England averages.

Of the elective admissions, gastroenterology most notably performed above the England average, with clinical oncology having the best performance.

In non-elective admissions, clinical haematology showed the worst performance, with general medicine being the only speciality to perform better than the England average.

**Elective Admissions – Trust Level**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

**Non-Elective Admissions – Trust Level**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.
The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit between April and June 2017.

### Team-centred KI levels

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
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<tbody>
<tr>
<td>1) Scanning</td>
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<td>N/A</td>
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<tr>
<td>2) Stroke unit¹</td>
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<td>A</td>
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<tr>
<td>3) Thrombolysis</td>
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<td>N/A</td>
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<tr>
<td>4) Specialist Assessments</td>
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<td>N/A</td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>8) MDT working</td>
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<td>N/A</td>
</tr>
<tr>
<td>9) Standards by discharge</td>
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<td>B</td>
</tr>
<tr>
<td>10) Discharge processes</td>
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**Team-centred SSNAP level (after adjustments)**

<table>
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<tr>
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<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
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</thead>
<tbody>
<tr>
<td>Team-centred SSNAP level</td>
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<td>B</td>
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**Team-centred Total KI level**

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<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team-centred Total KI level</td>
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<td>B</td>
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</tbody>
</table>

### Overall scores

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<tr>
<th></th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Audit compliance band</td>
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<td>B</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>

1 Included in IM reporting, indicator SSNAP02

**Source: Royal College of Physicians London, SSNAP audit**

Heart Failure Audit

In-hospital Care Scores

Results for North Middlesex University Hospital NHS Trust in the 2016 Heart Failure Audit were better than the England and Wales averages for two of the four of the standards relating to in-
hospital care.

Discharge Scores

Results for North Middlesex University Hospital NHS Trust results were better than the England and Wales average for all standards relating to discharge.

Source: NICOR - Heart Failure Audit (01/04/2015 - 31/03/2016)

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the

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England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 87 inpatients with diabetes at the trust, falling into quartile 4. 72% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile one, some way below the England average of 83%

(Source: NHS Digital)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 0% of nSTEMI patients were admitted to a cardiac unit or ward at the trust and 95% were seen by a cardiologist or member of the team compared to an England average of 96% and 56%.

The proportion of nSTEMI patients who were referred for or had angiography at the trust was 74% compared to an England average of 84%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 24.6%, which was notably far worse than the audit minimum standard of 90%. The 2016 figure was 15.9%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.5%, this is slightly above the national level. The 2016 figure was 28.3%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 62%, this is below the national level of 65% but within the expected range. The 2016 figure was 82.2%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 61.4%, this is below the national level but within the expected range. The 2016 figure was recorded as not significantly different from the national level.

The one-year relative survival rate for the trust in 2017 is 54.7%, better than the national aggregate of 37%.

(Source: National Lung Cancer Audit)

The trust did not meet NICE guidance on falls assessment and prevention (2013) and delirium (2010) and National Patient Safety Agency (NPSA) guidance on the prevention and management of inpatient falls. Data from the National Audit of Inpatient Falls (NAIF) 2017 indicated the trust had a multi-disciplinary working group for falls prevention were data on falls are discussed at most meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 69%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 47%. This did not meet the national aspirational standard of 100%.
The crude proportion of patients with a call bell in reach (if applicable) was 47%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff
From February 2017 to January 2018, 85% of staff within medicine at the trust had received an appraisal compared to a trust target of 90%. Nursing staff appraisal completion was only slightly below the trust target, with the 55% seen in medical staff.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of individuals required</th>
<th>Number completed</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>550</td>
<td>476</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>31</td>
<td>24</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Staff - Hospital</td>
<td>20</td>
<td>11</td>
<td>55%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Doctors we spoke with, that supervised trainees, confirmed they had adequate supporting professional activity time allocated 0.25 PAs per trainee in their job plan (programmed activities; equals to 1 hour of work if done within the normal working week). The trust issued a weekly bulletin email which was disseminated amongst all trainee doctors, it informed them of teaching opportunities they could access that week, such as Schwartz rounds and radiology meetings.

Junior and trainee nurses worked adequately supervised and any new staff worked supernumerary shifts for a period of two weeks. Nurses we spoke to felt they were provided with good developmentally opportunities and felt competent to perform tasks required to provide effective care and treatment. 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. Agency staff were given opportunities to learn additional skills when working frequent shifts. They also said they felt part of the team, able to contribute to discussions and challenge their colleagues should there be a need. However, permanent nurses told us that they often felt under pressure and needed to perform additional tasks as temporary staff, used on wards due to high vacancy rate, had not always had full set of skills.

There was a range of specialist nurses to provide advice and guidance on the care of specific groups of patients, such as those with diabetes, dementia, cancer and tissue viability issues. There were also lead specialist nurses for safeguarding and learning disability liaison nurse. We saw that clinical practice educators were available on some wards. Mandatory training records highlighted that not all nursing staff had completed training in basic life support, health and safety, conflict resolution or infection prevention training.

Multidisciplinary working
Therapists were not allocated to specific wards but provided cover across all inpatient wards.

There was appropriate nutrition and dietetics cover within all medical wards (9.0 whole time equivalent: WTE). Dieticians covered 13 medical wards in total.

Staff on medical wards told us physiotherapy team was working across medical wards and assessment units (4.5 WTE) and felt they provided sufficient cover.
Speech and language support was distributed across all inpatient wards (7wte).

We observed good multidisciplinary team (MDT) working culture where various grades and disciplines staff were participating in meetings. Staff were freely exchanging their professional opinions and contributing to decision making process.

For example, an MDT meeting on the stroke ward was well attended by junior and senior doctors, nurses, physiotherapist, occupational therapist, social worker, speech and language therapist and discharge coordinator. Staff discussed issues such as family involvement, reviewed arrangements related to patient’s mental capacity and decisions relating to cardiopulmonary resuscitation. They took into account patient’s social and cultural needs when deciding on how to progress their treatment.

There were numerous weekly MDT meetings organised by individual medical specialities including nephrology, dermatology, haematology, gastroenterology amongst other specialities. Each MDT team had a coordinator and a clinical lead allocated to them.

The trust also ran a ‘hospital at home’ service with a team focused on facilitating early discharge home and arranging all necessary care within the community before it was handed over to district nursing teams, day hospital staff or a local GP. This allowed patients to minimise their hospital stay and fully recover at their own home.

The hospital organised a number of GP hotlines to provide direct access to specialist advise with a view to promote best treatment outcomes within the primary care settings and prevent patient’s admission. This included hotlines for queries related to: medicine for elderly, stroke and transient ischemic attack, acute medical hotline, anticoagulation service, and radiology consultant amongst others.

Clinicians worked within the clinical partnership network, jointly with clinicians from other local hospitals. This was set up to review clinical pathways, benchmark outcomes against other hospitals and reduce variation in treatment provided across geographical patch. The trust told us this had led to review of pathways for management of chronic obstructive pulmonary disease or pneumonia management amongst other pathways.

**Seven-day services**

Speech and language support was available Monday to Friday 9am to 5pm.

Physiotherapy was also available only during weekdays 8.30am to 4.30pm.

The hospital allocated an occupational therapist (OT) to work with the admission avoidance team 9am to 5pm during weekends. They supported the Acute Assessment Unit and Acute Medical Unit; this was a pilot programme. Another OT worked with the same team 9am to 2pm on Saturday and Sunday. This was a temporary arrangement with OTs working bank shifts on those days in addition to their regular 8.30am 4,30pm weekdays shifts.

The pain team were available Monday to Friday 8am to 6pm and 9am to 5pm on weekend days. They also provided out of hours telephone support for patients with acute pain.

We reviewed the trust’s protocol for out of hours consultant cover to respond to upper gastrointestinal bleeding and found the process was incomplete. The flow diagram ‘How to acute organise an emergency endoscopy out of hours’ showed the following: “Medical Consultant to discuss the timing of endoscopy with on-call gastroenterologist (rota with switchboard)”. However, we found there were significant gaps in the rota and the protocol did not explain what should be done in circumstances when the cover was not available.
The protocol stated the rota was available to the switchboard team. We reviewed the rota available to the switchboard team, the rota did not always list who was to cover out of hours emergency endoscopy. There was a sticker informing staff there was no cover “over the weekend and during the week” (starting from 29 March 2018). This rota expired on 11 May and there was no updated rota available for the following weeks. The trust told us that approximately 20% of the May and June out of hours on-call rota for gastroenterologists was unfilled.

**Health promotion**

The trust ran a medical day hospital for older patients. The unit had a dedicated team of nurses specialising in geriatric care under a team of care of the elderly consultants who were available to assess patients’ needs on the day. Staff focused on preventing patient’s hospital admission through meeting their medical needs within the day hospital session providing comprehensive geriatric assessment and treatment. The medical day hospital provided rapid, multi-disciplinary assessments for older patients who required medical and social support but did not need to be admitted to hospital. Staff organised regular teleconferences with primary care doctors, social services and psycho-geriatrics to ensure seamless care for older patient. They also offered an in-reach service to many nursing/residential homes in Enfield and run a consultant geriatrician hotline where medical staff working within the primary medical services could obtain specialist advice.

**Mental Capacity Act and Deprivation of Liberty**

The trust had a service level agreement with the local mental health trust to manage and process the documentation related to the detention of patients in the hospital. The local mental health trust ensured that that patients detained under the Mental Health Act had their rights upheld. The local mental health trust also ensured that patients had tribunals arranged if necessary, and that patients had their rights explained to them in accordance with the law. The psychiatric liaison team was responsible for these functions. The trust detained 158 patients during the previous 12 months, and had 38 admissions of patients who were detained by other trusts.

The psychiatric liaison team supported the trust to assess patients suffering from mental illness. They aimed to see patients in the ambulatory medical unit within four hours and patients in all other wards within 24 hours. The trust target was for these patients to be seen 95% of the time within these timescales. The psychiatric liaison team said that they did not meet this target, and a review of minutes of meetings between the psychiatric liaison team and the trust confirmed it. The psychiatric liaison team told us that this was due to resource constraints.

The trust used restrictive practices under the Mental Capacity Act (MCA), such as placing mittens on patients who lacked capacity and who were at risk of self-harm by pulling out medication and respiratory tubes. We looked at two instances where staff had included placing mittens on patients in patient’s care plans. In both we found that staff had completed the trust’s template on best interests care planning, however, we did not find that a MCA assessment had been completed by the clinician before filling out the best interests document.

Staff we spoke to said if they had questions regarding a patient’s capacity, they would ask the psychiatric liaison team to assist them and to carry out a MCA assessment if necessary. However, the trust policy stated that clinicians responsible for the patient’s care should carry out a MCA assessment using the MCA template available. The psychiatric liaison team told us that it was not within their remit to carry out MCA assessments and that they were frustrated by the number of staff who asked them to do it.

Staff sometimes placed patients on a Deprivation of Liberties Safeguards (DoLS) authorisation if they lacked capacity. This was to ensure that the hospital had the legal authority to keep patients in hospital for treatment. The trust did not have a complete oversight over how many patients were placed on DoLS authorisations in the hospital as the ward staff did not inform the safeguarding
lead of all the authorisations which were signed by staff. For example, the trust said that two patients were under a DoLS authorisation during the month of May 2018, however we counted 14 patients on the wards for the month of May 2018. The safeguarding lead was actively trying to improve this situation through organising weekly training for staff.

The safeguarding lead said the staff were gaining confidence at carrying out a MCA assessment before a DoLS authorisation was completed. We looked at nine DoLS authorisations and four had a MCA assessment completed before the authorisation.

We only saw examples of DoLS urgent authorisations, which are completed and signed by trust staff and which last for seven days. We did not see any DoLS standard authorisations, which are completed and signed by the local authority and last for up to a year. Staff told us that they had never received a completed standard authorisation by the local authority, although staff made a request for a standard authorisation for all patients who required it. This meant that there were instances where the DoLS authorisation were extended more than once, which is not in accordance with legislation, and instances where patients were held in hospital after their DoLS urgent authorisation had run out. This meant that there was a risk of keeping patients who lacked capacity in the hospital without a legal justification for this.

The trust provided us with following figures for staff compliance with basic awareness of Mental Capacity Act and Deprivation of Liberties Safeguards training within the medical wards in May 2018 as reported in the table below. This was a part of the safeguarding training. The trust did not provide us with information on what was the completion rate across various staff groups and wards. Some staff also attended designated DoLS training, however, the trust did not provide us with information on how many staff and which groups had completed this training.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medical Unit</td>
<td>91.38%</td>
</tr>
<tr>
<td>Acute Assessment Unit</td>
<td>100.00%</td>
</tr>
<tr>
<td>Acute Stroke Unit</td>
<td>100.00%</td>
</tr>
<tr>
<td>Charles Coward Ward</td>
<td>92.86%</td>
</tr>
<tr>
<td>Michael Bates Ward</td>
<td>71.43%</td>
</tr>
<tr>
<td>Pymmes Zero</td>
<td>94.12%</td>
</tr>
<tr>
<td>Tower Ward 4</td>
<td>100.00%</td>
</tr>
<tr>
<td>Tower Ward 5</td>
<td>96.00%</td>
</tr>
<tr>
<td>Tower Ward 6</td>
<td>92.00%</td>
</tr>
<tr>
<td>Tower Ward 7</td>
<td>89.74%</td>
</tr>
<tr>
<td>Tower Ward 8</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

**Is the service caring?**

**Compassionate care**

We observed several interactions between staff and patients and saw staff treated patients with compassions and kindness. Feedback from patients and relatives was generally very good and they felt they were treated with courtesy, respect and compassion by staff. Patients felt able to speak about their worries and said staff at the hospital were compassionate. A relative of a patient told us “nurses were really kind and very respectful”, another patient said, “staff were always
happy and friendly”, one another added that “nurses at night were always smiling and are kind”. Other patients and relatives we spoke to expressed similar views related to staff working on medical wards. 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. The Friends and Family Test response rate for medicine at the trust was 20% which was worse than the England average of 25% from December 2016 to November 2017. Friends and family Test – Response rate between 01/12/2016 to 30/11/2017 by medical area.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Ann. Perf.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACU Assessment</td>
<td>1815</td>
<td>76%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Unit</td>
<td>386</td>
<td>11%</td>
<td>97%</td>
<td>75%</td>
<td>80%</td>
<td>92%</td>
<td>86%</td>
<td>95%</td>
<td>89%</td>
<td>100%</td>
<td>83%</td>
<td>88%</td>
<td>95%</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Acute Stroke Unit</td>
<td>110</td>
<td>16%</td>
<td>93%</td>
<td>100%</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles Coward</td>
<td>188</td>
<td>25%</td>
<td>83%</td>
<td>67%</td>
<td>80%</td>
<td>70%</td>
<td>100%</td>
<td>86%</td>
<td>93%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Inpatient Web</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michael Bates</td>
<td>47</td>
<td>6%</td>
<td>80%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>67%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>Podium 1</td>
<td>192</td>
<td>23%</td>
<td>84%</td>
<td>89%</td>
<td>94%</td>
<td>100%</td>
<td>97%</td>
<td>80%</td>
<td>100%</td>
<td>78%</td>
<td>93%</td>
<td>100%</td>
<td>94%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Pymmes 0</td>
<td>107</td>
<td>14%</td>
<td>88%</td>
<td>71%</td>
<td>100%</td>
<td>82%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>85%</td>
<td>100%</td>
<td>100%</td>
<td>92%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T5 Ward</td>
<td>346</td>
<td>51%</td>
<td>100%</td>
<td>94%</td>
<td>93%</td>
<td>97%</td>
<td>97%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>100%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>T6 Ward</td>
<td>264</td>
<td>38%</td>
<td>84%</td>
<td>92%</td>
<td>97%</td>
<td>100%</td>
<td>85%</td>
<td>84%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T7 Ward</td>
<td>257</td>
<td>30%</td>
<td>92%</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
<td>83%</td>
<td>79%</td>
<td>92%</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T8 Ward</td>
<td>308</td>
<td>39%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
<td>100%</td>
<td>99%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

The National Cancer Patient Experience Survey 2017 (NCPES), designed to monitor national progress on cancer care, indicated that 75% of patients felt treated with dignity and respect while they were in the hospital this was worse than the England average of 82%. Only in 40% of cases staff asked patient what name they preferred to be called by, this was worse than the average of 68% and 7% worse than the previous trust result. 69% reported that groups of doctors or nurses did not talk in front of them “as if they were not there” which was worse than the average score of 82%.

Emotional support
The trust organised support groups for patients and their relatives and carers with a view to promote self-care and offer emotional support. This included a focus group for patients affected by red cell cancer or a carer’s clinic where carers could book a 30-minute appointment for support, information and advice about local services available to help them caring for their relative. They were provided with information on how to access various support services within the community such as mental illness advice service or community stroke service. Cancer patients and their
Carers had access to support services located within the hospital that offered complementary therapies such as reflexology, aromatherapy and counselling to anyone who had been affected by cancer. Carers were also offered food discount at the hospital’s restaurant, concession car parking tickets, and could visiting their relatives outside of regular visiting times set out by individual wards.

The National Cancer Patient Experience Survey 2017 noted that only 26% of patient felt they were given enough support from health or social services during treatment. This was worse than the average of 45% for English NHS trusts.

Patients had access to the hospital multi faith chaplaincy service. They offered pastoral, psychological and spiritual support together with a befriending service. The team included, Christian, Muslim and Jewish chaplains and had access to faith leaders from many other communities.

Understanding and involvement of patients and those close to them
The National Cancer Patient Experience Survey 2017 (NCPES: data collection end of 2016), designed to monitor national progress on cancer care, indicated that 62% of patients were involved as much as they wanted to be in decisions about their care and treatment this was much worse than the England average of 78%. Ninety percent of respondents said that they were given the name of a clinical nurse specialist who would support them through their treatment. 85% respondents said that it had been ‘quite easy’ or ‘very easy’ to contact the specialist both results were in line with the England average. Only 74% felt they were given clear written information about what should / should not do post discharge and 85% were told who to contact if worried post discharge. This was worse than the England average of 86% and 94% respectively.

We observed staff involving patients and relatives in care planning and decision-making process. It was demonstrated by staff in all specialties and roles. Patients told us that their views were considered by staff and they felt involved in decisions made by clinical teams.

Is the service responsive?

Service planning and delivery to meet the needs of the local people
Patients had access to hot and cold drinks when awaiting transport in the discharge lounge. A patient and a relative told us that staff used to offer snacks but this was no longer provided. We noted that in most cases patients transport arrived within 40 minutes from booking. However, two patients we spoke to, who frequently used patient transport services, told us that it was common that they were waiting for over an hour with occasional two hours wait. Patient transport was delivered by a separate provider to the trust.

The trust reported that there were no mixed-sex accommodation breaches on medical wards for 12 months prior the inspection.

Visiting times were 2pm to 8pm every day. Relatives told us that staff were flexible with timing should the patient had prolonged stay in the hospital. Carers were provided with a ‘carer passport’ which made more frequent visits easier by allowing cheaper car parking or discount on restaurant’s food.

We noted that the patients’ activities’ room on Charles Coward ward was redecorated and some new equipment, such as large television, dementia friendly activity books, and games, had been purchased for patients to use. Patients on Charles Coward Ward did not have access to individual television screens or radios by the bedside. We observed that the activity room was not used by any of the patients. Staff said that they had restricted ability to support patients with leisure activities as they were frequently short staffed and needed to concentrate on care delivery. A nurse told us that activity room was used for meals which gave patients opportunity to
socialise.

The ward staff encouraged patients to move out of bed and sit on armchair by their bedside. Staff monitored how many patients they have managed to mobilise and recorded numbers with an aim to increase them in the coming months. They also encouraged patients to bring their own regular clothing to use during their stay instead of hospital gown. However, staff said the uptake amongst patients was marginal as many families were reluctant to laundry relatives clothing and staff were unable to offer this service.

**Meeting people’s individual needs**

The hospital participated in the patient-led assessments of the care environment (PLACE) in 2017. This assessed whether the environment was friendly to patients living with dementia. We noted that many of the findings were not addressed or were disputed by the action plan provided by the trust. These related to best design standards: lighting, individual radio and television provision, pictures and text used for door signage and standardisation throughout the environment, or painting bathroom doors in single colour to make them easily distinguishable.

The trust provided us with dementia screening rates, however, this were accumulated for the medical and urgent care division and we were unable to assess individual wards. Those figures indicated that 78% of elderly patients have been screened for dementia in February 2018, 82% in March and 80% in April 2018.

Patients’ records at the day hospital, which was used by patients older than 65 years who came for day treatment, indicated that dementia assessment was not routinely carried out. We reviewed five records of patients aged 72 -93. Only in one case, had a cognitive assessment been used and it indicated that patient was diagnosed with dementia. However, this recorded diagnosis was contradictory to that noted on patient assessment form, which explicitly noted this patient did not have dementia. There was no clear and objective indicator used to decide who needed the dementia assessment. The day hospital also did not use any dementia specific care plan which would support standardised approach, highlight good practice, ensure alignment with relevant cross condition care plans and help to reduce local variation in the process. A nurse told us that they used their professional judgement to decide who needed it. This did not follow best practice which indicates patients aged 75 and over should routinely undergo dementia screening.

Medical wards carried out call bells audit to check if patients had call bells within their reach and is when they buzz them staff responds promptly. Audits indicated compliance of 82% in February 2018 and 83% in March. Improvement was noted in April 2018 with 89% compliance across medical wards.

All the medical wards were divided into bays which provided single sex accommodation with designated male and female facilities in the bays.

The medical wards operated a protected meal time policy to ensure patients were not disturbed during that time and ward activity was kept to necessary minimum. A variety of food was available to meet people’s individual needs. This included special dietary needs and various culturally sensitive options.

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. For informal conversations they were often supported by relatives or utilised members of staff who were able to use the language. To meet patients’ needs some of the information leaflets, for example about preparing for endoscopic procedures, were available in other languages.

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.
Access and flow
Non-elective medical patients who had visited the emergency department were firstly admitted to 18 bedded acute assessment unit, where they could stay a maximum of 24 hours for the initial assessment and management. Should further investigations be necessary patients were moved to the 39 bedded short stay acute medical unit (AMU) where they could stay for up to 72 hours before being admitted to a specialist medical ward. A consultant saw all patients admitted to the AAU/AMU each day, along with all new admissions during twice daily ward rounds. Doctors from specialist medical wards which patients were transferred to participated in the handover process on AAU/AMU. We observed good communication and cooperation between all staff from various wards involved in the patient’s pathway.

The hospital organised bed management meetings four times a day where bed availability was monitored and potential problems that could affect access and flow were resolved. We observed the discharge lounge was mainly used by patients attending outpatient’s department. Patients from medical wards waited on the ward until they were fully ready to be discharged, had their medication, and the transport service was on site if this was relevant.

From December 2016 to November 2017, the average length of stay for medical elective patients at the trust was 7.7 days, which is higher than the England average of 5.8 days. For medical non-elective patients, the average length of stay was 7.7 days, which is higher than the England average of 6.5 days. Divisional leaders told us this was linked to number of elderly patients the hospital treated and complexity of their medical conditions. They felt this reflected medical and social needs of the local population.

The trust has exceeded the England average length of stay in all elective and non-elective categories except for elective clinical haematology. Within the elective categories, clinical oncology stands out as its length of stay is more than double the England average. Non-elective categories do not show such disparity between trust and England average, but all are worse than the England averages.

### Elective Average Length of Stay – Trust Level

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>7.7</td>
<td>5.8</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>4.7</td>
<td>4.4</td>
</tr>
<tr>
<td>Clinical Oncology (Previously Radiotherapy)</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Clinical Haematology</td>
<td>9.9</td>
<td>10.6</td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific trust based on count of activity.*

### Non-Elective Average Length of Stay – Trust Level

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>7.7</td>
<td>6.5</td>
</tr>
<tr>
<td>General Medicine</td>
<td>6.5</td>
<td>6.0</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>10.9</td>
<td>9.5</td>
</tr>
<tr>
<td>Clinical Haematology</td>
<td>6.5</td>
<td>6.3</td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific trust based on count of activity.*

From June 2017 to April 2018 there were 908 medical patients placed on surgical wards due to unavailability of an appropriate hospital bed on medical wards (approximately 91 patients per
month). Majority of those patients had fallen under the care of the elderly speciality (366). At the same time there were 700 surgical patients placed on medical wards with majority of them being general surgery patients (175). Those numbers were better to those reported in our previous report were 1456 medical outliers August 2015 to July 2016 were noted (approximately 121 patients per month).

There was a good handover process was in place for medical patients placed on surgical wards and surgical patients on medical wards (outliers). The trust told us no serious incidents had been reported which would relate to inappropriate care due to the patient being placed on inappropriate ward where no suitable bed was available. They used a real-time online system which allowed them to effectively locate all medical patients. Each medical team had their own base ward and was also responsible for one outlier ward, where they would attend and review all their patients daily with the responsible consultant.

We observed that various speciality medical doctors participated in handover meetings outside of their regular wards based on patients mix. For example, doctors from medical wards participated in the morning handover meeting at the acute medical unit (AMU). This allowed them to discuss patients transferred to their ward from the AMU during the previous night. There were also daily meetings with the relevant nursing staff.

There were 1072 out of hours transfers (25%) recorded for the medical wards between March 2017 and April 2018. These all occurred between 10pm and 7am. Great majority of those patients (94%) came from medical assessment or acute assessment units with 6% being transferred across other wards.

From November 2017 to May 2018 there were 136 out of hours hospital discharges from medical wards as presented in the table below. This refers to patients discharged out of hospital at night (10pm to 7am). Seventy-two of those patients were discharged after midnight and before 6am, majority of them from the T7, T4 and T8 wards (12, 11, 10 patients respectively).

<table>
<thead>
<tr>
<th>Ward</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>T7</td>
<td>23</td>
</tr>
<tr>
<td>T4</td>
<td>20</td>
</tr>
<tr>
<td>T8</td>
<td>20</td>
</tr>
<tr>
<td>T6</td>
<td>17</td>
</tr>
<tr>
<td>Michael Bates</td>
<td>16</td>
</tr>
<tr>
<td>T5</td>
<td>10</td>
</tr>
<tr>
<td>Acute Stroke Unit</td>
<td>9</td>
</tr>
<tr>
<td>Charles Coward</td>
<td>9</td>
</tr>
<tr>
<td>Pymmes Zero</td>
<td>6</td>
</tr>
<tr>
<td>Winter Ward</td>
<td>6</td>
</tr>
</tbody>
</table>

From January 2017 to December 2017, 63% of patients did not move wards during their admission, and 37% moved once or more. The trust was unable to comment on whether moves were made for clinical or non-clinical reasons.

The trust had employed prescribing pharmacists, who helped decrease the workload pressures on medical and nursing staff and facilitate early discharge of patients.

The trust’s referral to treatment (percentage within 18 weeks - admitted performance: RTT) performance was better than the England average between January to May 2017. There is then a notable dip in performance below the average, stabilising in July 2017 and remaining steady until October 2017, where a rapid improvement in performance is seen back above the England average.
Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>100%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.2%</td>
</tr>
</tbody>
</table>

Five specialities were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>91.4%</td>
<td>93.9%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>66.7%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>66.3%</td>
<td>83.2%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0%</td>
<td>83.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Learning from complaints and concerns

We saw leaflets informing patients’ how to complain were displayed in visible places on medical wards. Complaints were discussed at monthly divisional meetings. We saw that complaints were monitored and outcomes recorded with details of action points and learning identified. Staff used ‘governance boards’ to communicate any learning points, they also discussed complaints during regular staff meetings. Staff provided examples where they adjusted their practice and the environment in response to the feedback provided by patients and their relatives.

From January 2017 to December 2017, there were 117 complaints about medical care. The trust took an average of 42 days to investigate and close complaints; this was not in line with their complaints policy, which states complaints should be resolved within 30 days. The main themes were related to treatment (35%) and poor attitude of staff (15%).

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We reviewed how trust responded to seven formal complaints. We saw communication with complainants to agree extensions to the response deadline if this was needed. Quality of responses to complaints made was good and written communication with patients and/or their carers and families was considerate, individualised and information provided in letters was comprehensive.
Is the service well-led?

Leadership
The division was led by a clinical divisional director, divisional director of operations, and the head of nursing. They were responsible and accountable for patients’ experience, delivering clinical outcomes, budget and reported directly to the chief operating officer and the medical director.

Each of the medical specialities was managed by a clinical lead, general manager and a matron. We met with some of the speciality leads and divisional leaders and found them to be knowledgeable, and capable of managing their areas of activity.

Matrons participated in a ‘back to the floor’ day weekly. This allowed them to deliver care to patients alongside the trust’s frontline nurses and complete some of the regular audits.

During the inspection staff we approached spoke positively about members of the executive team. They said they were visible on the wards, approachable and aware of problems faced by the frontline staff.

Vision and Strategy
At the time of the inspection the trust did not have a long-term strategy. The trust prepared a divisional business plan for each of the specialities which highlighted service objectives and quality and clinical priorities for 2018/2019. This was driven by key performance indicators, strengths, weaknesses, opportunities and threats analysis and by the demand and capacity assessment. It focused on developing seven days working, developing divisional workforce, improving leadership and management of the division and expansion of services such as cardiology, endocrinology, and gastroenterology.

The trust’s vision was ‘to provide outstanding care for local people’. The trust’s values were promoting positive behaviours and encouraged staff to be ‘caring, helpful, open, honest’, and encouraged ‘teamwork’. The trust had embedded values and behaviours frameworks in the selection assessments, induction, staff professional development and appraisals.

The trust’s priorities for the year ahead were to improve the governance within the division and to achieve national standards such as those related to referral to treatment times and cancer treatment waiting times. They also aimed to focus on retention and recruitment, as well as culture development, which was seen as a key to improving staff morale.

The trust set out visits to other hospitals to identify learning which could be implemented by local teams. They were working in partnership with a trust providing specialist cancer services to develop plans for the service.

Culture
In response to the 2017 annual staff survey the trust prepared an improvement plan to address issues highlighted by staff. They have noted that more staff within the division reported a culture of bullying, harassment and discrimination or experienced discrimination and violence from patients/relatives or carers in last 12 months. The improvement plan emphasised “zero tolerance of bullying and harassment and violence on staff and service users” and issues related to was bullying and harassment were addressed through the trust wide plan. Thrust also worked on quality improvement programme and developed a project group which was tasked with addressing the findings from staff survey.

Overall, we found that individual teams were well motivated and focused on delivering quality care. Despite multiple changes in leadership of the trust and the divisional structures change undertaken in 2017 staff we spoke to were positive and optimistic about the future of the trust.
However, staff we spoke to felt they could not always fully concentrate on patient and delivering quality care and needed to focus on safety as they were frequently short staffed. They felt they could perform their jobs better if they had more staff on shift.

**Governance**

Wards had monthly wards meetings which were used to share learning from incidents, complaints, discuss findings from local audits and those indicators related to patient care delivery and their overall experience.

There were monthly divisional meetings attended by divisional and speciality leads. Those meeting were informed by performance indicators’ reports, which gathered all key indicators related to service delivery. It included information on: trends in relation to treatment delivery and waiting times; safety indicators such those related to falls, pressure ulcers, or infections; budget delivery information; and workforce performance relevant data.

Senior nurses at ward level used an electronic audit tool to carry out series of ward inspections. They then used outcomes from those audits to inform where there were areas for improvement; the aim was to help improve patients experience. This tool was used for monitoring various quality aspects including: staff training and completion of appraisal; hygiene and infection control measures; completion of clinical records, including care plans and other assessment tools. We observed outcomes from those audits were displayed on individual wards.

The governance around monitoring risk assessments, action plans delivery, responses to complaints and investigating incidents was not sufficiently robust. At the time of the inspection the governance team was short staffed and some staff were employed on temporary basis. There was no dedicated support to the division and it had hindered its ability to ensure effective management.

**Management of risk, issues and performance**

We noted not all risks identified at the time of inspection were noted on the divisional risk register (medicine and urgent care risk register). For example, well known to senior leaders risk related to inability to provide on-call support to respond to upper gastrointestinal bleed was not noted on the register. The risk register identified 57 risks in total 11 of which were initially placed on the register in 2014 (19%) or before. Three risks related to lack of compliance with national clinical guidelines for management of multiple sclerosis, Parkinson’s disease and epilepsy were listed there since 2007.

In the table below, we list the top 10 risks related to medical care (May 2018).
We noted that action plans to ensure improvement were not always developed promptly and were not sufficiently monitored. For example, trust did not respond promptly to the National Cancer Patient Experience Survey published in July 2017 where they scored worse than expected in 44 out of 59 indicators. The action plan was developed only in January 2018, 29 out of 35 deadlines for actions were not indicated on the plan and it was not clear how potential improvements would be monitored.

<table>
<thead>
<tr>
<th>Title</th>
<th>Opened</th>
<th>Description of the risk</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to recruit to Gastro / Endoscopy Consultant Post</td>
<td>03/2017</td>
<td>Failure to recruit to 2 consultant vacancies in Endo / Gastro may result in failure to sustain endoscopy activity and implement recovery plan. The department would be unable to sustain current performance and will result in increased wait times and failure to meet diagnostic waiting times.</td>
<td>06/2018</td>
</tr>
<tr>
<td>Old Pathology Building Issues</td>
<td>02/2018</td>
<td>Security – unauthorized individuals and rodents potentially able to enter the building. Communal spaces – used to store cages, furniture and equipment Potential unauthorised access to confidential records. Water leak when it rains; water damage to the ceiling tiles.</td>
<td>06/2018</td>
</tr>
<tr>
<td>Use of Chase Farm Hospital's Surgical centre</td>
<td>02/2017</td>
<td>Contract to use 2 rooms at Chase Farm Hospital Surgical centre due to expire June 18. Presently no plan to extend, no agreed plans for alternative.</td>
<td>08/2018</td>
</tr>
<tr>
<td>Non-renewal of JAG Accreditation</td>
<td>02/2017</td>
<td>Because of a December 16 JAG data submission, the trust has been informed that JAG accreditation will not be renewed until able to evidence a reduction in diagnostic waiting times to be sustained over a 3-monthly period and schedule a JAG visit.</td>
<td>10/2018</td>
</tr>
<tr>
<td>Historic loose filing</td>
<td>06/2017</td>
<td>Because of a backlog of approximately 3000 loose patient notes that have not been linked to medical notes there is a risk that required review of patient procedures prior to digital capture via current software will not be available for consultant review which may result in diagnosis delay or repeat diagnostic request due to no picture comparison available.</td>
<td>10/2018</td>
</tr>
<tr>
<td>Insufficient space</td>
<td>06/2017</td>
<td>1. Insufficient number of clinic rooms. 2. Insufficient consultant office space. 3. No office space for the nurses. 4. Insufficient general storage space. 5. Insufficient storage space for patients’ notes.</td>
<td>08/2018</td>
</tr>
<tr>
<td>Consultant haematologist significant staff shortage.</td>
<td>08/2017</td>
<td>Because of a significant reduction in consultant haematologist staffing there is a risk that consultant cover will not be available which may result in on call, ward and clinic duties not being covered.</td>
<td>06/2018</td>
</tr>
<tr>
<td>Delivery of safe and effective care – Charles Coward Ward (CCW)</td>
<td>08/2016</td>
<td>It was noted that there were significant shortcomings in 1 Delivery of care on CCW 2 Documentation - nursing and medical 3 Security of notes 4 The dementia friendly nature of the ward 5 Leadership and staff morale</td>
<td>07/2018</td>
</tr>
<tr>
<td>Performing cardioversions in the anaesthetic room</td>
<td>09/2016</td>
<td>The room is too small to perform cardioversions safely. Highlighted by medical staff and incident report completed. Cardiology medical staff have refused to continue performing cardioversions in the anaesthetic room.</td>
<td>08/2018</td>
</tr>
<tr>
<td>Local safety standards for cardiac catheterisation</td>
<td>09/2016</td>
<td>Failure to develop local safety standards that meets the requirements of national safety standards for invasive procedures, could result in never events and /or other avoidable patient safety incidents that could result in patient death or severe harm.</td>
<td>12/2017</td>
</tr>
</tbody>
</table>
The trust was in the process of implementing the GRIP program (governance risk improvement program) aiming to increase the number of people engaged with risk management and improving learning from incidents and complaints. Lack of administrative support from the governance team was seen as a stumbling block to improving risk management. The trust was in a process of appointing additional staff within the governance team who supposed to be working closer with the division and provide direct advice and support to its teams.

**Information Management**

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 at their admission, for example, details of their current medicine.

They used information available through divisional performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery as well as patients and families. Key data, such as that gathered through Friends and Family Test or data related to safety thermometer, was displayed on individual wards in visible areas and notice boards.

The trust could provide us promptly with most of the standard information requested at the time of the inspection. However, we have noted that records quality was variable with some patients' records missing important information which should be routinely included. For example, body assessment on admission, patient’s understanding related to their diagnosis and information related to their spiritual needs or mobility at the day hospital unit.

**Engagement**

The trust engaged patients by encouraging them to participate in surveys such as Friends and Family Tests and other inpatient surveys conducted with use of the electronic audit tool be senior nurses. However, we noted that response rates have not always been satisfactory and for some wards these were below 10%. In addition, the results were not reported on many of wards throughout the past 12 months. Some nurses when asked about feedback for their individual wards did not understand how to interpret the results even though those were displayed in visible areas of the ward. The results were reported at clinical governance meetings.

The hospital held Schwartz rounds, a forum for hospital staff to talk about the emotional and social challenges of caring for patients. The aim was to offer staff an environment in which they could share their stories and offer support to one another. Staff who could attend those meetings said these were beneficial. However, many nurses said due to the wards being frequently understaffed they were often unable to attend.

Overall staff reported that the executive management team (EMT) were visible and very supportive. They told us they felt EMT understood challenges faced by the front-line staff and were looking to engage them in discussions related to future of their departments and future of the trust. They felt there was an improvement when comparing with the time when our previous inspection took place. The trust held a monthly staff briefing and, question and answer sessions in which staff had the opportunity to hear about corporate priorities and to put questions to members of the executive and other senior leaders.

Staff told us about numerous staff’s motivational initiatives undertaken by the trust and its leaders. It included nominating nurses for the monthly nursing magazine’s awards, or honouring staff for their outstanding contributions to patient care during the trust’s annual staff awards ceremony held in June 2017. Three staff members from the hospital had also been shortlisted for an NHS ‘Windrush Award’ that celebrates the contributions and diversity of minority ethnic staff to the NHS.
Learning, continuous improvement and innovation
The trust planned to introduce NEWS 2, updated in December 2017 version of the early warning score tool used to identify deteriorating patients, before November 2018 which will require a large investment of training and support.

There were plans to open and additional room were endoscopies would be carried out, this mean to service consolidation and substitute for the service provided by the department on another site at Chase Farm Hospital.

Various teams were undergoing comprehensive Deprivation of Liberties Safeguards (DoLS) training which was broken into modules and focused on increasing staff awareness of the Mental Capacity Act and DoLS and improve the assessment processes linked to it.
Surgery

Facts and data about this service

The trust has eight main operating theatres covering ophthalmology, urology, general surgery, orthopaedics and gynaecology. The trust has three surgical wards with a total of 74 inpatient beds.

(Source: Routine Provider Information Request (RPIR) – “Sites-Acute” tab)

The trust had 18,583 surgical admissions from December 2016 to November 2017. Emergency admissions accounted for 6,153 (33%), 11,310 (60%) were day case, and the remaining 1,120 (6%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory Training

The trust had a mandatory core skills training policy. The mandatory training programme was delivered face to face and via online e-learning modules. Mandatory training included modules in health and safety, manual handling, fire safety awareness, infection control, information governance, basic life support, conflict resolution, and equality diversity and human rights.

Mandatory core skills monitoring and recording was centralised within each department. This enabled department or ward managers to have oversight of mandatory training compliance and address any issues with staff compliance. We reviewed four staff mandatory training records and saw it was easy to check the status of mandatory training.

Staff were allocated protected time 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 to attend training. 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. In addition, the requirement for mandatory training completion was discussed at staff individual performance reviews and appraisals. Managers we spoke with were proud of the improvement made in mandatory training compliance since our previous inspection in September 2016.

The trust’s education and learning department sent email reminders to staff who were non-compliant with mandatory training and included the staffs’ managers in the email.

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to February 2018 for nursing/midwifery staff in surgery is shown below:

The trust provided training data for medical staff, dated 16 May 2018, in the form of a red, amber, green (RAG) rated dashboard.

We found training compliance was not meeting the trust’s standards in some mandatory training modules. For example, 54% of staff had completed PREVENT, this is training to spot and prevent radicalisation; 100% of staff had up to date level 1 resuscitation training; whilst 52% of staff had up to date training in resuscitation and adult basic life support, level 2.; and 55% of staff had level 3 resuscitation training. Staff highlighted that staff that had completed level 3 training did not have to update level 2 or level 1 training and said this skewed the compliance figures.
<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>141</td>
<td>122</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>141</td>
<td>121</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>141</td>
<td>119</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>141</td>
<td>115</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>140</td>
<td>113</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>128</td>
<td>99</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 83% which did not meet the trust target of 90%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff had completed training in sepsis across surgery. Surgery had also introduced a sepsis trolley and staff were competent in its use.

**Safeguarding**

Staff were required to complete level one and two safeguarding training for adults and children and the trust set a target of 90% for staff compliance with the requirement. Records indicated that across surgery services there was 91% compliance with safeguarding training, this was slightly better than the trust's 90% target.

Staff we spoke with had a good understanding of safeguarding procedures, they were able to provide us with some examples when safeguarding alerts had been raised and knew who to contact should they require additional support. Nursing staff told us they would routinely raise a safeguarding alert in cases where a patient’s pressure ulcer was hospital acquired.

The trust’s domestic violence policy had been updated in 2017, as the issue affected some of the trust’s patients.

The adult safeguarding lead attended the adult health leads meeting and both the adult and child safeguarding leads attended external safeguarding supervision.

Adult and child safeguarding lead had direct contact with the designated safeguarding leads in the local clinical commissioning groups (CCG), local authority, and the police and/or the coroner if required.

The contact details of the named safeguarding lead for adults and the named safeguarding lead for children were displayed on each ward and department we visited.

We spoke to staff who knew the process for reporting safeguarding. Although none of the staff we spoke with had reported a safeguarding referral, staff could give examples of what they would report and how they would report.

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2017 to February 2018 for nursing/midwifery staff in surgery is shown below:

We viewed the trust’s mandatory training spreadsheet dated 22 May 2018. This recorded 100% of medical and dental staff had level 3 safeguarding children training and 100% of staff had completed level one training, and 87% of staff had completed level 2 training. Staff highlighted that some staff had completed level 3 training when their update was due and as a result were
not required to complete level 2.

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>138</td>
<td>125</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>138</td>
<td>124</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 90% which met the trust target of 90%.

**Cleanliness, infection control and hygiene**

Infection prevention and control (IPC) policies and procedures were readily available to staff on the trust’s intranet. These included policies on hand hygiene, deep cleaning procedure, patients in isolation, laundry guidelines, and mattress policy. In addition, there were policies relating to healthcare associated infections, such as Methicillin resistant staphylococcus aureus (MRSA) and Clostridium difficile (C diff) and norovirus. This was in line with the recommendations of ‘The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance, criterion 9’, which states that healthcare providers should “have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections.” Advice on the prevention of infection was available to the public on the trust’s main website.

We saw staff adhering to the trust’s (IPC) policies and demonstrated good hand hygiene in line with best practice. Data supplied by the trust demonstrated 98% to 100% hand hygiene compliance between November 2017 and April 2018 across surgical wards and departments. This was consistent with our observations during the inspection. Although we did see a band six nurse wearing nail polish on the surgery assessment unit (SAU). This could pose an infection risk if nail polish deteriorates. All staff were compliant with the trust’s ‘bare below the elbows’ policy in clinical areas.

Each department we visited was visibly clean and tidy. Clean equipment had ‘I am clean’ stickers attached to indicate to staff that the equipment was clean and ready for use. Cleaning schedules were displayed on individual wards; an external cleaning company provided cleaning services. This was inspected on a weekly basis by the cleaning supervisor and matron. This provided assurance that there was oversight of the effectiveness of the cleaning. The external provider showed us records dated May 2018 which provided evidence of the matron and cleaning provider’s joint inspections.

All patients attending the hospital for pre-assessment prior to admission for a procedure were swabbed for Methicillin resistant staphylococcus aureus (MRSA). Swabs were taken from nose and groin of all patients. Patients were rarely admitted for long enough for repeat MRSA swabbing seven days after admission.

The trust had a designated infection prevention and control team, in accordance with the recommendation of criterion one of the codes of practice. The team included the designated lead for infection control and qualified infection control nurses. The team worked across the trust, and coordinated with other healthcare professionals, patients, and visitors. The infection prevention and control team responsibilities included: advising staff, providing education and training in (IPC), monitoring infection rates, and auditing of (IPC) practices.
We saw personal protective equipment (PPE) was readily available and used correctly by staff. PPE refers to protective clothing such as aprons and gloves designed to protect people from the spread of infection.

Flooring in the ward areas was seamless and smooth, slip-resistant, and easily cleaned.

Each ward and surgical area had detergent cleaning wipes, antibacterial cleaning wipes for staff use. We saw staff using these appropriately. For example, we saw staff wiping down the trolley after every use in the pre-assessment unit (PAU).

We saw posters showing the National Colour Coding System for hospital cleaning equipment and materials. The National Reporting and Learning Service developed a National Colour Coding Scheme for cleaning materials thus ensuring that these items are not used in multiple areas, therefore reducing the risk of cross-infection.

We viewed cleaning schedules for surgery and records of daily, weekly and monthly cleaning and overall found these to be complete and up to date.

Waste was stored and segregated in accordance with ‘The Safe Management of Healthcare Waste Memorandum’, HTM 07-01.

We inspected eight yellow sharps disposal bins in theatres and the wards and found them to be correctly assembled and labelled. This was in accordance with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The hand washbasins in all areas were compliant with the health building note ‘Infection control in the built environment’, HBN 00-09. Washbasins did not have plugs and overflows, as well as lever operated mixer taps.

Cleaning chemicals were stored in a locked cupboard on the wards, this was in accordance with guidance on the ‘Control of Substances Hazardous to Health Regulations 2002’, (COSHH).

We saw theatre five orthopaedic team had a number of staff who entered the theatre during a surgical procedure. The theatre had a telephone for staff communication. Staff entering theatres should be kept to a minimum during procedures to ensure patients are protected from potential infection risks from staff entering theatres to communicate with the surgical team.

Environment and equipment

All patients were admitted to the day surgery ward if they were having a local or general anaesthetic procedure. From here, they went to theatre, then recovery and back to the day surgery ward if they were going home on the same day and to an inpatient ward if staying overnight.

We inspected 12 pieces of electrical equipment and found all of them had received electrical safety checks within the previous 12 months. Maintenance records were kept by the trust’s estates team. Staff told us staff also checked servicing dates on equipment prior to use.

We saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines ‘Safe Management of Anaesthetic Related Equipment’ (2009) was adhered to. This guideline stated that records must be kept of each safety check of all anaesthetic machines in a logbook, which was kept with the machine. This meant there were assurances that vital safety checks had been undertaken and the equipment was safe to use.

In theatres, there was an effective system to ensure the recording of medical implants used. This was in accordance with the Medical Devices Regulations 2002. A medical implant is a device intended to be either totally introduced into the body or to be partially introduced into the body through surgery and to remain there for at least 30 days.
We inspected the theatre resuscitation trolley. All items in the trolley were in date. We looked at a month of records and saw that the trolley had been checked daily. We inspected the resuscitation trolleys on wards. We found all items in the trolleys were in date. We viewed records of checks for the previous month and found them to be complete. This meant there was a system, which ensured emergency equipment was safe and available for use.

We inspected the resuscitation trolleys across surgery wards. We found all had recent records to say items on the trolleys had been checked and were in date. This meant that the system for ensuring that medicines used for resuscitation were safe to use was effective. We saw records of checks for the previous month and saw they were complete.

All fire extinguishers we examined had an annual maintenance record. All wards had visible fire action signs and exit signs in the event of an emergency. Fire exits were clearly signposted and free from obstruction.

Theatres had a difficult intubation (placing a breathing tube in the windpipe) trolley, which met the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Difficult Airway Society standard. The difficult intubation trolley had completed records to show it was checked on a regular basis and safe to use.

Theatres were fitted with an uninterrupted power supply which meant lifesaving equipment would continue to operate in the event of a power cut.

In theatres, we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients’ operations. This ensured no items were left in patient’s bodies following surgery and was in accordance with the Association for Perioperative Practice guidelines.

The surgery risk register recorded an increase in the use of invasive ventilators in the previous three years. The trust had mitigated the risk by having a policy of non-clinical transfer of patients requiring invasive ventilation if nine of the 10 ventilators were in use. The register also recorded that staff must ensure invasive ventilators were serviced in accordance with the manufacturer’s recommendations.

The surgery risk register recorded that the linear accelerator (Linac) machine was nine years old and was having more unscheduled downtime for maintenance. This created a risk that patients would miss treatments. In mitigation the service were offering Saturday appointments for missed treatments and had received funding to update the machine and were submitting a business case for a replacement.

Staff told us the trust’s staff identification cards allowed staff to gain entry to theatres via a swipe card system. However, trust staff who were unauthorised in theatres could gain access. Staff told us this had been raised on “numerous” occasions with the trust’s security team, requesting that theatre access was restricted to theatre staff, but this had not been rectified.

Assessing and responding to patient risk

The trust policies provided guidance, which was supported by a range of risk assessment tools for the staff to use to assess patient risk. These were available to all staff via the intranet and used to ensure the staff were aware of them and how they could mitigate avoidable patient risk.

Comprehensive risk assessments were carried out for patients in line with national guidance. These were carried out both pre-operatively and post operatively to highlight those who may need additional support. We reviewed eight care records, which showed risk assessments and actions taken. This included those patients at risk of falls, blood clots and pressure area damage.
Medical emergency, crash call arrangements were in place and staff had good knowledge of what to do in the event of a patient deteriorating. Staff on S3 Ward gave an example of when a situation had gone well and staff had called the trust’s crash team.

The pre-assessment unit was led by nurses and supported by health care assistants (HCA). The unit had a dedicated lead. If staff felt the patient required a medical review they were referred for an anaesthetist review. Anaesthetists ran clinics weekly. Patients were reviewed and referred to other healthcare services if required. Patient pre-assessments were undertaken in accordance with routine preoperative tests for elective surgery, as defined by the National Institute for Health and Care Excellence (NICE) guideline, NG45.

HCA’s did the initial screening and blood tests, then a qualified nurse completed a full nursing assessment.

The American Society of Anaesthesiology classification grading of patients were clearly recorded on admission in the surgical assessment unit (SAU). The American Society of Anaesthesiology grading is a system for assessing the fitness of patients before surgery. Of the four records we looked at, all had a clear American Society of Anaesthesiology grading recorded.

Arrangements for handover and shift changes ensured people were kept safe. There were regular handover meetings and ward rounds. Handover procedures included information about all patients and highlighted areas of concern, such as patients at risk of falls or patients at risk of developing pressure areas on their skin.

Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein, most commonly in a leg vein but a blood clot can travel to the lungs. The protocol at NMUH was that all surgical patients should have their risk of VTE and bleeding assessed on initial clerking once admitted under the surgical team. This risk assessment was then to take place again on the post-take ward round (first consultant review). The clerking booklet contained an assessment tool for both, in the form of the Department of Health (DoH) VTE risk assessment tool. This was initially completed by the doctor on call, with the subsequent post-take assessment completed in the presence of a consultant. The calculated risk of VTE was also recorded on the front of all trust drug charts, where the risk was stated as ‘low’ or ‘high’ based on the patients most recent assessment.

We reviewed six patients VTE records; three of these contained a fully completed VTE assessment and three had partially completed VTE assessments. Staff were also recording VTE assessments on drug charts. One member of staff was not sure which document they needed to complete, this had led to some staff recording partially on both the drug chart and the VTE risk assessment.

The trust audited VTE risk assessments on 9 March 2018 to assess the current performance in terms of both VTE and bleeding risk assessment and appropriate pharmacological intervention. The audit findings confirmed what had been found during the inspection. Audit data showed that the completion of initial risk assessments on admission was poor (42%). However, this was significantly higher than those who received re-assessment on post-take ward rounds (0%). The audit findings were that the absolute failure to document re-assessment may have suggested that both juniors and consultants were unaware of the need to do so.

In response the trust had produced an action plan with a range of actions, including a presentation at daily trauma meeting and departmental audit meeting to ensure doctors were aware of the trust’s protocol; inclusion of VTE assessment and prophylaxis prescribing in the induction booklet provided to doctors at the start of their rotation; posters displayed in trauma and orthopaedic ward office reminding doctors of importance of VTE assessment and prevention; and a meeting with ward pharmacists to emphasize the importance of VTE prophylaxis checks and assessment of appropriate dosing (i.e. that the assessment on the front of the drug chart correlates to the prescribed prophylaxis). The trust was also rolling out new VTE assessment documentation in
June 2018. The intention was to re-audit VTE once the new procedures and documentation were in place to measure compliance.

Staff told us they checked the pregnancy status of female patients of potential childbearing age on the morning of planned surgery by undertaking a pregnancy test. We saw the results of the test were documented on pre-operation checklist. Two people were required to verify and document the result.

A system was in place to support patients when they were discharged. On discharge, patients were given the ward’s telephone number and could contact the ward 24 hours a day seven days a week.

Staff followed the National Patient Safety Agency five steps to safer surgery as part of the World Health Organisation (WHO) surgical safety checklist in all operations we observed. The purpose of the checklist was to check the safety of a patient’s operation prior to undertaking surgical procedures. This included, for example, checking it was the correct patient, the correct surgical site, and ensuring staff were clear about their roles and responsibilities. We reviewed 12 WHO surgical safety checklists and found these were complete. Staff highlighted that compliance with the WHO checklist had improved since our previous inspection in September 2016 from 50% to 90%. This meant the trust could be assured that the WHO surgical safety checklists were undertaken consistently.

All qualified members of staff were required to complete intermediate life support (ILS) training. The matrons and resident surgical officers were required to complete advanced life support (ALS) training. If a patient became acutely unwell during admission, the staff would stabilise the patient and then transfer the patient to the intensive care unit (ICU). There was a pathway in place, which allocated if an acutely unwell patient required critical care.

Surgery wards were effectively using the National Early Warning Score (NEWS), this is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients, to monitor vital signs in adult patients on the ward and ensure early intervention if the NEWS indicated a deterioration in a patient’s condition. For example, staff told us about a patient with Sepsis where the patients NEWS results had prompted staff to take further action, such as increasing the frequency of monitoring of the patients vital signs and informing medical staff so they could review the patient and escalate their treatment. This was in accordance with National Institute for Health and Care Excellence (NICE) guideline CG50: ‘Acutely ill patients in unit- recognising and responding to deterioration’.

Surgery wards used the situation, background, assessment, recommendation (SBAR) tool to facilitate effective handovers and escalate clinical problems.

The trust highlighted that the National Bowel Cancer Audit 2017 confirmed that the trust had the highest number of American Society of Anaesthesiologists (ASA) category three, (patients with severe systemic diseases), and four patients, (patients with severe systemic disease that is a threat to life), in the region and the third highest in London. In response the surgical and cancer division had appointed an ‘enhanced recovery Fellow’ to complete twice daily ward rounds of these patients.

There was a risk assessment for individual patient outlier decisions. This clearly documented the decision-making process and reasons for patients being considered appropriate to stay on non-surgical inpatient wards. A patient could only be moved to a non-surgical ward on completion of a risk assessment and if the patient met all the ‘essential criteria’.
The surgical assessment unit (SAU) had a mental health liaison officer. If a patient had identified mental health needs the liaison officer could arrange for a registered mental health nurse (RMN) to provide specialist care for patients requiring supervision or observation due to their mental health needs. After 24 hours it was the trust’s responsibility to provide patients with RMN support.

**Nurse staffing**

Expected and actual staffing levels were clearly displayed on safe staffing dashboards at the entrance to all the wards we visited.

The surgical wards used a ‘Safe Care’ staffing tool. This was a tool that looked at patient dependency needs and the numbers of staff required to provide patients with safe care.

Staff moved across surgical services to ensure safe nursing staffing levels could be maintained across surgical services. Surgery had no unfilled shifts in the previous six months. The trust had achieved this by staff working bank shifts and having skills to flex across wards. However, some staff said staff on the surgical assessment unit (SAU) told us staff were disproportionately moved from the SAU to other wards. Staff told us managers worked clinically ‘on the floor’ during winter pressures to assist staff and cover vacant shifts.

During our inspections we found theatres were staffed in accordance with recommendations from the Association for Perioperative Practice (AFPP). Staff told us there was a shortage of scrub nurses in theatres. In response band 7 nurses were acting down to provide support.

There was one recovery nurse per theatre, or two nurses for paediatric patients. Nursing staff rotated between theatres, although some nursing staff had specific orthopaedic scrub skills and would be deployed in the first instance to orthopaedic theatres.

Recovery had a patient to recovery nurse ratio of 1:1, where there was complicated access, two recovery staff would be allocated to the patient.

Theatres had five registered nursing vacancies at the time of our visit. Vacancies were being advertised in professional journals, NHS jobs, and on the trust’s website.

The trust has reported their staffing numbers below as of January 2018.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>249.58</td>
<td>223.8</td>
<td>90%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From February 2017 to January 2018, the trust reported a vacancy rate of 15.5% in surgery; worse than the trust target vacancy rate of 7.5%. The trust had a rolling programme of recruitment to address the shortages of nursing staff.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From February 2017 to January 2018, the trust reported a turnover rate of 20.6% in surgery, worse than the 15% trust target.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From February 2017 to January 2018, the trust reported a sickness rate of 4.2% in surgery; worse than the trust target rate of 3.5%.
The trust has identified the trauma and orthopaedics department in surgery as one of the areas where bank and agency usage was highest.

**Medical staffing**

The general surgery business plan 2018 to 2019 outlined staffing in the department as 11 full-time consultant posts covering a number of sub-specialties and four full-time consultant emergency surgeons. These were supported by 13 registrars, including one enhanced recovery fellow and one senior colorectal fellow; 7.5 senior house officers (SHO) and 11 junior doctors (FY1).

There had been no unfilled medical staff shifts from December 2017 to May 2018.

The clinical lead for surgery told us the trust had an ‘enhanced recovery’ fellow who covered gaps in the surgical rota and this had led to substantial cost savings to the trust as it reduced the need to use agency locums.

The trust had four emergency surgeons providing cover from 8am to 8pm, Monday to Friday. The trust had also appointed a fifth emergency surgeon who was awaiting a start date. Weekend surgical cover was provided by general surgeon who did a twice daily ward round, in the morning and in the evening, on Saturday and Sunday.

The trust has reported their staffing numbers below as of January 2018.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>83.09</td>
<td>77.97</td>
<td>94%</td>
</tr>
</tbody>
</table>

(\textit{Source: Routine Provider Information Request (RPIR) P16 Total numbers – Planned vs actual tab})

As at February 2017 and January 2018, the trust reported a vacancy rate of 10.4% in surgery; worse than the trust target rate of 7.5%. Vacancies were being advertised in professional journals, NHS jobs, and on the trust’s website.

(\textit{Source: Routine Provider Information Request (RPIR) P17 Vacancies})

From February 2017 to January 2018, the trust reported a turnover rate of 21.7% in surgery; this is worse than the trusts target rate of 15%. Staff told us this was mostly due to staff gaining promotion either within the trust or with another employer. The service had a rolling programme of recruitment. The trust was also monitoring staff exit interviews to identify areas which the trust could improve in regard to staff retention.

(\textit{Source: Routine Provider Information Request (RPIR) P18 Turnover})

From February 2017 to January 2018, the trust reported a sickness rate of 2.2% in surgery, better than the trusts target rate of 3.5%.

(\textit{Source: Routine Provider Information Request (RPIR) P19 Sickness})

The trust was unable to provide data on bank and locum usage for the surgery division overall. However, the trust did provide the trust’s spending figures on bank and locum usage.
There were twice daily medical handovers. There were arrangements for the handover of patients if there were changes to the patients’ consultant or medical team. Following the handovers, consultants fed back changes in patients care and treatment to nursing and therapy staff.

From December 2017 to December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the whole time equivalent staff working at North Middlesex University Hospital NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>16%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

**Records**

We reviewed 15 patient records. Guidance on the falls risk assessment form advised staff to complete additional falls care plans for all patients at high risk. We found up to date and completed falls risk assessments in patients’ records.

During our last inspection, we found there was a lack of clarity in how changes to theatre lists were communicated to doctors and theatre staff. However, during this inspection we found this had improved as theatre lists indicated any changes implemented to the lists following dissemination the previous day. The lists were discussed at morning briefings.

The trust had introduced ‘perfect ward’ which is a system for the collection of data. The system enables staff to audit services in ‘real time’, as well as providing an on-going system of performance measurement. This is achieved by the use of smart phones and tablet computers with an application (app). For example, we viewed ‘perfect ward’ clinical record audits dated from February 2017 to April 2018 for wards: S2, S3; and T3. We found: Ward S3 had an average records audit score of 91% in the period: Ward S4 had a score of 94% in the period: Ward T3 had average score of 84% in the same period.

Perfect ward allowed staff to target specific areas of record keeping. For example, the system allowed managers to monitor patients’ chemotherapy records and fluid intake charts. Staff also used the system to flag whether action had been taken in response to the system identifying shortfalls in record keeping.
Medicines
The trust had a medicine policy, which was in date and referenced national guidance for example General Medical Council (2013), ‘Good practice in prescribing and managing medical devices’, and Nurse and Midwifery Council (2006), ‘Standards for proficiency for nurse and midwife prescribers’.

The trust had introduced critical medicines workshops every Thursday from noon until 1pm. Inpatient wards sent a member of staff to the workshops. Managers told us it was difficult to release more than one member of staff a week, but, learning from the workshops would be cascaded at team meetings.

We asked staff in theatres for ambient room temperature recordings for the medicines storage room but staff were unable to produce any records of the ambient room temperature with the exception of S2 ward. We noted the medicines room was hot. This meant there was a risk that flammable liquids were not being stored at the manufacturers recommended temperature. Staff showed us minutes of a meeting dated 5 April 2018 where the recording of the room temperature and monitoring was discussed and agreed. Staff told us they didn’t record room temperatures as they were not aware of a document for recording this.

We inspected four medical gas cylinders in theatres and found all of them to be correctly stored, labelled and within date. Surgical wards had piped oxygen.

Controlled drugs are medicines liable for misuse that require special management. All controlled drugs were kept in a double locked cupboard within a room that had code lock to access. The keys to the controlled drug cupboard were kept with a registered nurse at all times. The controlled drug register showed records were fully completed. Although we found three incorrect drug name entries in the controlled drug register, the pharmacist and nurse amended the CD register to record the correct name. Both the nurse and pharmacist signed the CD register and told us they would complete incident reports for these errors. The pharmacist also arranged extra training on this for nurses and escalated it to the lead nurse. The lead nurse confirmed this had been done.

We reviewed three medicine charts. They were legible, had drug allergies documented, had no missed doses, had the patient weight recorded and were signed. We found the completion of venous thromboembolism (VTE) assessments was variable. However, the trust was in the process of rolling out new VTE documentation across surgery.

We found intravenous fluids were stored in locked rooms on the wards and theatres. We checked intravenous fluids and found them to be in date and intact. This showed compliance with National Institute for Health and Care Excellence (NICE) guidance, CG174 ‘Intravenous fluid therapy in adults in hospital.’

We saw ten blank prescriptions, which were kept in a locked cupboard. These were occasionally given to patients on discharge to obtain medicines. An effective process ensured these were tracked and monitored correctly. This was in line with NHS Protect security of forms guidance prescription. Prescriptions clearly documented patient allergies.

In theatres a clinical treatment room was locked using a code lock. However, we saw a medicines storage cupboard in the room with a code lock, and the medicine cupboard lock code was displayed in small numerals near the door. This meant unauthorised staff might gain access to the cupboard. The clinical treatment room medicine trolleys were locked and attached to the wall.

Pharmacist non-medical prescribers could prescribe ‘to take away’ (TTA) medicines on all surgical wards to support effective discharges. Staff told us this had a positive impact on patient flow and patient experience, as patients didn’t have to wait for medical staff to prescribe medicines that the
pharmacist could provide. During our previous inspection in September 2016 TTA turnaround in one hour was 67%. During this inspection we found the TTA turnaround had improved. For example, in May 2018 the TTA turnaround was 100%.

We looked at the trust’s ‘medicines reconciliation’ audit conducted in May 2018. The audit reviewed the 90% target for pharmacy that patients should have their medication reconciliation completed within the last 24 hours. The surgical division scored an average of 88% over a 2-year period. During the months from December 2017 and January 2018 increased pharmacy workload had resulted in a drop in patient medication reconciliation not being completed within 24 hours. However, this improved in February and the trend continued in April. The pharmacy medication histories service was provided from Monday to Friday from the hours of 9am to 5:30pm and therefore some patients medication histories could not be completed within 24 hours.

Medicines reminder charts were given to people upon discharge to help them take their medicines correctly at home. For example, they contained information regarding possible side effects and how often they should take the medicines.

There were systems in place to check for expired medicines. We looked at a random sample of medicines at all the locations we visited and found all of the medicines we saw were within the expiry date. Staff told us that pharmacist and pharmacy availability was good. A pharmacist visited wards on a daily basis during the week and checked the patient medicine charts, medicine stock levels and ensured drugs for the patients to take home were available. Medicines advice was available out of hours via telephone to the pharmacy at the hospital.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported four incidents classified as never events for surgery. All four never events were classed as surgical/invasive procedures.

*(Source: Strategic Executive Information System (STEIS))*

However, staff explained that there had been three never events from March 2017 to February 2018, a fourth never event occurred in 2016 and could not be investigated by the trust until 2018, as the trust was awaiting the conclusion of a Police investigation.

In our previous report dated September 2016 we reported that actions in response to never events were not fully implemented. However, during this inspection we found the trust had addressed this and clear action plans were in place and monitored by the trust. For example, all the never events between March 2017 and February 2018 related to wrong site surgery. In response the trust had implemented a range of actions including:
- new world health organisation (WHO) safety forms for pain implemented in July 2017;
- new safety check lists were implemented in February 2018;
- human factors training was rolled out in November 2017;
- radiographers participation in WHO check lists were due to be implemented, and a standard operating procedure (SOP) for patients being transferred to theatres was introduced in April 2017. The trust had also introduced two staff checking patient central venous catheters prior to patients being taken to theatre.

In response to never events the trust had also rolled out ‘human factors’ training across surgery. This meant staff could use knowledge of human factors to make their work environment and activities safer.

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from March 2017
Of these, the most common types of incident reported were:

- Surgical/invasive procedure incident meeting SI criteria with five (71% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (14% of total incidents).
- Slips/trips/falls meeting SI criteria with one (14% of total incidents).

(Source: Strategic Executive Information System (STEIS))

The trust had an electronic incident reporting system to facilitate staff in reporting incidents and allow effective monitoring. Staff we spoke to could identify what incidents to report and how to report them. For example, a ward manager told us the always completed an incident report if staffing didn’t meet the ‘Safe Care’ standards.

Surgical services across all wards and departments including pharmacy reported 2082 clinical incidents between May 2017 and April 2018. Of these incidents 1671 resulted in no harm, 377 in moderate harm, five had resulted in severe harm, and six had resulted in death related to the incident rather than the patient’s illness or condition. The top three themes of incidents reported were: instruments missing, incorrect or damaged on return from the contractor, 203 incidents; records missing or unavailable, 101 incidents; and unobserved slips, trips or falls, 94 incidents.

There were named governance leads across the specialities. The lessons learned from the review of incidents were distributed via newsletters and at team meetings. Staff were positive about the trust intranet site and told us it contained lots of useful information with learning from incidents.

All staff we spoke to were aware of how to report an incident via the electronic reporting system.

The surgical and cancer division had a dashboard to monitor incidents by location. For example, from May 2017 to April 2018 the surgical location with the most reported incidents were general theatres with 222 incidents.

In our previous report dated September 2016 we reported that the reporting of actions from mortality and morbidity meetings was not formalised to allow learning and actions to be captured and shared across the trust. During this inspection we viewed three sets of mortality and morbidity meeting minutes dating from January to April 2018 and found the trust had introduced an ‘actions log.’ This clearly identified actions from the meeting and the member of staff responsible for disseminating information across the trust and to whom the information from the meeting would be disseminated. Actions from the action logs were monitored at subsequent meetings.

We viewed a letter dated 3 April 2018 which the trust had sent to a patient following a serious incident. The trust provided the patient with a copy of the incident investigation and offered the patient an explanation of actions the trust had implemented to minimise the risk of a similar
incident. The trust also offered the patient a sincere apology. This was in accordance with the Duty of Candour, this is a requirement that healthcare professionals must be open and honest with patients when something goes wrong with their care and treatment or has the potential to cause, harm or distress.

**Safety Thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the service reported 0 new pressure ulcers, 0 falls with harm and 0 new catheter urinary tract infections from February 2017 to February 2018 for surgery.

In our previous report we reported that patients with pressure ulcers had not had the incidents electronically logged despite staff’s awareness of the requirement of recording pressure ulcers. During this inspection we found the service had not had any incidents of pressure ulcers in the previous 12 months. However, staff were aware of the procedure for reporting pressure ulcers grade 3 or above as incidents and raising safeguarding alerts for grade 3 and 4 pressure ulcers or where there were multiple grade 2 pressure ulcers, in accordance with the Department of Health guidance, ‘Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry, 2018’.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, at North Middlesex University Hospital NHS Trust between February 2017 and February 2018**

![Graph showing prevalence rate of pressure ulcers](Source: NHS Digital)

**Is the service effective?**

**Evidence-based care and treatment**

The surgery services had processes to ensure care and treatment was based on current evidence-based practice.

Policies and guidelines were in place and reflected evidence based care and treatment. National Institute for Clinical Excellence (NICE) guidance was circulated to the identified lead within each directorate or department. However, we noted that some policies in theatres did not have a reference list of documents or sources. This meant staff reading the policy would be unable to easily identify what underpinning legislation the policy was based on or have a list of helpful sources.
The trust entered all medical devices onto national registers such as the joint register. This ensured all medical device implants could be traced if concerns were raised about the quality or possible adverse effects at national level.

The trust had introduced a range of clinical pathways since our previous report in September 2016. For example, we viewed a range of pathways, including the ‘prostate pathway’ dated February 2018, and ‘haematuria pathway’, (haematuria relates to the presence of blood in urine), dated January 2018.

Care and treatment was based on the ‘enhanced recovery pathway’. These pathways ensure patients are encouraged to participate actively in their preparation and recovery by promoting early mobilisation, eating, and drinking. For example, hip and knee replacements. This helped to ensure a shorter recovery time. We saw the discharge process started during the pre-assessment appointment. This meant any support a patient may require was organised in advance.

To support patients to mobilise early following surgery, there were processes to review timely removal of catheters. This also reduced the risk of hospital-acquired infections associated with these devices.

Staff followed World Health Organisation (WHO) guidelines for debriefings. We viewed electronic debrief records and found these to be detailed. Although staff told us surgery was moving to a new record system as the current system was time consuming.

Staff adhered to the National Institute for Health and Care Excellence (NICE) guidance ‘Surgical site infections: prevention and treatment; CG74’ to reduce the risk of surgical site infections.

We saw patients’ observations, including patients’ temperatures and pulse rates, were recorded appropriately in patient’s records. This was in accordance with NICE guideline ‘Acutely ill patients in unit- recognising and responding to deterioration, CG50’.

Staff assessed patients’ physical, mental health and social needs holistically, this started at the pre-assessment stage. For example, staff obtained information about patients social care needs and abilities with activities of daily living (ADL) to facilitate discharge planning.

The trust had a monthly ‘perfect day’ initiative. This included all staff including administrators in ensuring a perfect day in theatres. The perfect day was organised two weeks in advance. The perfect days audited how staff were using trust processes. The consultant divisional director told us the perfect days had been effective in identifying teams that were not fully following trust processes and gave an opportunity for this to be addressed. The clinical director told us it was an expectation of the clinical commissioning group (CCG) that the World Health Organisation (WHO) checklist was audited bi-monthly due to the service having had never events in the previous 12 months. This had resulted in all theatres having 100% compliance with the WHO checklist.

Nutrition and hydration
There was an effective process to ensure patients were nil by mouth prior to undergoing a general anaesthetic, each patient was asked to confirm when they last ate and drank on arrival to theatre. The amount of time patients were kept ‘nil by mouth’ prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon had an early breakfast, this was in accordance with best practice.

Staff told us if there were delays in theatres they would speak with the anaesthetist to see whether patients could be offered a drink or commence intravenous therapy (IVT).
Patients undergoing joint replacement surgery were given high calories to drink the day before and on the morning of their operation. The drinks are specifically formulated to ensure patients are adequately hydrated and help the body cope with the stress of surgery.

The trust used a Malnutrition Universal Screening Tool (MUST), to identify patients at risk of malnutrition. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines, which can be used in care planning. Patients admitted for more than 24 hours following surgery should have had a MUST assessment score.

We found the use of the MUST score was consistent. Patient records we viewed had complete MUST assessment. This was undertaken at pre-assessment so that patients who required additional input to enhance their nutrition were referred to a dietitian.

Staff could refer patients to a trust dietitian. The dietician advised patients and staff on all aspects of diet and nutrition. However, we did not review any patients that had required referral to a dietitian.

Patient’s dietary needs were recorded in their assessments and care plans. For example, if the patient was vegetarian. If a patient had specific dietary needs this would be highlighted at pre-assessment to ensure arrangements were in place to meet their specific needs.

All patients had drinks within reach. During our inspection we saw staff encouraging and assisting patients to drink.

Patients undergoing day surgery were offered light refreshments and drinks prior to discharge.

**Pain relief**

The department used the ‘one to three’ pain score on rest and on activity. One being no pain and three being extreme pain. Patients had their pain scored using a nationally recognised tool.

Patient’s pain was scored when they were resting and when they were moving. This assisted staff in identifying the most suitable method of pain control for each patient.

The staff told us they had good access to pain management advice from the trust’s acute pain service following patient’s surgery.

Different varieties of pain relief were discussed with patients during their pre-assessment. For example, epidural, a pain relief injection into the patients back; regional pain relief block, a pain relief that targets the patients central nervous system; patient controlled analgesia, a method of allowing a person in pain to administer their own pain relief; or continuous analgesic infusions, pain relief administered intravenously (IV) such as a syringe driver.

Patients we spoke with confirmed that their pain was managed. For example, one patient told us, “They are managing my pain. They ask about my pain levels.”

**Patient outcomes**

The trust contributed to national audits in order to measure patient outcomes. These audits included the national joint registry, this is a national registry that monitors patient outcomes after knee or hip replacement operations. This enables patients to be monitored, and recalled where necessary, as information relating to patients operations was stored. However, the trust did not contribute to the national vascular registry as the service did not offer eligible services.

We requested information from the trust on catheter urinary tract infections (CUTI). In response the trust sent us trust wide data on CUTI, but this only carried information on the percentage of patients with a catheter, which was 24% in February 2018. This was above the England average of 17.5%. The percentage of patients with a CUTI was not easily discernible from the chart the trust provided,
but varied between 0% to 3% from February 2017 to February 2018. The data did not discern whether patients developed CUTI after being catheterised. However, the trust acknowledged that this was an area they needed to address this with a break down of wards where there was a higher than National average, to enable the trust in developing ward based action plans.

We requested information from the trust on the prevalence of pressure ulcers in the previous 12 months. The trust returned a dashboard which was used to monitor the incidence of pressure ulcers across the hospital on a month by month basis. From April 2017 to March 2018 there had been one recorded category 4 hospital acquired pressure ulcer across surgical wards, this was on Ward S2. We noted there had also been five category 2 hospital acquired pressure ulcers in the same period on Ward S2. Other surgical wards did not have any incidence of hospital acquired pressure ulcers in the period, with the exception of Ward S3 which had two category 2 hospital acquired pressure ulcers.

The trust had a divisional dashboard that monitored patient outcomes. This was a spreadsheet which provided at-a-glance views of surgery key performance indicators (KPI).

The trusts performance in elective admissions was mixed, with both general surgery and ophthalmology at a higher risk of readmission than the England averages. The overall performance for elective admissions is better than the England average.

Overall performance in Non-Elective admissions is better, with two of the specialities having a lower risk of readmission than the England average.

**Elective Admissions – Trust Level**

![Elective Admissions Graph]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity* 

**Non-Elective Admissions – Trust Level**

![Non-Elective Admissions Graph]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*  

(Source: HES - Readmissions (01/11/2016 - 31/10/2017))

The trust informed us that historically they had a record via internal audit of low readmission rates and this mitigated patient’s longer length of stay. The trust told us the readmission rate in 2017 was higher than average due to a data coding issue. For example, when patients were returned to the surgical assessment unit (SAU) for a wound check or blood test, this was being coded by
staff as an ‘admission.’ The trust said the coding issue was being addressed as the surgical department had developed a work around with patients being returned to the clinic. However, the trust said the change in procedure wouldn’t be reflected in results until the 2018 data was published.

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 5.7% which was within the expected range. The 2016 figure was 10.2%.

The proportion of patients having surgery on the day of or day after admission was 91.6%, which was better than the national standard of 85%. The 2016 figure was 89.5.

The perioperative medical assessment rate was 98.6%, failed to meet the national standard of 100%. The 2016 figure was 98.7%.

The proportion of patients not developing pressure ulcers was 97.7%, which falls in the middle 50% of trusts. The 2016 figure was 95.3%. Therefore, the trend was improving.

The length of stay was 17.9 days, which falls in the middle 50% of trusts. The 2016 figure was 19.2 days. Therefore, the trend was improving.

(Source: National Hip Fracture Database 2017)

The trust highlighted that to mitigate the length of stay the trust had a higher than national average deprivation demographic. The trust also highlighted that there was a large non-English speaking population.

In the 2017 National Bowel Cancer Audit, 101.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate of 69.5%. The 2016 figure was 94.6%.

The risk-adjusted 90-day post-operative mortality rate was 15.1% which was worse than expected. The 2016 figure was 4.9%.

The risk-adjusted 2-year post-operative mortality rate was 14.3% which fell within the expected range. The 2016 figure was 18.3%.

The risk-adjusted 30-day unplanned readmission rate was 17.4% which was within the expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 67.8% which was within the expected range. The 2016 figure was 59.9%.

(Source: National Bowel Cancer Audit 2017)

In our previous report dated September 2016 we reported 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. We discussed the Bowel Cancer Audit results with staff. Staff said the trust was of the opinion that there were discrepancies with the trust’s data submission to the audit and this may have skewed results. However, a data clerk had been appointed in 2017 to rectify the issue. The trust also highlighted that individual surgeons had published mortality outcome measures that fell within accepted ranges. The trust said they had queried the data that indicated they were an outlier for 90 day post-operative mortality rates.

The National Bowel Cancer Audit 2017 confirmed that the trust had the highest number of
American Society of Anaesthologists (ASA) category three, (patients with severe systemic diseases), and four patients, (patients with severe systemic disease that is a threat to life), in the region and the third highest in London. In response the division were in the process of recruiting a geriatrician to review the medical and social needs of these patients.

In the 2016 National Oesophago-Gastric Cancer Audit, poor quality data were provided for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing.

The 90-day post-operative mortality rate was listed as not eligible. The 2015 rate was also listed as not eligible.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 37.4%, similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

In the 2016 National Emergency Laparotomy Audit (NELA), the trust achieved a red rating (less than 50%) for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 34 cases.

The trust achieved a green rating (over 80%) for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 15 cases.

The trust achieved an amber rating (between 50% and 80%) for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 18 cases.

The trust achieved a green rating (over 80%) for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 12 cases.

The risk-adjusted 30-day mortality for the trust was within expectations, based on 34 cases.

(Source: National Emergency Laparotomy Audit)

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 performance on groin hernias was about the same as the England average, with the EQ VAS metric showing a better performance than the England average.

For varicose veins, the trust did not undertake varicose vein surgery, hence no PROMS data was supplied at the time of production of this report.

For hip replacements, performance was slightly worse than as the England average.

For knee replacements was slightly worse than the England average.

(Source: NHS Digital)

Competent staff
Staff we spoke to were clear about their responsibilities, aware of patients’ individual progress and able to answer specific’ questions in regard to patients care and treatment in a confident manner.

Staff we spoke with told us they had received both a local surgery induction and a trust induction. A new band 5 nurse told us they had been supported when they took up their post by working supernumerary shifts to observe the ward. The band 5 nurse also told us they were fully supported by the trust with their preceptorship.

Surgery had two matrons who were professional development nurses (PDN), practice educators. The matrons worked 0.5 whole time equivalent as a PDN and 0.5 as a matron. The PDN monitored staff training and had oversite of the preceptorships of newly qualified staff. Student nurses told us they felt part of the surgery team and were provided with mentors. A student nurse told us they had been offered and had accepted a job with NMUH on qualification.

Health care assistants (HCA) were encouraged to complete the care certificate. This is a level 2 qualification which ensures HCA have the same introductory skills, knowledge and behaviours to provide compassionate and safe care and support. All HCA staff received training in phlebotomy.

Surgery were offering band 3 HCA apprenticeship opportunities to become assistant practitioners. The trust was also offering some HCA ‘assistant to nursing’ training which could lead to HCA becoming qualified nurses.

Nursing staff and operating department practitioners (ODP) staff working in theatres received an annual appraisal.

Scrub nurses were speciality based. However, scrub nurses also rotated around specialisms to maintain skills. Staff had paper based competency booklets, which were also held electronically, these were signed off by their mentors.
There were daily morning staff meetings at 8am in theatres where theatre staffing was discussed. There were also individual team briefings where theatre lists were discussed at 8.30am. Theatres also had team briefs at the end of the working day to discuss issues from the day’s work.

Theatre staff competency training was monitored, planned and recorded in a competence booklet, according to staff roles and responsibilities, this included training in the use of specialist equipment and diagnostic tools. The theatre recovery lead was a trained anaesthetist. They told us they were supported to maintain their anaesthetic skills by the trust.

Staff had access to a range of clinical nurse specialists (CNS) for advice and guidance. For example, there was CNS for stoma care, urology, diabetes, pain management, gynaecology and breast, oncology and haematology. Staff told us there was good access to CNS.

All staff attended clinical skills updates, ‘skills and drills’, these included ward based training on pressure ulcer care. There were also a range of link nurses; these were staff that had increased education and training in specific areas of practice. For example, surgery had a link nurse for VTE. Staff also had access to study days. Some staff told us they had attended study days provided by the pain team and dietitian.

Bank and agency staff underwent a thorough induction and orientation. For example, staff told us about training in new equipment, the WHO checklist, radiation protection, and sharps management. Bank and agency staff had to provide evidence of their competence, including proof of intravenous fluid administration (IV) training prior to administering IV medication. Staff we asked told us they were competent and their agency provided evidence of competence to the trust prior to staff being allowed to work in surgery.

The trust monitored whether staff maintained their registration with a professional body including the Nursing and Midwifery Council (NMC). Doctors received appraisal and revalidation in accordance with the requirements of the General Medical Council (GMC) on doctors’ fitness to practice.

In response to never events the trust had introduced bi-monthly multidisciplinary training in human factors during a late theatre start. This was training that looked at the role human factors played in patient safety, and also raised awareness across disciplines of the important role human factors play in improving patient safety.

From February 2017 to January 2018, 90% of staff within surgery at the trust had received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of individuals required</th>
<th>Number completed</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>21</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>248</td>
<td>221</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working
Staff said there was good multidisciplinary working with doctors, other internal services and external organisations, including social services and the transportation team. For example, staff
told us that patients with social care needs were only discharged home during the day and with the knowledge that a package of community care was in place. This was in accordance with NICE guidance ‘Transition between inpatient settings and community or care home settings for adults with social care needs, NG27’.

There were a range of multidisciplinary meetings across surgical disciplines that surgical ward staff attended. For example, there was a ‘bone score’ meeting twice a month, this was attended by ward staff, physiotherapists, occupational therapists (OT), pain team staff, and a pre-assessment nurse.

Staff from the surgical assessment unit (SAU) attended bed meetings with staff from the emergency department (ED). Risk assessments were reviewed at the meetings for all ‘outlier’ patients; these are patients who are in hospital wards that do not provide specialist care for their conditions. Patients are usually outlying due to a lack of available beds on specialist wards.

We observed a shift handover and ward round on T3 ward and found at both meetings members of the hospital-based multidisciplinary team comprehensively reviewed and updated patients progress towards discharge.

We attended the daily ‘red amber green’ (RAG) meeting on ward S2. This involved consultants, doctors, the ward manager, physiotherapist and occupational therapist. The meeting involved a comprehensive discussion about patients, the assessments they needed, test results, social factors, infection status, and diagnosis, as well as plans for patients discharge.

Staff had access to the pain team, pharmacy and dietitian via a bleep. Surgery staff told us other health professionals responded quickly when bleeped.

The service had theatre briefings every morning to review theatre schedules this was attended by all members of the theatre multidisciplinary team. This ensured the service was planned and there was suitable capacity, staffing and equipment available. Senior managers told us the theatre brief had been moved to 8.30am to enable team huddles at 8.00am.

Physiotherapists based at the hospital provided physiotherapy input pre-operatively and post-operatively for surgical patients. Physiotherapists reviewed theatre schedules in advance, to ensure they could provide the correct staffing cover.

**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. The 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.

Operating lists were occasionally undertaken on Saturdays if demand deemed it necessary. For example, urology was planning an extra list on Saturday from June 2018 to improve theatre utilisation.

Support services such as pharmacy advice or physiotherapy was available via telephone from staff working at the hospital out of hours. Pharmacists visited all wards Monday to Friday. The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday.

Surgical patients had access to diagnostic imaging at all times. For example, patients had access to 24 hour ultrasound scans.

Resident surgical officers provided medical care and treatment 24 hours a day seven days a week.
The trust had reviewed its performance in regard to meeting NHS seven-day hospital services clinical standards for seven-day services. For example, Standard 3 MDT review. A business plan was in discussion to extend the weekend presence for allied health professionals (AHP), including occupational therapy (OT) and physiotherapy.

**Health Promotion**
Staff supported patients to live healthier lives and manage their own health, care and wellbeing.

Staff recorded the smoking status for each patient when booking during their initial assessment and offered smoking cessation advice to patients that smoked.

Printed information was available to patients on alcohol and drug misuse across surgery services.

Patients diagnosed with diabetes were provided with advice and support by staff to manage their diabetes.

Patients with a body mass index greater than 35 were referred to a local agency for support and advice with weight loss, healthy eating and exercise.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**
The Mental Capacity Act 2005 (MCA) was included in new staff inductions and in staff mandatory training updates. Deprivation of Liberty Safeguards (DoLS) was covered as part of MCA training during the trust induction and MCA mandatory training core skills updates.

There were e-learning modules for both consent and mental capacity assessment, which were tracked through the trust’s leaning and development department. All new staff received training in consent processes at induction; this included managing patients unable to consent. Staff we spoke with demonstrated awareness of the MCA and DoLS.

Mental capacity and Deprivation of Liberty Safeguards policies were in place and in date. A poster identified the safeguarding leads in all areas. Staff could refer directly to the lead or raise a concern via the electronic reporting system.

All patients over the age of 75 or patients with a diagnosis received dementia screening.

The trust employed a Learning Disabilities Liaison Nurse who provided a link for people with learning disabilities. The nurse worked with the patient with learning disabilities to produce a patient passport, improve communication with ward staff, support with reasonable adjustments, support capacity assessments and be a link person.

If input from the dementia and learning disability teams was required, this was highlighted at pre-assessment to ensure any special arrangement regrading admission could be made.

Consent was obtained in outpatients or at pre-assessment to avoid consenting on the day of surgery, where possible; consent was then confirmed on the day of surgery. Consent to treatment is the principle that a person must give permission before they receive any type of medical treatment, test or examination. Patients were encouraged to take a copy of their consent and written information was provided. Patients’ consent forms were paper based due to the complexity of obtaining signatures on an electronic system.

We reviewed 15 patient records and found that consent had been obtained from patients in accordance with NHS guidance; they were fully completed, legible and did not contain any abbreviations.

The trust’s adult safeguarding lead attended the Law Commission debate on review of national guidance for the DoLS framework.
Following our inspection, the trust informed us they were unable to provide % compliance for MCA / DoLS Level 2 as the trust’s training needs analysis (TNA) for MCA and DoLS was in the process of being completed. However, staff we spoke with understood the principles of the MCA including the assumption that a person had capacity and decisions in the best interests of people assessed as lacking capacity to make a decision.

The trust provided trust wide data this recorded that both medical and nursing staff were achieving the trust’s 90% target for MCA and DoLS training. The training rates were 90% of medical staff and 91% of nursing staff had up to date training.

Is the service caring?

Compassionate care

We saw staff across the surgical wards and departments ensuring patients dignity was respected. Staff closed doors to patients’ rooms and drew curtains to ensure other people could not look through internal and external windows when supporting patients with personal hygiene activities, or when medical staff examined patients.

The service had access to tablet computers to facilitate patients in leaving feedback on services.

Patients told us the staff were caring and respectful of them as individuals. Most patients we spoke with were positive about the kindness of the staff across surgical services. For example, a patient on ward S3 said: “They are all friendly and caring. I like this ward.” Another patient told us, “The nurses are all very friendly and respectful.” Another patient told us the staff protected their modesty by always pulling the curtains around their bed and keeping them as covered as possible during physical examinations. Although one patient told us staff could be noisy at night when speaking at the nursing station.

Patients on ward S2 told us, “On the whole they treat us with compassion and kindness. They absolutely do their best.” Another patient told us, “The commitment is good. You cannot fault what the staff do. I haven’t had a nurse that wasn’t good.”

We saw staff on ward T3 conducting a bedside handover. Staff spoke quietly with the patient and each other to minimise the risk of patient’s information being overheard.

We saw staff drawing curtains and attaching ‘engaged’ signage to curtains to alert people coming in to the ward when patients were receiving personal care or treatment.

The Friends and Family Test (FFT) response rate for surgery at North Middlesex University Hospital NHS Trust was 50% which was better than the England average of 29% from December 2016 to November 2017. A breakdown of response rate by site can be viewed below.

### Friends and family test response rate at North Middlesex University Hospital NHS Trust, by site.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical 2</td>
<td>1065</td>
<td>46%</td>
<td>Dec-16: 93% Jan-17: 92% Feb-17: 95% Mar-17: 91% Apr-17: 93% May-17: 95% Jun-17: 98% Jul-17: 88% Aug-17: 95% Sep-17: 90% Oct-17: 96% Nov-17: 93%</td>
</tr>
<tr>
<td>Surgical 3</td>
<td>992</td>
<td>66%</td>
<td>100% 100% 96% 95% 95% 96% 99% 100% 97% 94% 97% 96% 99% 97%</td>
</tr>
<tr>
<td>T3 Surgical</td>
<td>541</td>
<td>38%</td>
<td>100% 95% 98% 100% 96% 98% 97% 100% 100% 93% 100% 98%</td>
</tr>
</tbody>
</table>

Highest score to lowest score

Key

| 100% | 50% | 0% |
Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Following our inspection, the trust provided us with updated FFT data for February to April 2018. During this period Ward S3 achieved a response rate of 58%, with 100% of these patients responding they would recommend the service. In the same period Ward S2 had a response rate of 40% with 96% of patients responding they would recommend the service. Ward T3 had a response rate of 58% with 100% of patients responding they would recommend the service.

**Emotional support**

Staff could request support for patients from the multi-faith chaplaincy. The chaplaincy provided a 24-hour service, 365 days of the year and offered pastoral, psychological and spiritual support. The chaplaincy also offers a confidential befriending service, irrespective of people’s beliefs.

Staff recognised that emotional support extended beyond patients’ physical needs. We observed staff supporting patients by allaying anxieties in theatres and providing reassurance and comfort. Throughout our inspection, we observed staff supporting patients, responding to their needs and communicating in a supportive manner.

The Helen Rollason cancer support centre helped patients emotionally and physically by providing complementary therapy services such as massage.

**Understanding and involvement of patients and those close to them**

Patients told us they had no concerns about the care they had received. Families and carers told us they had been involved in decisions regarding patients’ surgery.

Patients were provided with printed information that explained their surgery. For example, we saw a leaflet that explained ulcerative colitis (UC), this is a condition linked to colon cancer. The information explained the ‘pro’s and con’s’ of surgery, as well as giving patients information on actions they should take if they experienced side effects post-operatively.

S2 ward had information displayed on a noticeboard informing patients and families how they could access a GP or nurse at weekends. The notice was published in English, Polish, Russian and Turkish. A patient on the ward told us, “Everything has been explained. I have discharge paperwork. I have a letter for a wound check. I am ready and all set to go home.” Another patient told us, “My results were discussed with me after each procedure. That put me at ease.”

We observed a patient with communication needs having their needs explained to staff at a T3 ward handover as well as methods of communication.

Patients could choose to wait for their procedure in the day surgery unit or could choose to sit in a room off the ward with relatives. Relatives were provided with regular updates for example when the patient had reached the recovery unit.

Ward S2 used the staff room for breaking bad news to people. Staff said this was not ideal, but an ‘in use’ notice would be placed on the staff room door. Macmillan nurses broke bad news to cancer patients. Staff told us they could access support from the mental health team for patients receiving bad news.

All patients were discharged with contact number of the ward and encouraged to contact ward if they had any problems relating to their care or treatment.
The Macmillan cancer support service was based on the hospital site. If provided support, advice and information on cancer drugs, treatment and management as well as on finance and local support services.

We spoke to 12 patients across the surgical wards who felt the staff were friendly and listened carefully to their needs. Patients were given time to ask questions about their care and treatment and address any anxieties or fears. Patients were supported in making decisions about their own care and treatment.

**Is the service responsive?**

**Service delivery to meet the needs of the local people**

The department of general surgery is the largest surgical department at the hospital and includes the sub-specialty services of: breast surgery; colorectal surgery, gastro-intestinal (GI) surgery; vascular surgery (outpatient services); emergency surgery. The department also provides emergency cover for the hospital, treating around 2,000 admissions per year.

There were three surgical wards. Ward S2 was a 30-bed ward, ward S3 also provided 30 beds, whilst ward T3 provided 22 beds. The day surgery unit provide eight escalation beds, and the surgical assessment unit (SAU) provided nine escalation beds.

The department offered surgical, laparoscopic, endoscopic and outpatient treatments, including a one-stop minor operations service. General surgery offered enhanced recovery across all specialties. A pelvic floor service had been introduced offering sacral nerve stimulation service (SNS) and rectal physiology testing. The department also offered an oncoplastic service for breast surgery.

The surgery risk register identified a risk on the 10 August 2016 due to a failure to develop Local Safety Standards for Invasive Procedures (LocSSIP) that met the requirements of the National Safety Standards for Invasive Procedures (NatSSIP). These procedures enable NHS trust’s to audit and benchmark performance and share best practice. The risk register had been reviewed on 25 June 2018 and recorded that the trust intended to conduct a gap analysis to address this. However, there was no date recorded on the risk register of when the gap analysis would take place.

During our previous inspection in September 2016 we reported that the hospital did not comply with national guidance, Health Building Note 26 (HBN 26), that the ratio of recovery beds to operating theatres should not be less than two. This was due to a decision to relocate a catheterisation laboratory (cath lab), (this is an examination room in a hospital or clinic with diagnostic imaging equipment), to theatre eight. However, work was in progress on a review of the cath lab location to eliminate the risk and ensure the hospital met the requirements of HBN 26.

The risk register recorded theatres one to eight lacking prep rooms, these are rooms where patients are prepared for surgery prior to entering theatres. The risk register identified a risk that theatres may not be fully utilised due to the need for cleaning following surgical procedures. In mitigation the trust was ensuring controls were in place in regard to cleaning and equipment checks prior to surgery and were monitoring theatre incidents to ensure efficient utilisation of these theatres.

Staff in theatres told us the lack of a formal reception in theatres could be problematic, as this meant theatre staff had to attend to tasks receptionists would usually deal with.

The risk register also recorded that patients with kidney stones awaiting lithotripsy, (a treatment, typically using ultrasound shock waves, by which a kidney stone or other calculus is broken into small particles that can be passed out by the body), had to wait for many months to commence treatment due to a rented machine only being available fortnightly. In response the trust had initiated extra lithotripsy lists and had produced a business case to purchase a machine. However, the business case submission was on hold due to capital cost issues. In the interim the trust was referring patients to other hospitals for lithotripsy.
A senior nurse told us surgery was under pressure from the trust to complete business as usual during winter pressures. Day surgery and some SAU beds were allocated to winter pressures. Staff said winter pressures had led to theatre lists starting late every day during the busiest winter months due to medical outliers occupying areas that would usually be used to prepare patients pre-operatively.

Divisional managers told us they were aware some staff were unhappy with the trust plan for winter escalation. This involved elective lists being closed from 27 December 2017 to 10 February 2018. This was planned in advance to free up beds for winter demands. Day surgery beds were returned to surgery in March 2018. Divisional managers for anaesthetics and surgery told us they would be reducing escalation usage in the SAU and day surgery. Managers said the division had also to consider the needs of the hospital when planning services. The ward manager told us the service manager spoke to staff prior to the decision to make the SAU a medical winter pressures escalation ward. The ward manager told us the ward coped during winter pressures as the trust allocated extra resources to the ward.

The trust reported there had not been any mixed sex breaches in the previous 12 months. There was a big emphasis on minimising hospital visits for patients. For example, the haematuria clinic had introduced a ‘one stop’ shop.

The colorectal surgeons conducted a telephone ward round at weekends to ensure patients care was reviewed and progressed at the weekend. The trust was appointing a fifth emergency surgeon with colorectal experience to increase the number of emergency resections, (this is a surgical procedure of the bowel).

Overall, patients told us call bells were answered promptly on surgical wards.

We found signage on the lifts at the tower was incorrect. This meant patients would be guided to the incorrect directions to services and would have to ask staff for directions. This was confusing for vulnerable patients and meant patients with mobility problems could make more journeys than was necessary to locate services.

For elective length of stay, the trust performed below the England average overall and for two of the top three specialities. Length of stay for trauma and orthopaedics was better than the England average.

For non-elective specialities, the trust gave a stronger performance, with the overall length of stay and the length of stay for the top three specialities performing better than the England averages. The best performance was in trauma and orthopaedics, where the trust’s average length of stay was almost three days shorter than that of the England average.
Meeting people’s individual needs
We found reasonable adjustments were made to take into account the needs of different people for example on the grounds of religion, gender disability, or preference. The service was responsive to patient’s needs. For example, nursing staff were provided with a ‘paper slip’ which slotted behind their name badges on their uniform. The slip had the contact details of the trust’s learning disability team, adult safeguarding lead, dementia lead, and freedom to speak up guardian.

The trust had a learning disabilities service that provided a link for people with learning disabilities. A learning disability is defined as ‘a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning) which started before adulthood with a lasting effect on the person’s development (developmental delay).’ (Valuing People, 2001). Any patient with a learning disability, who was known to the learning disability service at the hospital, was ‘flagged up’ on the internal electronic systems and a hospital passport would be used. The aim of the hospital passport was to provide up to date information on patients with learning disabilities on admission and prevent delay in their assessment and treatment. The document provided staff with important information about the individual patient and included useful contacts with community partners. This ‘hospital passport’ remained the property of the person with learning disabilities and was returned to the individual on discharge from hospital. This ensured that staff were aware of patients’ needs and could make adjustments where required.

Staff sought accessible ways to communicate with people to meet their needs. Staff assessed patients’ communication needs to ensure effective communication. Staff had access to tablet computers and could access large print information, language translation pages, and communication tools for people with learning disabilities and autism.

Staff could access face to face interpreters, by appointment, for patients who did not speak English. Staff also had access to telephone interpreting services. Although the trust would usually ask their own staff group if they required an interpreter before approaching external agencies.

The trust held a dementia awareness week for staff in May 2018. The trust also had a ‘10 things about me’, which provided inpatients with a card attached to their bed listing ten things about them and their background. This information helped the patient build and maintain relationships with ward staff and other staff they came into contact with.

Surgery had a member of staff who was a designated dementia champion. There was a variety of policies and guidelines in relation to caring for a patient with dementia available on the staff intranet. Staff were able to describe what they would do to ensure patients dementia were cared for appropriately. For example, a nurse told us staff could access advice from a telephone hotline directly to an older people’s consultant geriatrician.
The trust used the ‘forget me not’ system to identify patients with dementia. This involved a symbol being placed in patients’ notes to alert staff to patients with dementia.

The trust provided a signing service to use for patients who were hearing impaired. Staff we spoke with were able to describe how they could access this service via appointment on the trust intranet. However, the surgical wards did not have hearing loops, this is a special type of sound system for use by people with hearing aids. The trust was piloting an ‘app’ that could translate the spoken work into British Sign Language (BSL).

Double appointments were booked for patients with special needs. For example, people with a learning difficulty or living with dementia. Staff could request a member of the dementia or learning disability team to attended appointments with patients.

Patients with additional needs were allowed to have relatives or carers stay and a separate quiet room was available for the purpose.

We saw ‘Let’s Talk’ leaflets were available across all wards and departments in a range of languages. The leaflets had information on how patients with mental health needs could access support from the hospital. Staff told us how they could access the trust’s mental health liaison nurse for patients with mental health needs. The mental health team provided on-call provision. Staff could also access the community mental health team.

A specialist mental health service was based in the hospital provided by a mental health NHS trust, for patients whose physical conditions needed hospital treatment and who may also have mental health problems. This was a 24-hours a day, seven days a week mental health service staffed by specialist psychiatric nurses, psychiatrists, a clinical psychologist, social worker, and associate mental health workers. The team would see any patient aged over 17 years old upon referral.

The trust had employed an external auditor to undertake a review of theatre utilisation. The auditors reviewed productivity and efficiency in theatres. The review found issues with the air flow in theatres. As a result, theatre staff opened all theatre kit in theatres as the cost of renovating ‘prep rooms’ was prohibitively expensive. Staff told us patients would not be anaesthetised until staff were sure theatres were ready for the next patients. The procedure had led to a 10 to 15-minute delay for patients, as theatres had to be cleaned before new theatre kit was opened.

Day surgery was combined with the main theatres. Staff told us this didn't impact on theatres as the trust had the advantage of having single flow for all theatres. This meant people could be moved on theatre lists, as most patients were prepared for theatre on the day of surgery.

**Access and flow**

There was an effective process, which ensured only patients whose needs could be met were treated at the hospital. Patients were pre-assessed to ensure they were suitable to have their surgical procedure at the hospital. For example, the trust had introduced a number of surgical pathways since our previous inspection. Staff also told us surgery had introduced a new system of theatres telephoning recovery staff to inform them that a patient was being transferred to recovery to ensure recovery staff were ready for the patient. Although, we saw an emergency list patient in theatre 1 (CEPOD) who had their surgery delayed for 45 minutes due to the emergency department (ED) not completing the relevant paperwork and the patient not being fitted with compression stockings, (these are stockings used to prevent venous disorders), or the surgical site marked.

The trust used the ‘safer flow’ patient bundle. This was an approach recommended by NHS Improvement (NHSI) that blended five elements of safe practice. The five elements of the SAFER patient flow bundle are: S (Senior review). All patients had a senior review before midday by a
clinician able to make management and discharge decisions; A (All patients had an expected discharge date and clinical criteria for discharge, assuming ideal recovery and assuming no unnecessary waiting); F (Flow of patients commenced at the earliest opportunity from assessment to inpatient wards. Wards that routinely received patients from the surgical assessment unit ensured the first patient arrived on the ward by 10 am; E (Early discharge) a minimum of 33% of patients were discharged from base inpatient wards before midday); R (Review), a systematic multidisciplinary team review of patients with extended lengths of stay with a clear ‘home first’ mind-set.

The SAFER patient flow bundle was used with the ‘Red2Green’ approach. This was a visual management system to assist in the identification of wasted time in a patient’s journey and reduce unnecessary delays. ‘Red2Green’ board meetings took place following ‘Red Amber Green’ (RAG) meetings.

Theatre staff and finish times were monitored by the trust. There was a daily average of one theatre finishing late. The average late finish time was 14 minutes. This was usually due to clinicians arriving late.

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, patients with a learning disability or those living with dementia were prioritised on theatre lists.

There was a process whereby the orthopaedic nurse was alerted to all patients with a fractured neck of femur who arrived in the hospital’s emergency department (ED). The orthopaedic nurse would initially assess the patient in the ED. The patient would then be transferred to the orthopaedic ward. Staff told us patients were usually transferred promptly.

There were daily pre-operative assessment clinics. Patients referred to surgery by the hospital’s fracture clinic or outpatients had a ‘walk in’ service.

Patients were prioritised on the basis of clinical need. There were dedicated theatre lists for emergencies during normal working hours were in accordance with the recommendations of the National Confidential Enquiries into Perioperative Deaths (NCEPOD), these lists are commonly known as CEPOD lists. A CEPOD list handover was completed every morning at the 8.00am theatre briefing. The trauma theatre briefing was also held at 8.00am in the fracture clinic.

The clinical site management team and matrons attended daily bed management meetings to manage bed availability. The meeting discussed patient numbers and specialities to ensure patients were cared for in an appropriate ward and new patients could be admitted. Patients receiving elective surgery had their needs discussed the day before their surgery to ensure bed availability.

Theatre staff told us that post-operative patients were transferred from theatre to recover in a timely way. Surgery had a stage one and stage two recovery processes. Stage two was the stage at which patients were deemed ready for discharge.

Day surgery patients were booked for surgery between 7am and 3pm. Staff told us times could be staggered throughout the morning and afternoon dependent upon the number of patients booked for surgery. For example, on the 25 May 2018 the surgery operating times were 7.30am to 10.00am and 12 noon to 15.00pm. Day surgery patients would go to stage two recovery post-operatively.

Urology clinics had improved the access and flow through the department for patients with the introduction of ‘one stop’ clinics. This meant patients could have care, tests, and treatment in one
visit. Although staff said demand still exceeded capacity in some clinics. For example, haematuria, (blood in urine), clinics.

The surgical assessment unit (SAU) assessed patients who had a confirmed or probable surgical condition. Patients were referred to the SAU via their GP or admitted via the Emergency Department (ED). Dependent upon the patients’ clinical condition and care needs, the patient would either be assessed in the clinic or admitted to an inpatient ward. Patient stays on the SAU ranged from 12 to 96 hours. The SAU also accommodated patients coming back for reviews post discharge from the wards to check wounds and dressings.

Doctors told us it was rare for them to visit surgical patients on medical wards, as surgery usually had sufficient numbers of beds available.

The addition surgical assessment unit (SAU) objective was to reduce pressure in emergency department (ED) and ensure surgical patients were reviewed by surgical teams without delays. The SAU and day surgery were co-located. Staff worked flexibly across both units to ensure patients were discharged in a timely manner.

Some beds on the day surgery unit were used for patients who should be placed on the SAU. Day surgery staff told us there were SAU outliers in day surgery on most days. However, staff told us these patients were monitored by nursing staff from the SAU and were moved to the SAU on the same day as soon as a bed was available.

The ‘hospital at home’ service provided 17 ‘virtual beds’ which were shared across specialities.

Patients were greeted by ward clerk and allocated a patient trolley within the male or female bay where they waited for assessment by the nurse, anaesthetist and surgeon. Patients went from here to the theatre holding bay to wait for their procedure. After their procedure patients spent time within recovery, which ensured their pain was controlled and they were sufficiently recovered to return to the ward. Day case patients went from recovery to the day surgery ward and patients staying overnight went to an inpatient ward.

Each consultant operating on that day was allocated a specific nurse to help them. This provided continuity of care.

Every hour the nurse in charge undertook checks, which ensured each patient, was in the correct place and updated patients on their expected surgery time. We saw completed records, which confirmed this.

There was a standard operating procedure (SOP) in place which ensured that if patients operations were cancelled it was decided in a risk based way. Factors such as the reason for operation and if the patient surgery had been previously cancelled were considered before cancellation.

Surgical nurse practitioners (SNP), cared for patients before, during and after surgery. SNP could discharge patients could discharge some non-emergency patients, for example, patients who had undergone superficial lymph node biopsies.

In our previous inspection in September 2016 we reported that theatre utilisation was low. In response theatres were monitored to determine reasons for delays. Weekly operational meetings were undertaken to review the forthcoming admissions for surgery. This ensured the correct capacity, equipment and specialist care was available. Theatre start and finish times were monitored. On the 22 May 2018 theatre utilisation was 85%, this was an improvement on the 2016 rate of 62%.

Overall, surgery consistently met the referral to treatment standard (RTT) in 2017/2018. From
January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was higher than the England average across the entire reporting period. Performance showed little change between February to September 2017, then dipped down to just above the England average in October 2017 before a minor improvement toward the end of the reporting period.

(Source: NHS England)

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, two specialities were above the England averages and the remaining seven specialties were below the England averages.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>89.4%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>80%</td>
<td>61%</td>
</tr>
<tr>
<td>Urology</td>
<td>76%</td>
<td>77%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>64.7%</td>
<td>72.3%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0%</td>
<td>71%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0%</td>
<td>83%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>0%</td>
<td>82%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>0%</td>
<td>64.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>0%</td>
<td>64.3%</td>
</tr>
</tbody>
</table>

The surgery, cancer and associated divisions integrated performance report dated January 2018 recorded that division had put in place mechanisms to review all over 18 week waits individually on a weekly basis. This review included identifying any process delays in booking appointments or reporting test outcomes. The division had reduced activity during the elective shutdown from 27 December 2017 to 9 February 2018; this had an impact on the RTT admitted position in December 2017. The report highlighted that in January 2018 the trust was in the fifth rated trust in the country in regards to RTT waiting times.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Data provided by the trust indicated that there had been 719 cancelled operations between April 2017 and March 2018. The reasons for cancellation were as follows: Patient cancelled (122); hospital cancellation non-clinical (166); patient did not attend (DNA) (142); clinical (280). The main cause of clinical cancellations was patient medically unfit (201).
Percentage of patients whose operation was cancelled and were not treated within 28 days - North Middlesex University Hospital NHS Trust

Over the two years, the percentage of cancelled operations at the trust showed an increasing trend, although the trust was better than the England average for the entire reporting period.

Cancelled Operations as a percentage of elective admissions - North Middlesex University Hospital NHS Trust

Over the two years, the percentage of cancelled operations at the trust showed an increasing trend, but throughout the period this was better than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

The surgery risk register recorded a risk of patients due to late discharges. The register recorded that the Intensive Care National Audit and Research Centre (ICNARC) report January to March 2016 identified that the hospital was amongst the worst performers nationally in relation to late night discharges. In response the trust had implemented a system whereby the decision to discharge patients was made before 8.30 am in the multidisciplinary handover, which was attended by the head nurse for surgery and matron for critical care. The medical team wrote provisional discharges in advance of discharge decisions and nurses commenced discharge planning as soon as a decision to discharge was made. Work was also in progress on an audit of the time a vacant bed was allocated a patient left the hospital. This was scheduled for July 2018. Furthermore, work was in progress to develop league tables for consultant discharge summaries.

Learning from complaints and concerns
The trust had a centralised team to deal with complaints. There were also Patient Advice Liaison Service (PALS) staff that supported patients through the complaints process. Surgical services provided complaint responses with actions to the central team for logging.

We saw information in all areas about how to complain and information leaflets on how to contact the PALS office. Staff told us all patients were provided with PALS information prior to discharge.
The matron in charge was responsible for investigating all complaints and had received training to undertake this. Responses to complaints were appropriate and offered patients an apology where the trust was found to be at fault. For example, staff on the SAU told us there had been one formal complaint to the SAU in the previous 12 months. The patient that raised the complaint was invited to the hospital and was given an apology and involved in discussions about how the service could improve. Staff told us this had resulted in a change to the discharge planning process, whereby patients must have all equipment in place in their home before a patient could be discharged.

From January 2017 to December 2017 there were 116 complaints about surgery. The trust took an average of 35 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 30 days.

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

Is the service well-led?

Leadership
The divisional lead for the surgery, cancer and associated service division was the divisional director of operations. Service leads such as the theatre manager and head of nursing reported directly to the director of operations. The service leads had oversight of ward level service leads. For example, the nursing lead had oversight of ward level leaders including matrons and associate nurse practitioners. The theatre manager had oversight of the deputy theatre manager and admissions managers. This meant surgical services had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

There were clinical leads for surgery and anaesthetics and pain management. The clinical leads reported to the surgical director. The surgical director reported directly to the trust board’s medical director. There were also medical leads for education who reported to the surgical director.

The surgical director held a coffee morning on Wednesday which any member of staff could attend to raise issues.

All nursing staff spoke enthusiastically matrons and felt supported by them. Staff told us that the matrons undertook daily ward and department visits.

Staff told us that ward and department managers were approachable and supportive offering advice and training as required.

We saw managers arranged ward or departmental meetings regularly to ensure staff were kept up-to-date with relevant information about the ward and the hospital. This meant staff had the opportunity to raise issues, which affected them.

Mortality and morbidity meetings discussed all deaths with complications. Learning from the meetings were recorded and escalated via the trust’s electronic incident reporting system. Staff had access to mortality and morbidity data and meeting minutes as this was kept on the trust’s shared drive.

Vision and Strategy
The trust had identified the following values: “caring, helpful, open and honest, teamwork.” The trust’s values provided a set of standards for how staff were expected to behave towards others and conduct themselves as professionals.

We saw posters with the trust’s values displayed on wards, and computer screen savers. Staff understood the trust’s vision and told us this was linked to staff annual appraisals.
The surgery and cancer division had produced divisional objectives for 2018 and 2019. These included a vision of: “reducing inequality, timely treatment in the appropriate location, achieve financial balance, collaboration with staff and patients, excellent outcomes.” We saw posters on noticeboards across surgical wards displayed the divisional objectives.

We viewed the general surgery business plan 2018 to 2019. This outlined delivery of services in 2017, and “the road ahead,” this was a three-year strategic vision for general surgery. The strategy included a focus on the gall stones pathway, colorectal enhanced recovery, reducing length of stay as a priority, restarting paediatric surgery at NMUH, a move to electronic records and innovative IT solutions to improve communications between staff and primary care providers.

The general surgery business plan 2018 to 2019 outlined a number of cost improvement programmes including a reduction of patients admitted to surgery who did not require a surgical procedure. The business plan also highlighted that the medical team in surgery were strengthening teams by recruiting locums to permanent staff.

Culture
Managers were promoting a positive culture that supported and valued staff creating a sense of common purpose based on shared values. Staff we spoke told us the culture had improved in surgery over the previous two to three years. Staff morale throughout the surgical services was generally good.

Staff told us surgery was a friendly and supportive division to work in. Staff told us they could report issues to managers without fear of retribution. Staff told us the culture in surgery was “open and honest.”

Staff told us they received feedback from incidents they had reported and learning from incidents in other departments within the trust. This meant wider learning from the organisation was reaching staff at department or ward level.

We asked staff if there were aware of the Freedom to Speak up Guardian role. We had a mixed response, which may indicate some staff were unaware of the role, its function, and its benefits.

We attended a ‘tea and talk’ meeting on the 23 May 2018. The meetings provided an opportunity for staff to speak with senior managers. The meeting was attended by three executive directors and the divisional director of operations for the surgery and cancer division. We noted that the meeting was not well attended by junior staff. Directors told us they were considering making the meetings department specific. Directors said they were considering alternative ways of engaging staff with the meetings including inviting staff on their birthdays. The meeting also feedbacks to staff that work was in progress on introducing ‘Listening into Action’, this is a method of staff engagement, where staff are provided with a range of opportunities to feedback ideas for service improvements to senior staff.

Governance
Ward and department managers attended the monthly clinical governance meeting. There was a discussion of complaints, incidents, ward level audits and Friends and Family Test (FFT) performance. Information from this meeting was cascaded to staff via department meetings. For example, staff told us audits were discussed at monthly ‘theatre users’ group meetings. We also viewed minutes from monthly matrons meetings, dated February 2018 to April 2018, and saw quality and performance was a regular agenda item, as well as incidents and complaints. We asked the trust if there was a clinical governance group with responsibility for reviewing surgical procedures, but, did not receive a response in response to this request. However, in response to our request the trust informed us there was a sepsis lead responsible for sepsis management in the department.
There was a divisional dashboard which included all key performance indicator (KPI) metrics. A divisional performance report was produced quarterly and shared with the trust’s board. The dashboard included a trend analysis to enable managers in monitoring the division’s performance over time.

A monthly integrated performance report was produced and reviewed by the hospital management team. We viewed the report dated 26 January 2018. The report reviewed the services KPI performance and included the divisional dashboard. We saw that in January 2018 the surgery and cancer division were meeting most KPI, with the exception of hand hygiene compliance where the trend was worsening in December 2017 and January 2018, and risks overdue for review, although the trend was improving.

Non-executive members of the board had oversight of targeted areas such as infection prevention and control.

Staff told us they had access to funds for equipment. Although any purchase over £5000 had to be submitted to the trust for capital funding.

The divisional director of operations led the divisional brief to the trust’s senior management team every month. The board and staff across the surgery and cancer division received a monthly quality report highlighting good practice as well as concerns. Data showed trends in areas such as tissue viability, falls and the safety thermometer, which were discussed, and action plans developed.

We reviewed ward meeting minutes and saw a formal agenda was kept for consistency.

The trust was addressing issues where audit data indicated improvements were required. For example, the trust had identified and were addressing coding issues in regards to readmission rates; and the trust was reviewing data input to the National Bowel Cancer Audit.

**Management of risk, issues and performance**

Senior leaders and managers of the surgical service had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions. There was an established risk register to monitor the risks across surgical services. The risks on the register reflected the risks we identified during our inspection. In our previous report in September 2016 we reported that the surgery risk register did not fully indicate how risks were mitigated and who was responsible for implementing actions. There were 14 identified risks recorded on the risk register. These included risks related to the need for seven-day palliative care services, ongoing issues with the decontamination service, lack of clinical information system in the critical care complex, and staffing shortages. All risks on the register had been reviewed in the previous 12 months. Risks on the risk register recorded actions the trust was implementing to mitigate identified risks. The risk register had clear timescales for completion of actions to mitigate risks, and clearly identified the named person who was responsible for implementing actions.

In our previous report dated 2016 we reported that the reporting of actions from mortality and morbidity meetings was not formalised to allow learning and actions to be captured and shared across the trust. During this inspection we found there were clear formalise action plans in place. The trust highlighted that the surgical and cancer division had “a low two-year mortality rate in 2017, vastly improved compared to a few years prior.” The mortality and morbidity review committee meetings gave staff the opportunity to discuss errors and adverse events in an open manner, review care standards, and make changes if required. Mortality and morbidity meeting minutes were shared with the board and reviewed at subsequent mortality and morbidity review
committee meetings. Staff told us the meeting minutes were accessible to all staff on a trust
shared drive.

In theatres, there were quality assurance processes in place. For example, compliance in
undertaking anaesthetic machine safety checks.

**Managing information**

Staff had access via the trust's intranet to the internet and the trust's policies and practice
guidelines. In addition, they could also access mandatory training information and training
opportunities.

Staff spoke positively about the trust’s intranet, they told us it was very informative especially
articles and blogs relating to incidents.

All wards operated a ‘Perfect Ward’ system. This gave staff access to tablet computers with an
'app'. The ‘app’ had a set of questionnaires, which were tailored for different types of clinical
areas. Standardised questions meant staff could compare clinical areas on a consistent basis, but
free-text comments meant staff could describe what was meant and add pictures where required.

The trust had the trust’s IT systems team who were responsible for the running of data quality and
to correct patient demographic data on the trusts databases. The trust had a data quality team
who corrected admissions, transfer and discharge information on a daily basis. Logs of errors
made were collated by the team and fed back to the source of the information to minimise the risk
of reoccurrences.

Any data quality issues raised to the IT systems team were investigated and if necessary checked
against nationally defined standards (NHS Digital). The trust was in the process of appointing a
dedicated data controller, the candidate was waiting to take up their post following pre-
employment checks, the intention was to ensure the validity of the trust’s data.

The risk register recorded a risk regarding all staff accessing decision to provide chemotherapy
letters from another hospital provider to oncology clinics. In response patients had a 24-hour
hotline they could telephone. The trust was introducing new oncology IT systems by August 2018.
The trust had also scheduled improvements to the interoperability of IT systems, this work was
scheduled for September 2018

**Engagement**

There was a theatre users group which a patient representative attended with the clinical
director, risk managers, and matrons.

The trust had a monthly patient focus group. We did not see any minutes from the group, but,
staff were aware of the group and the group were advertised on the wards.

Patients could leave feedback on social media and NHS choices website and all comments were
responded to by the trust.

Surgery had a ‘star of the month’ scheme, patients and staff could nominate a staff member who
they thought had embodied the trust’s values in their work.

The trust had an annual staff survey. However, the divisional manager told us the 2018 results had
been received three weeks prior to our inspection and the trust had not had the time to produce an
action plan in response.

NHS staff survey data 2017 found the trust was better than other trusts for: 92% of staff agreeing
that their role made a difference to patients / service users, compared to other trusts at 90%; staff
motivation at work, with a score of 4.01, this was better than the average for other trusts at 3.9;
quality of non-mandatory training, learning or development, with the trust scoring 4.13 compared
to the National average of 4.05. The trust was worse than other trusts for: Percentage of staff believing that the organisation provided equal opportunities for career progression or promotion with the trust scoring 69%, compared to a National average of 85%. Although it should be noted that these results should be treated with caution as the results were trust wide and not exclusive to surgery staff.

The trust had an annual awards programme to recognise staff excellence and commitment. Awards included excellence, leadership care and compassion awards.

Some staff told us that in April 2018 they had attended a photography exhibition and a talk from the carer of a former patient who had dementia.

**Learning, continuous improvement and innovation**

Staff at NMUH had developed ’10 things about me’ initiative. This involved inpatients’ with dementia at the trust having a card at the end of their bed listing ten things about their preferences and their background. This information helped the patient to build and maintain relationships with ward staff and other staff they came into contact with.

The trust introduced a ‘carers’ passport’, to encourage carers to come into the hospital and provide help and support for dementia patients.

Urology was involved in an NHS improvement (NHSI) initiative “getting it right first time” (GIRFT). The ambition of the programme was to identify innovative and efficient service delivery. This would be achieved by the programme looking at divergence from the best evidence based urological care. The programme would culminate in a report and a set of National recommendations aimed at improving the quality of care and reducing expenditure.
Facts and data about this service

The trust has 16 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, North Middlesex University Hospital NHS Trust and England

This trust

- Neonatal, 37.5%
- Adult, 62.5%

England

- Neonatal, 24.0%
- Adult, 68.5%
- Pediatric, 7.5%

(Source: NHS England)

The trust has one critical care ward with an additional critical care outreach team.

(Source: Routine Provider Information Request (RPIR) – Sites)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to February 2018 for nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Basic Life Support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>97</td>
<td>84</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>97</td>
<td>84</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>97</td>
<td>82</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>97</td>
<td>78</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>96</td>
<td>74</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 83% which did not meet the trust target of 90%. At the time of our inspection we requested more up to date information on mandatory training. The practice development nurse and matrons monitored the completion of refreshers and training...
updates. All staff had either completed a training update or were scheduled to do so within the next six months. Matrons monitored the status of mandatory training through the clinical staff inspection element of monthly quality checks.

Sepsis management was not a mandatory training module although senior nurses had completed training in this and the trust’s sepsis lead was available to provide on-demand support and guidance.

The trust did not submit data around mandatory training for medical staff in critical care ahead of our inspection. We requested this information after our inspection and the trust provided it as overall percentage completion rates only. This meant we were not able to identify the completion rates by training course. Medical staff were 82% compliant with training completion.

Safeguarding
The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2017 to February 2018 for nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>97</td>
<td>88</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>100</td>
<td>79</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 85% which did not meet the trust target of 90%. At the time of our inspection all staff had either completed an update or were scheduled to do so within the next six months.

The trust has submitted no data around safeguarding training for medical and dental staff in critical care. This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. It will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff knowledge of the principles of safeguarding had improved since our last inspection. A safeguarding link nurse was in post and had prepared an information reference tool for staff to help them identify patients at risk of abuse or exploitation. All the staff we spoke with knew how to contact the trust safeguarding lead and gave examples of situations in which they would do so. Arrangements were in place to provide safeguarding intervention for patients at risk of, or who experienced, female genital mutilation. Staff demonstrated understanding of how to access out of hours urgent crisis teams and when to escalate concerns to the trust’s safeguarding lead.

Matrons assessed standards of safeguarding practice against hospital standards in monthly quality assurance checks. In April 2018 and May 2018, the unit scored 100%, which was significantly better than the hospital average of 89% and the target of 90%.

Between May 2017 and May 2018, staff reported five safeguarding incidents. We looked at the nature and investigation of each and found staff had acted appropriately, including through liaison with other clinical teams, the community psychiatric team and the police.

Cleanliness, infection control and hygiene
A hand washing station was located at the entrance to the unit and included a touch-free sink with soap and antibacterial gel. Signs posted at the entrance instructed visitors to wash their hands and guidance was displayed in line with the World Health Organisation six steps to hand hygiene.

Side rooms were designated as areas available for patients who required respiratory isolation.

Staff did not always challenge colleagues visiting the unit who did not adhere to local infection control policies. For example, we saw a consultant from another department enter the intensive care unit (ICU) without washing or gelling their hands and they did not comply with the bare below the elbows policy. A matron had identified this as an area for improvement and included it as a specific item on a hand hygiene improvement plan as an ongoing concern.

During our observations of staff delivering clinical care or treatment we saw they consistently and correctly used the aseptic non-touch technique (ANTT). However, we observed inconsistent handwashing practices amongst staff when entering and leaving side rooms and inconsistent adherence to infection control policies for patients with infectious conditions. For example, in one side room two nurses and a student nurse each followed different practices in relation to the use of personal protective equipment (PPE) and hand washing. We spoke with the staff who said the infection control guidance posted on the entry door to the side room was not mandatory and they exercised personal preference in relation to the PPE they used and when they used it. This meant we were not assured infection control protocols were consistently followed.

Three infection control link nurses assessed staff for adherence to good ANTT practice. Between January 2018 and June 2018, they had completed assessments with 67% of the nurse and healthcare assistant team. This demonstrated a significant improvement on 2017, during which only 18% of staff underwent an assessment.

Nurses carried out a rolling infection prevention assessment for each patient. This included a weekly test for Methicillin-resistant staphylococcus aureus (MRSA) and carbapenemase-producing Enterobacteriaceae (CPE), a group of bacteria resistant to antibiotics.

During our inspection we found a fridge that contained expired disposables, intravenous fluids and other unidentifiable fluids. The fridge was putrid to smell and was in a sterile laboratory environment. We spoke with staff about this who said it needed to be condemned and removed but no individual had taken responsibility for this. We escalated this to the nurse in charge and found during our unannounced inspection the fridge had been emptied, cleaned and was awaiting disposal by the estates team.

Staff used bright green ‘I’m clean’ tape to note when equipment had been cleaned, disinfected and was ready for use. However, it was not evident this system was always used effectively. For example, we saw an ultrasound machine with a green sticker and ready for use that had gel on the probe from its last use. This presented a cross-contamination risk to the next patient. In addition, staff did not consistently use stickers to indicate an item had been cleaned. For example, we found equipment placed inside rooms ready for use without green stickers on them. In addition, a commode had a green ‘I’m clean’ sticker attached but was soiled. Although the nurse in charge acted immediately to rectify this, it meant cleaning and infection control processes were not consistent or effectively monitored.

The clinical environment was fully compliant with the Department of Health (DH) Health Building Note (HBN) 00/10 in relation to flooring and 00/09 in relation to infection control in the built environment.

Staff asked patients about their perception of infection control practices as part of the critical care survey. In April 2018 and May 2018, 98% of patients said they found the unit, including the bathrooms, to be clean. In the same period 93% of patients said they observed staff wash their
hands before providing care or examining them.

Daily cleaning of the environment was carried out by a contractor and we found most areas to be visually clean. We found evidence of high-level and low-level white dust and fluff on equipment in one side room that was occupied by a patient. This presented an infection control risk and could present a risk to patients being cared for with breathing equipment. In an unoccupied side room, we found extensive areas of dust, including on the bed frame, the computer monitor and the windowsill. We spoke with the matron about this who addressed the matter with the contractor. However, this meant there was not an effective monitoring system in place though which the unit leadership team monitored the standards of work of the contractor. There was evidence of ongoing substandard practice from the cleaning contractor in the results of the monthly quality assurance checks carried out by the matron. For example, in April 2018 and May 2018 the unit scored 59% compliance against standards for an environment free from dust and dirt.

Although the overall management of sharps disposal was good, two sharps bins had been assembled but not labelled, signed and dated by staff. None of the sharps bins in use in the HDU had the temporary aperture closed when they were not in use. This meant staff did not always adhere to European Council Directive 2010/32/EU in relation to the labelling and location of sharps bins or DH Health Technical Memorandum (HTM) 07/01 in relation to the safe management and disposal of healthcare waste.

Staff monitored adherence to trust standards through a monthly hand hygiene audit. Between April 2017 and April 2018, the unit scored an average of 80%. This was significantly below the trust minimum target of 95%. This was an average figure and represented monthly performance between 61% in May 2017 to three instances of 100%. This was a nurse-led audit and the infection control link nurse and matrons had implemented an action plan to improve results. This included the introduction of a bi-annual hand hygiene audit for all critical care staff to supplement the samples from monthly audits and an intensive, extended training programme to start in July 2018.

Environment and equipment
Critical care was not connected to the hospital’s main air conditioning system. This meant it often became very warm in bed bays and storage areas, although staff could control the temperature in some side rooms. We saw it was common practice to open windows to cool the temperature. However, this presented a risk as it reduced the pressure-controlled ventilation in patient rooms. There were two two-bedded patient rooms in the ICU and air pressure or ventilation for each patient could not be controlled independently. Staff told us they used these rooms last due to the challenges of managing level 3 patients in a shared room. When they were in use we saw staff routinely kept doors and windows open. Although this made the environment more comfortable for the patient, it reduced the ability of the ventilation system to work efficiently to prevent the spread of airborne infection. Staff said they did not usually risk assess this. Matrons monitored the use of doors to side rooms used for isolation in monthly quality assurance checks. In April 2018 and May 2018, the unit scored 88% compliance with the requirement to keep doors closed.

Side rooms in the high dependency unit (HDU) were not equipped to provide negative pressure therapy. Staff transferred patients who needed respiratory isolation to the ICU, where side rooms could ensure negative pressure.

The ICU did not have enough ventilators for each patient if the unit was full. The unit had 12 beds for level 3 patients and usually had nine ventilators. This was reduced to eight at the time of our inspection with an additional three transfer ventilators available. We spoke with the senior team who told us the ICU was commissioned for nine beds but regularly provided urgent treatment above this level. This restricted the number of ventilators the unit could purchase. Where patients needed ventilator support and each unit was in use, an emergency transfer protocol was in place that meant the patient would be transferred to another hospital.
During our observations of handovers, we saw nurses routinely carried out a safety check on each item of equipment, including breathing equipment. This was good practice and meant medical equipment was regularly checked to ensure it was functioning as needed.

Staff had carried out a medical devices audit in May 2018 and identified several items of equipment that were overdue for service. In each case the auditing member of staff had noted the action they had taken.

Staff on each shift documented checks on emergency equipment, including resuscitation and airway trollies. We looked at the checklists for each trolley for the two months leading to our inspection and found staff had completed these consistently. However, one resuscitation trolley was not sealed with a traceable tag. This meant we were not assured the stock inside the trolley met the required specification because staff could not guarantee it had not been tampered with. A master checklist was in place that required staff to document checks on specific items of equipment daily for the whole unit. There were four dates in the previous month in which daily checks had not been documented.

We did not find effective stock rotation systems were in place for consumables, such as fluids and liquid feeds. For example, we found a number of expired items that had not been disposed of that were stored alongside new items. This included multiple nutritional supplement drinks that had expired three months previously and intravenous fluids that had expired over three years ago. We escalated these issues to the nurse in charge and saw they had been removed at our unannounced out of hours inspection. Staff had also improved the storage area and stock was in a clear date rotation system.

Assessing and responding to patient risk
As part of our inspection we observed a consultant-led ward round. This was well attended by the medical team, the nurse in charge and specialists appropriate to each patient. The ward round included a full, systematic review of the clinical needs of each patient and addressed their immediate risks and medical status as part of evidence of good, consistent team decision-making and review practices.

A microbiologist reviewed patients daily and participated in consultant ward rounds when needed. This was an increase in microbiology cover and an improvement in practice since our last inspection in September 2016.

At our last inspection we found a number of issues with fire safety in the unit, including a lack of named fire wardens, a lack of staff training, incomplete electrical safety testing and a risk assessment action plan that had not been completed. At this inspection we found all electrical equipment had an up to date safety test. The trust had appointed a fire safety officer who, with the head of estates and facilities, had significantly improved fire safety standards. This included a complete review of fire safety policy and evacuation plans in the department and the introduction of more detailed and practical training for staff. A team of critical care staff had been trained as fire wardens and were responsible for leading the unit in the event of an emergency. In addition, an appointed external officer provided specialist oversight and assessment of fire safety procedures and training. The fire officer had introduced improved communication policies and procedures to aid staff in the event of a fire, including a more specific framework for communicating with the hospital switchboard.

We spoke with staff about the improvements and changes to fire policies and standards. Although it was evident practical training, such as in the use of fire extinguishers, had demonstrably improved, we were not assured staff had a clear understanding of their responsibilities in an emergency. For example, three members of staff said they did not know who would be in charge in the unit during an evacuation if a fire warden was not on shift. We asked the fire officer about
this who confirmed the senior nursing team had been briefed on these procedures and that all staff should understand them.

We also found areas for improvement in how the environment was managed with regards to fire safety. For example, the main evacuation route from the HDU was through the adjacent surgical assessment unit. However, for most of our inspection this route was partially blocked with clinical and housekeeping equipment, which meant staff would not be able to quickly and safely evacuate patients in beds. We also found staff routinely kept windows in the disposables store room open. This room contained significant quantities of flammable material and unattended open windows presented an increased risk of fire spreading. We spoke with the fire officer and the head of estates and facilities about these issues and they told us they would address them. During our out of hours unannounced inspection we found the exit route was free from clutter. In addition, fire safety notices had been displayed on the windows to remind staff to close them when the room was not in use. However, we found the windows remained open. We escalated this to the site manager, who told us they would address it.

The critical care outreach team responded to deteriorating patients in the hospital and provided advanced nursing support, including in vascular access. An on-call critical care consultant provided medical support to the team.

The matrons had increased the number of nursing staff with advanced life support (ALS) training, including all band six and band seven nurses. Band five staff nurses had training in immediate life support and healthcare assistants were trained in basic life support.

Nurses used the national early warning scores (NEWS) system to identify when patients were at risk of deterioration. This was a manual system that required them to escalate a deteriorating patient to a doctor. Matrons monitored completion of NEWS documentation in line with trust standards through the monthly ‘perfect ward’ system. The latest results, for May 2018, indicated a need for improvement in standards. For example, in April 2018 and May 2018 the unit scored 0% for compliance with expected standards of documentation relating to NEWS, including calculation and escalation. This was significantly worse than the trust average of 96%. In addition, in May 2018 the unit scored 0% in the recording of vital signs in NEWS calculations. In the previous month the unit scored 100% in this measure, which meant staff could meet the hospital’s requirements and needed to ensure these were more consistently embedded. We looked at NEWS calculations in a sample of seven patient records and found staff had consistently and accurately completed them.

All nurses were trained annually in the transfer of critically unwell patients. This meant if an unplanned medical transfer occurred the nurse in charge arranged a nurse escort rapidly.

All clinical staff had up to date training on sepsis testing, treatment and risk management. This included the use of the national Sepsis 6 care pathway and the use of National Institute for Health and Care Excellence (NICE) guidance. Sepsis training had been included in nurse annual study days to ensure the team maintained up to date knowledge. Between April 2017 and December 2017, 12% of patients were admitted to the unit with high levels of clinical risk relating to sepsis. This was higher than the national average of 8% and had remained similar to this since 2015.

Clinical risk assessments were comprehensive and we saw evidence staff completed them thoroughly and regularly. Where a patient was at increased risk of a specific condition, we saw staff implemented more extensive monitoring and care. For example, where a patient was at increased risk of venous thrombo-embolism (VTE), staff used a protocol that included prophylaxis, stockings and compression pumps. Staff had signed and dated prescriptions for each item and where the patient could not tolerate one type of intervention, staff worked to find an alternative. This included the use of slings and foot drops to keep heels elevated.
Matrons assessed the standards of clinical reassessment following an intervention as part of a monthly quality assurance audit. In April 2018 and May 2018, the unit scored 69% against a target of 90%. This was worse than the hospital average of 83%.

**Nurse staffing**

The trust reported their staffing numbers below as of January 2018.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>111.51</td>
<td>106.76</td>
<td>96%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From February 2017 to January 2018, the trust reported a vacancy rate of 9.2% in critical care; this is worse than the trust target of 7.5%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The matrons had significantly reduced nurse vacancies in the previous 12 months and at the time of our inspection there were no vacancies for staff nurses or senior staff nurses. The senior team planned to increase the establishment of band seven nurses to 10, which included a second practice development nurse. This post had been successfully filled and the new member of staff was due to join in summer 2018.

From February 2017 to January 2018, the trust reported a turnover rate of 7.0% in critical care; this is better than the trust target of 15%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From February 2017 to January 2018, the trust reported a sickness rate of 6.9% in critical care; this is worse than the trust target rate of 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The sickness rate of 6.9% was a significant improvement in the previous 12 months and reflected the work of the senior team to stabilise the unit.

The unit had not used agency staff nurses in the previous 12 months. This was a significant achievement resulting from a sustained, successful period of recruitment. The senior team had established a critical care bank team for nurses and healthcare assistants. This team attended the same training updates and governance processes as permanent staff, which meant they provided care and treatment in line with unit policies and care pathways.

Nurse staffing levels and nurse to patient ratios met the standards of the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). This included a nurse to patient ratio of 1:1 for patients receiving level 3 care and two supernumerary nurses on shift at all times.

The ICU and HDU were directly connected by a corridor within the critical care complex (CCC) and each unit had a supernumerary nurse in charge. In addition, two nurse ‘runners’ were scheduled to each shift to enable both teams to communicate with each other and to have support for obtaining equipment and disposables. This system meant nurses allocated to patients had additional support when needed. For example, on one day of our inspection one nurse runner had been deployed to provide one-to-one care for a patient in the HDU who had deteriorated and had been ventilated.
The ITU and HDU had originally been two separate units and the matron completed a merger in 2016 that combined them into a single critical care complex. As a result, nurses who had previously been assigned to either unit were required to work in the other area. While all nurses had appropriate training and support to work in all areas of the unit safely, the nurse in charge of each shift deployed staff based on their skill base and experience. This meant if patients were admitted with complex needs there was always a pool of suitably experienced and qualified nursing staff to deliver safe care.

We observed two nurse handovers. Bedside handovers were thorough and included a detailed review of the patient’s condition and treatment in previous 12 hours. This included an update of planned or ordered tests and their most recent test results. During the bedside handovers we observed staff were compassionate, enthusiastic and focused on patient safety. The whole-unit handovers were of variable quality. In one handover the nurse in charge discussed incidents and safety cross updates with the team. However, the handover during our out of hours unannounced inspection was disorganised and had little structure to it. We were not assured staff skill mix was considered during patient allocation and there was no discussion of the shift plan. The shift was short staffed but this was not discussed during the handover and we were made aware of it only when a senior divisional nurse attended the unit with the site manager. This meant staffing challenges were not always openly discussed with staff, which reduced their ability to strategise to reduce the impact on patients and the rest of the team. The site manager told us their team monitored short staffing in the unit and critical care staff routinely escalated these issues to them.

Between May 2017 and May 2018, staff reported eight incidents where they felt care was unsafe due to low staffing levels. In each case the unit did not meet the standard ratio of nurses to patients identified by FICM. In each case the incident was caused by a failure of agency or bank staff to report for a shift or late-notice sickness.

**Medical staffing**

The trust has reported their staffing numbers below as of January 2018:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>23</td>
<td>21.11</td>
<td>92%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From February 2017 to January 2018, the trust reported a vacancy rate of 17.9% in critical care; this is worse than the trust target of 7.5%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

We were unable to establish the reason for the high vacancy rate during our inspection and the senior team said this had been addressed by the recruitment of an additional consultant, with one remaining vacancy.

From February 2017 to January 2018, the trust reported a turnover rate of 41.6% in critical care; this is worse than the trust target rate of 15%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

At the time of our inspection the turnover rate had reduced to 11% and the senior team noted the previous higher figure reflected the relatively small nature of the medical team, which meant any turnover was represented as a significant figure when converted to a percentage.
From February 2017 to January 2018, the trust reported a sickness rate of 0.2% in critical care; this is better than the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust has not provided total shifts including those covered by permanent staff. This data will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

A team of eight consultants led medical treatment in critical care with additional support from an acute medical physician. Four consultants worked between anaesthetics and critical care and four were solely dedicated to the unit. The level of cover met Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS) standards during Monday to Friday daytimes and all eight consultants were registered by FICM. However, out of hours weekdays and at weekends the ratio of consultants to patients was 1:23. This was significantly below the FICM guidance ratio of 1:15. Out of hours the ratio of junior doctors to patients was 1:23, which was significantly worse than the FICM guidance of 1:8. In a November 2017 peer review the north east and north central London adult critical care network identified medical staffing levels as an area of concern.

Six junior doctors worked in the unit at the time of our inspection and there was one vacancy for a trust fellow. A trust specialist registrar had been deployed to the unit to provide additional cover.

Consultants held twice daily structured handovers, which included all patients in the CCC. Consultants used a checklist to ensure essential clinical information was consistently included in each handover. Staff had submitted three incident reports relating to substandard handover communication between May 2017 and May 2018. There was no harm to patients and matrons and consultants identified learning opportunities from each.

During the ‘winter pressures’ period in 2017/18 three junior doctors were allocated to the CCC to cover out of hours shifts. This had been reduced to two junior doctors in Spring 2018. Junior doctors we spoke with told us the level of patient activity and work had not decreased at the same time, which meant they were working under increased pressure. To address this the senior team had prepared a winter pressure business case for the trust for 2018/19 to secure funding for additional staffing and equipment. As a result, a third junior doctor would join the unit from September 2018.

Medical cover overnight typically included two specialist registrars and one senior house officer, with a consultant on call.

All patients were reviewed by a critical care consultant within 12 hours of admission, which was in line with FICM and ICS standards.

Between May 2017 and May 2018, staff reported three incidents where they felt care was unsafe due to low staffing levels or the use of locum doctors without an orientation or induction. One incident found a critical care consultant was unaware of the indication process for locum doctors.

**Records**

Clinical staff used a combination of electronic and paper records for patient notes. Medical staff, dietitians, physiotherapists and others in the multidisciplinary team used the electronic system and nurses used a paper-based system. Consultants duplicated their clinical plan on large format observation sheets used by nurses to ensure all members of the team responsible for care were aware of the latest plan. Each patient side room or HDU bed bay was equipped with a computer connected to the electronic records and imaging results systems. This meant clinicians could
instantly access imaging and blood results while they were with the patient.

We looked at 11 patient records and found a consistent standard of risk assessment and documented nurse and therapies observations. This included for Waterlow scores, moving and handling, VTE and infection risk. Staff completed daily progress notes for each patient that included a review of their care bundles, resuscitation status and communication with family members. Staff had clearly documented allergies in prescribing documents.

Matrons monitored the completion of patient records against trust standards. In April 2018 and May 2018, the unit scored 100% compliance, which was better than the trust average of 95%. In the same period 100% of patients had a completed care plan.

Staff used assessment pro formas specific to critical care for risk assessments and when assessing other elements of care and treatment. This included formalised documentation for patients being stepped down to an inpatient ward.

**Medicines**

Two pharmacists were based in the CCC during weekday daytimes. They managed medicine reconciliation and prescriptions and provided support and guidance to staff. There was no weekend cover available on the unit and instead the hospital pharmacy team provided an on-call service.

We found evidence of learning from medicines incidents and errors. For example, following an incident of a missed dose of a prescribed medicine followed by an administration error, senior staff and the pharmacy team carried out reflection exercises with the individuals involved. They also identified errors could be reduced if the unit moved to an electronic prescribing system, which the senior team told us they planned to introduce within two years. The medicine safety link nurse group developed and introduced a tool that required two nurses to document the administration of medicines as part of a safety thermometer strategy, called ‘eagle eye’, to reduce medicines errors. Where a nurse was involved in a medicine error, the practice development nurse reviewed the incident with them and reassessed competency using a drug calculation test. Staff also completed a reflective piece of writing to identify personal opportunities for learning.

Medicines were not always managed safely. On two occasions during our inspection we found partially used bottles of Propofol, a sedative, stored in patient’s rooms for re-use. This medicine should only be administered as a single-use item and remaining liquid disposed of safely. On one day of our inspection we found medicines belonging to specific patients had been left in two unlocked bedside cupboards despite the patients no longer being cared for there. We spoke with a matron about the issues and they said they would address the practice. During our unannounced out of hours inspection we found the storage and safety issues had been resolved.

The pharmacy team provided an induction for new staff based on their role and level of responsibilities. For new doctors this included a guide to microbiology and trust standards on the use of the British National Formulary. Access to prescribing guidance for antibiotics was available electronically, which doctors told us reduced the risk of prescribing errors.

The pharmacy team carried out a daily spot-check of Controlled Drugs (CDs) and a full audit every three months. In addition, the team completed a medicines safety thermometer audit every three months. Overall this reflected a safety structure to ensure medicines management remained safe and that mistakes resulted in improved practice. For example, the pharmacy team carried out training with nurses following a medicine error that resulted from an administration oversight and introduced a tracking system for medicines in each bed bay.

We looked at the records for the return to stock or destruction of CDs between November 2017 and April 2018. Out of 30 entries, 23 were fully completed with the initials and date of a CD technician and a witness signature by a trust nominated officer. Nurses we spoke with
demonstrated a clear understanding of the requirements relating to CD administration and documentation.

Staff carried out a daily antimicrobial stewardship ward round Monday to Friday to ensure prescribing practices were in line with trust policy and national standards. Antibiotics pharmacists had carried out an anti-infective point prevalence audit in May 2018 to establish standards of practice in the unit and compared with the rest of the trust. The audit found a good standard of practice, including a review by a consultant microbiologist before anti-infective medicines were prescribed. The audit found 100% compliance with documentation standards, including completed allergy boxes, the duration of the course of medicine and the indication for the medicine. The auditing pharmacists included sedated patients and found prescribing practice was safe and appropriate for these patients.

A specialist pharmacist carried out an audit in March 2018 to identify standards of medicine handling against trust policy. The audit reviewed the practices of senior nurses responsible for medicine management and rated the unit on a red, amber, green (RAG) scale based on compliance with trust policy. Out of nine measures, the audit found 100% compliance in eight measures and 67% compliance in the clean utility room measure. This related to the absence of a thermometer in this area. The audit directed the senior ward team to resolve this issue within one month although we found this had not been completed at the time of our inspection.

The matron monitored instances of missed medicine drug doses through a monthly quality assurance system. In April 2018 and May 2018, the unit scored 97% compliance, which was better than the hospital average of 95%. In the same period the unit scored highly for other medicine safety measures. This included 100% compliance for antibiotic review date, allergies recorded, legibility of drug charts and evidence of actions taken with prescribing.

Between May 2017 and May 2018, 9% of reported incidents related to medicines. This represented 33 incidents including omitted doses and incorrect types, doses and routes of medicine. In each case we saw the senior team and pharmacy team worked together to identify causes and reduce the risk of future recurrences. Where incidents involved other teams or specialist medicine that the critical care team did not often see, we found a multidisciplinary approach to investigation. For example, one incident involved a nurse administering an incorrect type of antiretroviral medicine to a patient living with HIV. The HIV pharmacist and consultant and the critical care senior team and pharmacist were involved in the investigation, which resulted in improved training from the pharmacy team and the practice development nurse. The outcome of another incident resulted in closer working and communication between critical care nurses and the chemotherapy team.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported no incidents classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from March 2017 to February 2018. The two types of incident reported were:

- One treatment delay meeting SI criteria (50% of total incidents).
- One surgical/invasive procedure incident meeting SI criteria (50% of total incidents).
Appropriate clinical staff and a serious incident (SI) panel carried out a rapid review immediately after an SI was reported. This established the course of action to take in addition to the routine root cause analysis. During our inspection the senior clinical team told us one of the above noted SIs had been incorrectly categorised and was an incident, not an SI.

We found evidence of learning from the investigations and outcomes of SIs. For example, following an SI involving a misplaced central venous catheter, the clinical team modified the local safety standards (LocSSIP) form on the electronic patient records system to include a check of blood results. The investigation identified a need to consider providing more senior supervision for new doctors carrying out invasive procedures. The second SI related to a misplaced nasogastric (NG) tube followed by an incorrect X-ray to check positioning.

We saw examples of the presentations delivered to staff following SIs, which included details of the root cause analysis and the learning implemented to avoid a future recurrence. Audit nurses and a consultant had analysed instances of accidental line and tube removal since September 2015 as an audit tool to improve safety measures and practice. This improved communication with staff after incidents and established learning from each. The audit team had introduced new practice because of this learning, such as providing new clinical single-use equipment to fix lines in place and increased one-to-one nursing for patients who were agitated. In addition, matrons monitored the correct documentation in nursing notes for NG tube care using a monthly quality assurance audit. In April 2018 and May 2018, the audit found 100% compliance.

The trust sent out an electronic newsletter every quarter with details of reported SIs and their investigations. This provided staff with an opportunity to learn from incidents in other departments. Although this reflected good practice we saw the newsletter was very detailed and lengthy and lacked summaries, which meant staff needed to allocate substantial time to read and digest the information.

Between May 2017 and May 2018 staff reported 357 incidents. Senior staff and the hospital’s risk team classified severity on a scale from one to five, where one was the lowest severity and five the highest. Of the total, 251 were classed as level one, 101 were level two, one each was level three and level four and three were level five. Although staff recorded details of each incident in a tracking file that enabled them to monitor time to closure and identify themes, we were not assured this was an accurate or effective system. This was because of inconsistencies in the classification of each incident. For example, safeguarding incidents were classified as either safeguarding or an adult at risk incident. In addition, staff classified 14 incidents as ‘other’ when there were existing, more specific categories for all of them, including infection control, pressure sores and staff communication.

We looked at the key features of each incident investigation and the outcomes and found senior staff carried out thorough investigations that involved relevant staff and teams. For example, one incident resulted in a member of staff experiencing a fracture after they slipped on a wet floor that was not adequately signed. The investigating officer reporting the incident to the Health and Safety Executive and worked with the hospital security team to review CCTV. They found gaps in safety practice by the cleaning contractor, which they addressed through leadership teams in the trust and in the contractor.

Staff said they usually received feedback from incident reports but that this could sometimes be delayed significantly. For example, staff told us they sometimes waited four weeks or longer for feedback after an incident had been closed. However, they said feedback was offered through a number of routes including by e-mail, during handovers and through weekly ‘cobra’ meetings.
It was not evident learning and outcomes from incidents was always accessed and understood by staff. For example, two incidents had occurred relating to patients being transferred to wards without full sets of notes. Although changes to practice had been implemented, some nurses we spoke with said they were unaware of these. In addition, none of the nursing staff we spoke with knew about previous SIs and there were discrepancies between doctors with regards to serious incidents they knew about.

**Safety Thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, no falls with harm and no new catheter urinary tract infections in patients with a catheter from February 2017 to February 2018.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at North Middlesex University Hospital NHS Trust**

![Graph showing pressure ulcers prevalence rate](image)

(Source: NHS Digital)

Staff carried out a pressure ulcer assessment of each patient daily for the duration of their inpatient care as part of a protocol to reduce instances.

The unit had a consistently good track record in ensuring unit-acquired blood infections were low. In 2017 there were 1.4 instances, which was slightly better than the national average of 1.6 The unit had performed better than the national average since 2014.

Between May 2017 and May 2018, staff reported 10 incidents relating to slips, trips and falls. In each case matrons investigated contributing factors, such as confusion, disorientation or staffing levels and took action such as ordering x-rays or scans.

**Is the service effective?**

**Evidence-based care and treatment**

The critical care team had a demonstrable approach to delivering evidence-based care and had appointed two audit nurses to ensure this was a continual process. The audit team ensured data returns for the Intensive Care National Audit Research Centre (ICNARC) were up to date and carried out local audits to benchmark standards of care and treatment.

Doctors provided care and treatment in line with standards endorsed by the European Society of
Intensive Care Medicine, the Society of Critical Care Medicine and the American Thoracic Society in relation to acute respiratory distress syndrome. All the clinical staff we spoke with demonstrated how they accessed clinical policies and standard operating procedures using electronic access. This included National Institute of Health and Care Excellence (NICE) guidance and reference material.

Nurses and healthcare assistants adopted link roles to specialise in certain areas, such as pressure area care and infection control. Link nurses attended meetings and training with specialist teams and used critical care meetings and training days to deliver up to date information and guidance. They also presented their project and audit work at monthly audit and mortality meetings.

Clinical staff were encouraged to develop audits that would establish standards of care in the unit and drive improvements. For example, one doctor had completed an initial audit cycle of the use of prophylaxis for stress ulcer management. The protocol used in the audit had produced positive results for patients and the trust had adopted it across the hospital. A second audit cycle was planned to ensure the results were reliable and to develop the protocol further.

The audit nurse was completing monthly audits of the use of two new items of equipment introduced following previous incidents. One audit monitored the use of a new type of endotracheal tube that reduced the risk of it falling out and another monitored the use of a new type of naso-gastric (NG) tube. The audit nurse was also leading the unit in participation of a national research programme to explore care options for patients living with asthma.

Staff used national Sepsis 6 and NICE guidance to assess for sepsis and to provide treatment. There was an up to date local sepsis policy in place that reflected national best practice and had been updated to accommodate national changes.

The pharmacy and microbiology teams maintained an up to date database of antimicrobial and antibiotic prescribing guidelines on a mobile phone app, which clinicians could access at any time. This meant staff had continual up to date access to trust guidance and policies.

The trust used a ‘perfect ward’ quality monitoring system to enable each ward or clinical unit to benchmark care and treatment against the rest of the hospital. Critical care performed consistently well in this system and improved its ranking progressively between September 2017 and May 2018 where staff achieved a ranking of fourth out of 23. The standard of care and treatment was measured through the outcome to 39 individual questions, each of which had a trust standard or target.

The unit was part of the north east and north central London adult critical care network, which included undergoing network peer reviews to benchmark standards of practice.

**Nutrition and hydration**

Dieticians saw most patients in critical care and prioritised those who required NG feeding and total parenteral nutrition (TPN). Although this team was short staffed and experienced high levels of agency usage they provided guidance and teaching to staff opportunistically.

Nurses used a standard protocol to initiate NG feeds out of hours. However, there was no protocol in place for TPN to be started out of hours when there was no dietetics cover. In addition, the trust
did not employ a nutrition nurse. This meant cover outside of standard Monday to Friday hours for nutrition support was limited.

From looking at patient notes we saw there was consistent input from speech and language therapists and dieticians. Staff from each team worked together to assess each patient’s dietary needs, including risks for malnutrition and dehydration. Where patients had complex comorbidities, dieticians worked with critical care nurses and clinical nurse specialists from the relevant discipline to ensure nutritional needs were assessed and met. Appropriate evidence-based assessment tools were in place and staff used these to monitor patients, such as by using the malnutrition universal scoring tool (MUST).

Five patients we spoke with said they were happy with the quality and frequency of food and said they had access to snacks out of hours.

Matrons monitored nutrition and hydration standards monthly through a quality assurance system. In April 2018 and May 2018 the ward scored 100% for compliance with correct completion of food and fluid charts and the completion of a MUST nutritional assessment. This was better than the trust average and standard in each measure. In the same period the unit scored 87% for the completion of each patient’s weight on admission followed by periodic updates. This was worse than the trust average of 96%.

**Pain relief**
Staff assessed pain and prescribed pain medicine in line with the Core Standards for Pain Management Services Faculty of Pain Management (2015). This included through consultant-led pain management, individual analgesic plans and appropriate documentation of pain assessments. Doctors prescribed pain medicine when patients were ventilated and the pharmacy team monitored this daily.

A specialist acute pain team was available in the hospital on demand for patients with complex needs and routinely provided assessment for patients who were prescribed patient-controlled analgesia (PCA).

Clinical staff used a non-verbal pain assessment to establish individual pain needs when a patient was not able to talk. This included by interpreting body language and facial expression. Where patients were ventilated, staff used the Richmond Agitation-Sedation Scale to assess pain within checks for delirium.

All five of the patients we spoke with said staff had been responsive in managing their pain, which they said had been well controlled.

The matron monitored completion of pain assessment documentation during monthly quality ward checks. In April 2018 and May 2018, the unit scored 95%. This placed the unit as the highest performing ward in the hospital for this measure.

**Patient outcomes**
The trust has one unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.
For the intensive care/high dependency unit, the risk adjusted hospital mortality ratio was one in 2016/17. This was within the expected range. The figure in the 2015/16 annual report was 1.1.

For the intensive care/high dependency unit, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.8. This was within the expected range. The figure in the 2015/16 annual report was 1.1.

A consultant and nurse led a follow-up clinic for patients who had been ventilated during their inpatient stay or who had been an inpatient for longer than seven days. The clinic provided patients with an opportunity to reflect on their experiences and memories as a method of improving their ability to cope with the psychological impact. The follow-up team provided the clinical bi-monthly and a clinical psychologist was available for support and discussion.

The critical care tissue viability group were taking on-going actions to address a trend of increased pressure ulcers. They had reviewed each incident report to identify if changes to clinical procedures or the use of specific equipment could reduce risk. The group introduced new standard procedures to prevent pressure ulcers, including for the elevation of heels and new guidelines for staff during the night. The healthcare assistant team were involved in the pressure ulcer prevention plan and were allocated specific patients to monitor on the SSKIN care pathway. We saw each patient's side room or bed space had an SSKIN monitoring sign in place, which staff used to note their last monitoring time or turn. They completed this at two-hourly intervals for patients at greatest risk. Along with a weekly documented review of tissue viability, this represented a substantial improvement in practice for better patient outcomes.

Tissue viability and pressure care were elements of the matron’s monthly quality assurance checks. In April 2018 and May 2018, the unit scored 100% for pressure ulcer risk assessment and use of the SSKIN care bundle. Between May 2017 and May 2018, 17% of reported incidents related to pressure sores. Of this, 32% were acquired in the hospital.

The critical care outreach team reviewed each patient within 24 hours post-discharge from the unit. This took place on the ward they were discharged to and the CCOT team ensured their treatment plan and prescriptions were working for them. Where patients on the wards experienced deteriorating medical conditions, the CCOT team provided a response service based on the patient’s national early warning score. This ranged from an immediate ward visit to a telephone consultation with ward staff depending on the extent of their deterioration.

Processes were in place to ensure treatment decisions about weaning were not influenced by the lack of available ventilators in the unit. Consultants led ventilator weaning and the transfer protocol meant patients who needed ventilating would be transferred when all equipment was in use. This meant patients being cared for on a ventilator would not be weaned prematurely.

A team of five physiotherapists provided rehabilitation to patients in line with NICE clinical guidance 83, which relates to rehabilitation after critical illness. Although the staffing levels met the Faculty of Intensive Care Medicine and Intensive Care Society standards, this was not the case when a therapist was on leave or training. Additionally, the senior physiotherapist was the only permanent member of the team and the junior physiotherapists were in rotational posts. This meant not all patients received an assessment within 24 hours of admission, which was not in line with London standards. In addition, the physiotherapy staffing levels and skill mix meant the team could not get involved in tracheostomy care and weaning.
In 2017 0.4% of patients were readmitted within 48 hours of discharge, compared with the national average of 0.9%. The unit had performed similarly to, or better than, the national average in this measure since 2014.

Consultants reviewed sepsis management during monthly morbidity and mortality meetings. As part of this process they identified areas of good practice in sepsis screening and areas for improvement.

The trust monitored the effectiveness of sepsis screening and management. However, they were unable to provide this at ward or unit level.

**Competent staff**

From February 2017 to January 2018 84% of staff within critical care at the trust had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of individuals required</th>
<th>Number completed</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>103</td>
<td>91</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>4</td>
<td>0</td>
<td>0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

We looked at appraisal rates for medical staff during our inspection and found 100% of doctors, nurses and healthcare assistants had completed an appraisal in the previous 12 months. This was better than the trust target of 90%. Consultant appraisals were completed annually in line with their job plans and we found a positive attitude towards the learning and development opportunities presented by appraisals during our discussions. Staff who provided services to critical care but were not part of the permanent team, such as allied health professionals, managed appraisals within their own team structure. We were not able to establish who the trust referred to as ‘Other Qualified Scientific, Therapeutic, Technician Staff’ in the table above.

A dedicated practice development nurse (PDN) had introduced a five-day introduction to critical care nursing programme for new staff and had significantly increased the overall access to training. During the induction and probationary period, the PDN provided one to one support and ad-hoc bedside teaching to staff. During this period new staff worker on a supernumerary basis, which the PDN could extend if needed. New staff completed basic competencies within three months and then began specific intensive care competencies. This structure meant nurses had access to training and development at an appropriate pace and also meant the unit was more aligned with similar units for the training of band five staff nurses.

All the staff we spoke with said they felt access to training and learning had improved in the previous year. One nurse said, “It feels like we have lots of learning. I think it keeps people here and keeps them improving and getting better.”

The unit demonstrated a significant improvement in the number of nurses who held a post-registration qualification in critical care nursing. Matrons had pursued an increase in the proportion of nurses with this qualification and in 2017 seven senior nurses had successfully completed the accreditation. At our last inspection 27% of nurses had this qualification and in June 2018 70% of nurses held it. This was better than the Faculty of Intensive Care Medicine standard of a minimum of 50%.

Improving staff skills and knowledge was a key element of the critical care strategic plan for
2018/19. This was reflected in the recruitment of a second PDN and the introduction of a nurse-led introduction to critical care course for new staff.

Staff recruited from outside of the UK told us they had been well supported in transferring their skills to be able to work effectively in the hospital. For example, where doctors had been recruited with critical care experience but without suitable airway skills competencies, the consultant team addressed this immediately. Doctors said this increased their confidence and ensured they were ready to provide care and treatment without constant supervision from consultants. Airways skills teaching took place every two months in theatres and anaesthetics and included practical activities and competency-based testing.

Consultants led teaching sessions for clinical fellows and junior doctors three times weekly. Session topics adapted to the needs of the unit and included specific case reviews of patients and standing items on the electronic patient records system.

The senior team invested in mentorship training in 2016/17 and 60% of nurses were qualified mentors at the time of our inspection. This meant new nurses had access to more consistent supervision and mentoring during their induction and probationary periods in the unit.

New staff attended a two-week induction, which included one week in the unit working on a supernumerary basis.

Staff from the multidisciplinary therapies teams offered training sessions to critical care staff. However, pressures on the service meant individuals were not always able to attend. For example, the speech and language therapy (SLT) team and PDN had planned swallowing assessment training for new nurses. However, the senior team had been unable to provide protected time for attendance, which meant none of the new nurses had completed the training.

Two members of the critical care outreach team had completed a non-medical prescribing course and were awaiting sign-off. This would increase the capacity of the team to provide specialist care and treatment to acutely unwell patients.

Nurses and healthcare assistants received regular supervision and annual appraisal and said they found these to be useful processes to reflect on their progress and to identify their training needs. However allied health professionals who worked in critical care did not always have regular access to supervision. They said this was because managers were often based off-site and were not visible or accessible. This had been escalated to the head of therapies but staff told us there had been no resolution.

We looked at an anonymised sample of five annual appraisals for nursing staff. In each case we saw evidence staff had structured support for professional development and were given the opportunity to reflect on their work to identify achievements and to set goals for the next year.

Microbiology and pharmacy teams provided education sessions to new doctors twice annually on effective antibiotic and antimicrobial prescribing. They delivered training to junior doctors and medical students continually.

**Multidisciplinary working**

We saw daily ward rounds were attended by members of the multidisciplinary team, including from pharmacy, SLT, microbiology and physiotherapy in line with patient needs. Staff from each team contributed to a discharge handover prior to patients moving to a ward. We also observed effective handovers between specialists and critical care staff after patient reviews.

A team of 12 SLTs provided cover for the critical care unit and included individuals who provided care for patients in the critical care and acute medical settings. This team used a bedside swallowing assessment poster as a prompt and guide for nurses and doctors to identify changes
Multidisciplinary staff met daily to review patients as part of a handover that included the critical care outreach team and nurses and doctors from the main unit. Staff from each therapy met weekly as part of broader multidisciplinary meeting to review all patients who had been admitted to critical care for more than seven days. Additionally, therapists joined critical care monthly meetings to provide support in reviewing specific patient cases. This structure meant patients were reviewed continually by the wider specialist team, who maintained structured communication to ensure patient care was well coordinated.

A dedicated HIV service was available in the hospital and an HIV consultant carried out weekly reviews of patients in the unit who were HIV positive. This was a comprehensive specialty service and an HIV clinical nurse specialist liaised with the patient’s relatives with regards to ongoing treatment and care.

A tissue viability specialist nurse (TVN) provided assessment and care for patients and guidance for staff in the management of pressure areas, including in the use of the SSKIN bundle. We saw examples of positive and consistent coordinated working between the TVN and the critical care team. For example, where one patient had significant co-morbidities, including in relation to pressure sores, the TVN scheduled reviews of the patient every five days and trained critical care staff to use medical photography to monitor the progression of the patient’s skin condition.

A nurse from the critical care outreach team joined the hospital cardiac arrest team for emergency calls. To improve the working of this team they had established a briefing at the beginning of each shift to enable the team to get to know each other and to identify any potential skills gaps.

The unit did not have access to a dedicated occupational therapist, who would normally be involved in the early review of daily functional tasks and reorientation following delirium.

**Seven-day services**

A consultant intensivist was available on-site within one hour of being called for high risk patients 24-hours, seven days a week.

Microbiologists and radiologists were available Monday to Friday with on-call services available out of hours.

The critical care outreach team provided services 24-hours, seven days a week.

Physiotherapy, SLT and pharmacy provided seven-day cover using an on-call system. This included chest physiotherapists who provided on-demand specialist therapy. The dietetics team was unable to provide a seven-day service due to short staffing.

**Health promotion**

Staff signposted patients to specialist and community health services on discharge, including for smoking cessation and the management of alcohol and drug use. Staff who provided the follow-up service provided guidance on health promotion strategies including for good mental health.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

The trust did not provide Mental Capacity Act (MCA) training as a specific module for staff. Staff we spoke with said that they did not have MCA training, and if they had questions regarding a patient’s capacity, they would ask the psychiatric liaison team to assist them and to carry out a mental capacity assessment if necessary. However, the trust policy stated that clinicians responsible for the patient’s care should carry out a MCA assessment using an MCA template.
The psychiatric liaison team told us that it was not within their remit to carry out MCA assessments and that they were frustrated by the number of staff who asked them to do it.

We reviewed the clinical notes of patients with reduced mental capacity or those who had been cared for with a ventilator to identify if staff had applied for a Deprivation of Liberty Safeguards (DoLS) authorisation. In each case we found staff had carried out appropriate mental capacity assessments as well as best interest assessments with the mental health team. Where a patient had been cared for on a ventilator for a significant period without a DoLS authorisation, they had acted in line with FICM guidelines for life-saving care.

Where patients were at risk of self-harm due to reduced mental capacity, staff had documented an assessment of the least restrictive way of protecting them. In one patient we reviewed this included appropriate use of soft mittens to prevent injury. A consultant had completed a risk assessment for the use of mittens and reviewed this daily. However, we found clinicians had not completed a mental capacity assessment in advance of approving the mittens. This meant restraint techniques were applied without staff establishing a full understanding of the patient’s capacity to understand why they were applied.

Staff demonstrated varying knowledge of the Mental Capacity Act (2005) and their responsibilities in relation to mental capacity. For example, some nurses we spoke with demonstrated a good understanding of patients with capacity issues and what this meant for their care and consent. However other staff were not clear on the distinction between capacity, consent and restraint. For example, we asked the nurse in charge about one patient who had a partially-completed restraint form and clinical notes that suggested a DoLS may have been indicated. They were not able to differentiate between DoLS and restraint. This meant we were not assured they always understood the needs of patients they were caring for with complex mental health issues. However, staff carried out a weekly capacity assessment for each patient cared for with the use of bed rails on their bed. This ensured their use was appropriate and did not unnecessarily restrain them.

New clinical staff had requested training in the MCA and DoLS as these were previously unfamiliar to them when practicing medicine outside of the UK. All staff we spoke with who had undertaken this training demonstrated a good level of knowledge.

As part of a project to improve the overall support provided to patients with reduced mental capacity or with mental health needs, staff had developed a code of practice for the use of the Mental Capacity Act (2005). This helped them to identify if a patient needed a referral for an independent mental capacity advocate (IMCA), which the senior team could arrange.

In October 2017 staff completed an incident report relating to the absence of a documented capacity assessment for a patient with a do not attempt resuscitation (DNACPR) in place and who had mental capacity. Staff arranged for a full capacity assessment along with an interpreter for the patient’s first language and identified they had capacity to make their own decision about resuscitation status. The outcome of the incident did not identify why the consultant had not completed consent documentation.

Is the service caring?

Compassionate care
All five of the patients and three of the relatives we spoke with said they were happy with the care they had received on the unit. One relative told us they had found being in the critical care environment challenging and that nurses had been kind and understanding when they had been upset. One patient said, “Nothing ever seems too much trouble. They are a lovely group of people.”
A patient and relative’s survey was in place and staff used this to monitor feedback on the care and service in the unit. Staff maintained a folder of feedback at the entrance to the unit that included action taken as a result of negative feedback. Between January 2018 and April 2018 there were four feedback themes that indicated areas for improvement. One area of feedback related to noise during the night and another related to the business of the unit, which the respondent felt led to a premature discharge. Two other items of feedback related to communication and identified areas for improvement, including in the sensitivity of discussions relating to organ donation. Matrons had documented responses to each area, including how they had addressed them.

Senior nurses prepared a monthly presentation that reviewed patient and family feedback for all staff, which focused on plaudits and areas for improvement. This included an on-going review of how patients rated their care in terms of compassion and dignity. We looked at the reviews from the previous 12 months and found the team were responsive to feedback and comments. For example, patients noted that personal care was not consistently offered. The senior team addressed this with nurses and there were no further comments regarding this in the survey.

Matrons monitored patient experience as part of monthly quality audits. This included 26 criteria to measure how patients felt they had been treated in the unit and whether this included dignified and friendly care. In April 2018 and May 2018 100% of patients said they had been treated with dignity and respect and 98% of patients said staff were kind and caring.

A carers passport scheme was in place but had not been updated in the previous five years. This meant it did not reflect the latest guidance issued by the trust or national best practice. Staff we spoke with demonstrated variable knowledge of this scheme and none of the nurses we asked were fully aware of the benefits of this. This meant we were not assured carers were always offered the range of support available to them.

The north east and north central London adult critical care network found the unit to be “very welcoming and friendly” in a November 2017 peer review.

Mortuary staff had submitted two incidents regarding poor adherence to dignity measures from critical care. Both incidents involved the transfer of deceased patients from the unit to the mortuary without appropriate practice.

**Emotional support**

The follow-up clinic team, which included a clinical psychologist, provided patients with emotional support if they needed it following discharge.

Staff had the training and resources to provide emotional support to patients and their relatives following significant mental health events, including self-harm and attempted suicide. We saw staff had referred patients rapidly to the mental health team when they had been admitted as a result of self-harm and maintained close contact with their relatives.

The unit had established visiting hours to reduce disturbance and distress to patients. However, where family members or patients were distressed the nurse in charge could relax the times and allow visitors at times to suit patients.

Staff demonstrated an understanding of the emotional needs of patients and took steps to meet these. For example, one patient told us they had become distressed during the night and staff had called their carer and asked them to come to the unit as they knew this was the only person who could calm them down. The patient said they had appreciated this gesture and it showed how staff understood their emotional support needs.

Two patient and family experience link nurses had prepared information for relatives on how they could access emotional support in the hospital. This addressed different types of support,
including spiritual, religious and non-denominational.

**Understanding and involvement of patients and those close to them**

Where patients were cared for by multiple specialties we saw staff from each team maintained communication with their relatives. This included discussions led by clinical nurse specialists from the medical discipline and from consultants leading the treatment plan.

Staff recorded evidence of conversations with family members when a patient’s condition changed or deteriorated. For example, after a patient had a cardiac arrest, the treating doctor recorded a summary of their conversation with the patient’s next of kin. This meant staff had a reference point for conversations so that they could provide up to date information for relatives without providing repetitive or contradictory information.

Two patients we spoke with said they felt doctors had involved them in discussions about their care during ward rounds and they felt they understood their treatment plan. Other patients described inconsistent communication from the medical team and relatives said communication could be clearer. Communication was a recurring theme in our discussions with patients and relatives. For example, one family told us they wanted to be able to touch and hug their relative but staff had not given them any instructions or information on whether this was appropriate in the side room. They said the impact of not being able to touch their relative was increased sadness and anxiety and they felt staff could have been more open with them.

Patient and family experience link nurses had worked to more closely involve patients and relatives in their care. To achieve this, they published an information booklet that included details, using plain language, of common medical conditions, procedures and outcomes in critical care. This included details of why the symptoms of some conditions could be upsetting and how relatives could better cope with what they saw. The booklet included a definition of medical terminology patients and relatives might hear in the unit to help them better understand processes and procedures. Link nurses had included information specifically for patients, including what they could expect after discharge and common feelings and anxieties once they left hospital.

**Is the service responsive?**

**Service delivery to meet the needs of the local people**

The site team sometimes redeployed critical care nurses to inpatient wards for shifts if this meant patient safety would be maintained in the unit and the needs of patients on wards could be better met by a critical care nurse. For example, if a patient was admitted to an inpatient ward and needed tracheostomy care, critical care nurses had training to be able to provide this. Nurses told us they tracked the frequency of redeployment to ensure it was fair and proportionate.

A clinical transfer policy was in place, which staff used in the event a patient could be better treated in another unit or where there was no capacity in this unit. The policy had been reviewed in the previous 12 months and all clinical staff had training. However, clinicians told us the process was protracted and caused unnecessary delays in service delivery.

The clinical team identified patient’s needs as part of the discharge process. This included liaising with district nurses and community physiotherapists to support patients who would find daily activities challenging. Doctors included this information in discharge summary reports for GPs and provided patients with signposting on how to access other types of care. The follow-up clinic team supported patients to reintegrate into their community and to access community services.

Matrons assessed the completion of discharge and transfer documentation through a monthly quality assurance audit. In April 2018 and May 2018, the unit scored 100% for both measures,
which placed as the highest performing ward or clinical area in the hospital. This audit also monitored the required completion of demographic details in the admission and history documentation. In April 2018 and May 2018, the unit scored 100%. This was better than the trust average of 95%.

Staff were proactive in liaising with the specialist nurse organ donation (SNOD) to identify potential organ donors. We saw an example of this where a patient was admitted to the intensive care unit (ICU) through the emergency department. Staff liaised with the patient’s family and worked quickly to alert the SNOD that organ donation may be possible. In 2017 the unit facilitated five organ donations.

Staff facilitated overnight stays for relatives if this was appropriate based on the patient’s condition. There was no dedicated on-site accommodation for relatives and staff assisted relatives in finding local hotels. Limited catering was available on site out of hours and critical care staff provided snacks on request.

Meeting people’s individual needs
There was a quiet relative’s room in the unit, which we saw was well used by visitors. Staff provided them with drinks to help make them more comfortable. A waiting room was available adjacent to the unit for relatives to have some quiet space. This room had recently been refurbished to make it more comfortable and relaxing. Relatives had access to tea and coffee making facilities and a fridge to store snacks in.

The team had prepared and implemented a code of practice for patients living with mental health needs or reduced capacity. This included establishing a self-neglect assessment tool that promoted wellbeing and safety as well as prompts to help staff identify and act on early warning signs of types of abuse, including modern slavery, neglect and human trafficking.

There were limited resources available for staff to help them provide individualised care to patients living with a learning disability or with dementia. Some staff we spoke with could articulate how they would adapt their communication methods to help in supporting people with these needs but there was no formal training or structured support for them.

Assisted shower rooms were available on both the ICU and HDU and staffing levels were sufficient to support patients with personal care on request. Relatives told us they were pleased that when their family member started to recover staff took care of their personal hygiene, which improved their sense of wellbeing and dignity.

Relatives told us they felt staff worked hard to meet individual needs. For example, one family told us their relative had recovered well and wanted some fresh air. They spoke with the nurse in charge who found a wheelchair and allowed the patient to leave the unit into the hospital grounds.

Patient and family experience link nurses had designed, developed and produced an informative information booklet for patients cared for in the unit and their relatives. This was a highly visual, easy-to-read publication that included a substantial amount of information to help ensure people were better informed about critical care. This included a diagram of a typical bed space set up, with information on each item of equipment. Staff had provided a separate diagram with equipment description for patients receiving life support. The booklet included information on hospital services, including private waiting areas and catering facilities.

Matrons monitored the completion of care plans for patients receiving end of life care through a monthly audit. In April 2018 and May 2018, the unit scored 100%, which was better than the hospital average of 96%.

Monthly quality assurance checks indicated a need for more consistent dementia screening for
patients over the age of 75. In April 2018 and May 2018, the unit scored 75% against trust requirements, which was worse than the target of 90%. This audit also checked for care planning that included diversion activities for patients with cognitive impairment. In April 2018 the unit scored 50% and in May 2018 it scored 100%.

Staff completed comfort rounds to monitor individual needs and matron’s monitored completion in monthly audits. In April 2018 the unit scored 50% compliance in this measure and in May 2018 it scored 100%.

We asked the trust to provide evidence they were compliant with the NHS England Accessible Information Standard. They were unable to provide this and told us they did not have any relevant details in relation to the standard for critical care.

**Access and flow**
From March 2017 to February 2018, North Middlesex University Hospital NHS Trust has seen adult bed occupancy fluctuate both above and below the England average, with performance that is generally better than the England average.

**Adult critical care Bed occupancy rates, North Middlesex University Hospital NHS Trust**

![Graph showing bed occupancy rates]

Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

For the high dependency unit at the trust, there were 3650 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 9%. This compares to the national aggregate of 4.9%. The figure in the 2015/16 annual report was 1.2%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Delayed discharges remained a significant challenge on the unit. Although the senior team demonstrated awareness of this there was limited evidence of a structured, well-defined approach to resolving the causes.

For the high dependency unit at the trust, there were 970 admissions, of which 0.1% had a non-clinical transfer out of the unit. This was within the expected range. The figure in the 2015/16 annual report was 0.1%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The clinical lead explained that non-clinical transfers out had increased over the winter pressures period and that in each case ICUs and HDUs within the local network were identified first before considering transfers further afield.

For the high dependency unit at the trust, 5.1% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am.
This was worse than expected. The figure in the 2015/16 annual report was 10.1%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

After our inspection the trust provided date for the whole critical care unit with regard to discharges and delays for the period April 2017 to December 2017. Overall 2% of patients experienced a non-delayed, out-of-hours discharge to a ward. This was a significant improvement of 8% from the previous year. In the same period 9% of patients experienced a discharge delay of between eight hours and 24 hours and 6% of patients experienced a discharge delay over 24 hours.

In 2017 3% of patients were discharged home directly from the unit, which was better than the national average of 6%. The unit had performed better in this measure than the national average since 2014.

The average length of stay in the unit was four days, which was similar to the national average.

Between May 2017 and May 2018, 7% of reported incidents in critical care related to bed management, discharge or transfer issues. This reflected 23 incidents, of which 18 were out of hours transfers. One incident record included four individual out of hours transfers that occurred on the same date between 10.30pm and 12am, which meant there were 21 total incidents of this type. We saw in each case consultants and the site management team were involved in identifying causes of the incident.

Learning from complaints and concerns
Between June 2017 and June 2018 critical care received seven formal complaints, four of which were open at the time of our inspection. The tracking tool supplied by the trust was not sufficiently detailed to identify the average length of time the trust took to close complaints. The senior team had taken between two and three months to resolve two complaints that had been fully closed. They had not yet acknowledged one complaint that had been received two days previously. Six of the complaints were made by relatives of patients and related to concerns such as dissatisfaction with a documented cause of death and an incorrect intravenous medicine administration.

Matrons and the clinical lead investigated complaints and required the complainant to sign a consent form before they could provide information. We looked at the trust’s formal and investigation to two complaints, both of which were signed off by the director of nursing and midwifery. In both cases each of the complainant’s concerns had been addressed and information was supplied to help people understand the nature of the care and treatment they were unhappy with.

The team received significantly more written compliments than complaints, which they displayed around the unit.

The trust complaint policy was displayed in the unit, including in relative’s waiting areas and in a patient and relative’s information booklet. Staff encouraged people to raise issues with them verbally when they occurred so that they could address them immediately. Staff also directed people to the patient advice and liaison service (PALS) if they wished to discuss their complaint with an independent team.

Is the service well-led?

Leadership
The critical care complex delivered services within the surgery, cancer and associated services division.
A consultant lead, clinical lead and two matrons led clinical care in the critical care complex (CCC) and a business manager was responsible for non-clinical staff. We spoke with 15 staff in various roles in the department about the leadership structure. In each case staff spoke positively about this and said there had been notable and significant improvements since our last inspection. Nurses told us the matrons regularly carried out clinical duties in addition to their management role and had supported the team during the busy winter pressures period. They also said the matrons had worked one-to-one with new nurses to ensure they had support when joining the unit during a period of exceptional demand.

The senior medical team was structured with a clinical director, a deputy clinical director and a clinical lead. A lead consultant was in post for the critical care complex and for the critical care outreach team.

Band seven nurses played a key leadership role in the nursing team, including team leadership of nurses, shift management and supervisions. The matrons had recruited additional band seven nurses to provide more consistent senior nurse presence and planned to have a nurse at this grade in charge of every shift by the end of 2018. As of June 2018, each day shift was left by a senior band seven nurse and the increase in staffing would enable this to be replicated for night shifts.

Leadership in the unit had been recognised by the trust and nationally. In 2017 the matron was awarded by a national body as nurse leader of the year and senior nurses had won leadership awards in the trust’s annual ‘Oscar’ nominations. Such awards recognised the sustained improvements made in the unit and the feelings of their senior team’s peers and staff about their support and leadership.

**Vision and Strategy**

The team had established a five-step critical care strategic plan for 2018/19 that focused on staff development, improving infrastructure and improved, broader engagement with the rest of the trust. All 12 of the staff members we asked demonstrated aware of the strategic plan and explained how they had been part of establishing it.

Staff wellbeing was a key element of the unit’s strategy for 2018/19 and contributed to the overall sustainability plan of the unit. Staff told us this had a positive impact on their work–life balance and said they felt more motivated as a result. For example, new staff told us the matrons were supportive of family-friendly working hours, which had been a key element of their acceptance of a post in this unit. This policy meant staff could work a full shift and still be home around their children’s school hours to spend time with them.

**Culture**

At our last inspection in September 2016 we identified several issues with staff cohesion, support and engagement. This included staff speaking to us on the condition of anonymity about bullying and marginalisation in relation to race, religion and sexual identity. These are protected characteristics under the Equality Act (2010) and the trust did not have processes in place to ensure staff were protected. Following our findings, human resources business partners were assigned to units in the division and held open forum listening sessions to help understand the experiences of staff and to address their unmet needs and concerns. The matron and human resources team worked together to ensure staff understood the external support option available to them, including counselling and reporting hotlines.

At this inspection all the staff we spoke with told us they felt working relationships had improved and we saw a number of initiatives to improve the working culture within the unit. For example, the matron had prepared a display of flags that represented the country of origin of each member of staff as a strategy to demonstrate their pride in the unit’s community. In addition, the senior team had organised quarterly diversity days and encouraged staff to bring in food native to their
country of origin. This had succeeded in bringing together staff with opposing cultural views and beliefs and helped to establish new levels of respect between individuals. This reflected a significantly more positive approach to respecting the background of each member of staff based on race and ethnicity.

The trust had not demonstrably succeeded in ensuring work to embed equality also applied to staff with different sexual identities. During our last inspection some staff told us the working environment was openly homophobic. At this inspection the trust told us they had appointed an associate director of equality, diversity and inclusion. The individual was not available during our inspection and none of the staff we spoke with were aware of work to ensure staff were supported and protected from bullying in relation to this.

A group of seven nurses were enrolled on the post-registration critical care nursing course as part of their clinical development. The matron provided group study time for them in the unit and had organised this to contribute to the on-going strategy to improve relations between staff from different cultures and backgrounds. For example, each of the nurses was originally from a different country and the matrons encouraged them to share their different approaches to studying and learning as a way to build strong relationships.

The matrons had introduced an ‘employee of the month’ award to improve motivation amongst staff. This was a peer-nominated award that built on the work to improve relationships. Each month the nominated individual was displayed on a celebratory display and staff told us this was a positive aspect of working in the unit.

Matrons had arranged a sports day fundraiser for the unit, which formed part of their strategy to significantly improve staff relations and cohesion. Staff told us they felt such initiatives had been very successful and also said a fair and caring approach to supporting them after a bereavement or injury meant they were better able to deliver a high standard of patient care.

The north east and north central London adult critical care network noted a significant improvement in staff satisfaction and working culture in the unit in a November 2017 peer review. As part of the review the network carried out a 360 survey, which includes feedback from staff.

Although overall, we found evidence of sustained improvements in the working culture of the unit, there were areas for improvement in communication between doctors and nurses. For example, when discussing the outcomes of incidents some nurses told us they were unaware of all relevant information when they thought an incident was a “doctor’s area.” The north east and north central London adult critical care network found similar issues in a November 2017 peer review that highlighted a need for more junior nurses to have better communication opportunities with doctors. We found evidence of this from an incident report, which a nurse submitted when a doctor refused to support them with a medicine issue and spoke to them sarcastically.

**Governance**

As part of the governance structure, the CCC team held a weekly ‘cobra’ meeting to review significant events and incidents. During our inspection we joined a meeting and found it was well attended by 14 members of staff in various roles in addition to the matron, support matron and lead consultant. We saw the team carried out a detailed discussion of each incident and the latest findings from each investigation. However, it was not evident learning was carried forward from week to week to identify and prevent recurring themes of incidents. For example, three medicines errors had been reported in the week prior to our inspection. This involved a duplication of therapy, administration of six doses of medicine without a valid, signed prescription and administration of medicines that were contraindicated. Although staff resolved each issue, it was not evident from the minutes of the cobra meeting that learning from previous incidents had been reflected in the learning outcomes. We asked staff for clarity on this and were not assured that a learning process had been embedded. For example, most staff told us the meetings were a useful process although could not articulate a track record of learning. One member of staff said
they felt there could be more useful detail and clearer actions; two areas they felt were lacking in the current model.

A consultant led a monthly morbidity and mortality meeting, which the whole critical care team was invited to. The team reviewed each patient death at the meeting and included staff at all grades in discussions of the events leading to their death as a strategy to identify opportunities for learning.

The senior team led monthly governance days in the unit, which alternated between multidisciplinary audit and mortality-focused meetings. This schedule was supplemented with weekly team meetings and regular educational meetings.

A governance board was on display in the staff room and included up to date information on information important to all staff. This included themes of incidents and complaints, including detailed information of the most common three themes of each. The information board also included details of staff vacancies, trends in sickness and mandatory training completion.

Management of risk, issues and performance
Matrons used a ‘perfect ward’ quality assurance system to monitor performance against 39 key questions monthly. This established how well the unit performed compared with other clinical departments and enabled the team to respond to issues that resulted in reduced performance. Between August 2017 and May 2018, the unit performed consistently better than the trust, with an average score of 97%. During this period the unit scored above 90% in each month and in May 2018 was ranked fourth in the hospital for performance, which represented an upward trend of improvement from September 2017. The data analysis system enabled matrons to highlight key areas of good practice and areas for most significant improvement.

The senior team used a risk register to identify, track and mitigate risks. There were three active risks on the register at the time of our inspection. These related to out of hours discharges to the ward, a shortage of ventilators and the lack of an electronic patient information system. Matrons told us the most significant risks were overnight discharges to the wards due to late bed clearance and a shortage of ventilators in the unit. The risks documented reflected our findings. However, we were not assured the senior team effectively used the risk register to establish the level of risk or to track changes. For example, the risk relating to out of hours discharges was based on data from 2016. Performance data had changed since then but the risk register did not identify how this changed the risk. There were also out of date actions in the risk register, including three actions that had been due for completion by October 2017 in relation to reducing out of hours discharges.

The senior team recognised a need for more doctors, nurses and equipment during the 2017/18 winter pressures period. They had prepared a business plan for the trust to secure funding for an improved response in the 2018/19 winter period.

The fire safety officer had most recently carried out a fire safety audit and inspection in November 2017. The audit found five areas to be addressed, including the introduction of fire drills, trained fire wardens, documented monthly fire safety checks and repairs to fire doors.

As part of the subsequent improvements to fire safety standards, the hospital’s fire officer had implemented ongoing safety audits to critical care. This involved them carrying out a six-monthly full fire risk assessment. In addition, a fire warden carried out a monthly focused premises survey to identify any risks to fire safety. This was more frequent than required to address the significant concerns we had previously identified. During our inspection we found an increased risk of fire spreading in the unit due to the common practice of staff keeping windows open in a storeroom that was unattended for most of the day. The fire officer said they would add this area to the monthly unit fire safety checklist. Overall this reflected an improve focus on risk management and
governance for the environment. Improvements in critical care reflected broader positive changes across the hospital. This included a new structure for monthly health and safety meetings in which attendance from relevant departments was mandated and a more accurate system for tracking fire reports and audits in each area, including critical care.

We looked at four monthly fire safety checks documented by the new fire wardens carried out between March 2018 and June 2018. Although each audit was fully completed they each demonstrated 100% compliance with standards, with no identified areas of improvement. This did not match our findings during the inspection, such as the routine storage of clinical equipment in a fire escape route. This meant we were not assured fire wardens accurately completed audits.

The site had a number of security challenges and risks, which were not consistently managed. For example, the critical care unit had provided a microwave for relatives when they spent extended time in the unit. However, this had recently been stolen. During our out of hours unannounced inspection, which took place in the evening, we found an unauthorised person sleeping in the critical care waiting room. This presented a significant risk to people as the site team were unaware of their presence. We spoke with the head of site management about this who said security was an on-going challenge. They contacted the security team to challenge the unauthorised person but we were not assured this was a safe situation for patients, visitors or staff walking through the hospital.

**Information Management**
Staff stored paper medical records securely when not in use in areas with restricted access. We saw staff locked computer screens when not in use, which helped to prevent unauthorised access to confidential information.

Where information had not been properly managed and contributed to an incident, we saw the clinical team was proactive in improving practice. For example, one incident occurred when staff had not transferred clinical notes from a speech and language therapist (SLT) to the ward during a patient transfer. Working with the SLT team and the critical care nursing team, a nurse established the contributing factors to the incident and drafted and implemented new protocols for information management during transfers and discharge.

**Engagement**
Junior doctors we spoke with said there had been an improvement in engagement with them from the senior team. This included involvement in new job descriptions and involvement in local morbidity and mortality meetings. They told us issues they raised were presented at site wide meetings by the clinical lead, which meant they felt included in governance and operational areas of the unit.

Previous patients in the unit were scheduled to attend staff study days as an engagement strategy. The patients would provide insight into their experiences of being cared for in the unit and contribute to staff development. This would be a collaborative process that helped staff to understand what patients felt had gone well and situations in which they experienced the most anxiety or fear. Matrons recognised this as a significant learning opportunity for staff and had issued an open invite to the whole department to attend the patient-led session during the study day.

Staff attended a monthly forum that was an opportunity for the team to meet and discuss the week’s experiences, challenges and issues. Senior staff did not attend the meeting, which was a strategy to encourage the critical care team to establish their own working relationships and to problem-solve themselves.

The hospital held regular Schwartz rounds and doctors who had participated from critical care told us these had been beneficial. Schwartz rounds are evidence-based, multidisciplinary forums used to discuss the emotional impact of working in healthcare. Access to Schwartz rounds meant staff had the opportunity to discuss their mental health and build strong emotional support.
Learning, continuous improvement and innovation
In 2017/18 staff had contributed to four in-house studies and two national studies. Staff designed in-house studies to contribute to improvements in patient experience and outcomes. For example, in one study staff considered how they could better predict patient outcomes before their admission to intensive care. Another study aimed to identify how staff could use patient’s facial expressions to predict deterioration. External research was carried out in line with UK clinical research network protocols and contributed to larger data sets. An audit and research nurse was due to take up post in July 2018 and would drive the unit’s plan to increase their research footprint and contribute to the establishment of research based in the unit. This was part of the strategy to ensure the service remained forward-thinking and sustainable.

The senior team recognised the need to ensure the service remained sustainable and aimed to ensure the nursing team were at the centre of this. As part of the staff retention strategy, matrons encouraged nurses to participate in the leadership development programme, which provided opportunities for promotion to band seven.

The critical care outreach team was leading on the trust implementation plan for the national early warning scores 2 (NEWS 2) system and planned to achieve this by October 2018, ahead of the March 2019 national deadline. The team planned a NEWS 2 awareness week for September 2018.
**Maternity**

**Facts and data about this service**

North Middlesex University Hospital (NMUH) NHS Trust provides maternity services to approximately 5,000 women in Enfield, Haringey, Middlesex and surrounding areas. Inpatient maternity services are provided solely at the North Middlesex University Hospital site. Outpatient maternity services are provided in the hospital and community. Five community midwifery teams are based in five locations across the hospital and the boroughs of Haringey and Enfield. The community midwives undertake the majority of antenatal and postnatal care. The maternity service includes specialist clinics for women with diabetes, raised BMI, perinatal mental health, haemoglobinopathies, vaginal birth after caesarean section (VBAC), fetal abnormality screening or safeguarding concerns.

The maternity service at NMUH has 59 inpatient maternity beds and provides consultant-led and midwife-led care for both high and low risk women. The consultant-led delivery suite has 14 beds, 11 delivery rooms and three high dependency unit (HDU) single rooms. There are two dedicated theatres with four recovery beds and a bereavement suite. The Birth Centre has eight delivery ensuite rooms, four with birthing pools and sofa beds, for women on the midwifery-led pathway.

The maternity service has a discharge lounge and 31 bedded joint maternity ward for antenatal women, and for postnatal mothers and babies. The service also has a maternity day assessment unit (six beds), triage unit (three single rooms) and four beds in the (blue) bay for the induction of women with moderate risk. The antenatal clinic has a reception area, waiting area, six clinic rooms and a quiet room.

The maternity service employs community midwives, who provide care for women and their babies both during the antenatal and postnatal period. They also provide a home birth service. From April 2017 to March 2018, the trust reported 63 (1.3%) homebirths. This was lower than the national average of 2.3%. The community midwives are aligned to local GP practices and children’s centres.

The trust has a level 2 neonatal unit for babies needing extra medical and nursing care. This unit has 28 special care cots.

The transitional care unit was not in use during inspection and staff told us this was only used during winter pressure or overflow.

From October 2016 to September 2017, there were 4,519 deliveries at the trust. This was a 12% increase in the total number of births at the trust, compared with 2013/14 data (4,199). Recent data received during inspection showed a further increase, 4,689 deliveries between April 2017 and March 2018. Of these, 32% were non-assisted deliveries, which is lower than the England average (60%) and 9.2% were instrumental deliveries (ventouse or forceps), which is lower than the England average (13%). Additionally, 12% were elective caesarean deliveries, which is similar to the England average (12%) and 19% were emergency caesarean deliveries, which is higher than the England average (15%).

A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below. *Source: Trust Provider Information Request – Acute sites*
Number of babies delivered at North Middlesex University Hospital NHS Trust – Comparison with other trusts in England.

A profile of all deliveries from October 2016 to September 2017 can be viewed below.

<table>
<thead>
<tr>
<th>Single or multiple births</th>
<th>NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>4,449</td>
<td>4,519</td>
</tr>
<tr>
<td>Multiple</td>
<td>70</td>
<td>805</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother's age</th>
<th>NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>164</td>
<td>168</td>
</tr>
<tr>
<td>20-34</td>
<td>3,436</td>
<td>3,414</td>
</tr>
<tr>
<td>35-39</td>
<td>738</td>
<td>715</td>
</tr>
<tr>
<td>40+</td>
<td>181</td>
<td>188</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number of deliveries</th>
<th>NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>4,519</td>
<td>607,089</td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

Trends by quarter for the last two years can be seen in the graph below.
Number of deliveries at North Middlesex University Hospital NHS Trust by quarter.

SOURCE: HES - Deliveries (October 2016 - September 2017)

We last carried out an announced comprehensive inspection of the maternity and gynaecology service in September 2016. The service was rated requires improvement for safe, caring and responsive, inadequate for well-led, and good for effective. The service was judged to be requires improvement overall.

We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings directly with previous ratings.

We carried out an announced inspection of the maternity service on 22 to 24 May 2018. We did not inspect the gynaecology service. During our inspection, we visited all clinical areas in the service including delivery suite, theatres, antenatal and postnatal wards, the birth centre, transitional care unit, antenatal clinics, and maternity day assessment unit. We spoke with 23 women and their relatives and 73 members of staff, including midwives, consultants, anaesthetists, senior managers, student midwives and support staff. We observed care and treatment and reviewed 37 medical care records and 10 prescription charts. We also reviewed the trust’s performance data.

Is the service safe?

Mandatory Training
There had been no improvement from our inspection in September 2016. The service provided mandatory training in key skills to all staff, such as basic life support, information governance, fire safety, manual handling, infection control and fire safety. Training was provided via e-learning modules or face-to-face sessions. Staff could access e-learning modules at work or home. Staff within the maternity service understood their responsibility to complete mandatory training. Matrons could monitor staff training records and received reminders from managers and human resource when training were overdue.
There were announced and unannounced simulation “skills and drills” training to rehearse response to obstetric emergencies such as birth pool evacuation, neonatal resuscitation and sepsis. The skills and drills training was run by the practice development nurse, practice development midwife, ward manager and clinical practice facilitator.

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to February 2018 for nursing/midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>92</td>
<td>83</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>110</td>
<td>94</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>110</td>
<td>90</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>110</td>
<td>88</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>110</td>
<td>73</td>
<td>66%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>99</td>
<td>64</td>
<td>65%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff at that time was 78% which was worse than the trust target of 90%. Only one of the modules, conflict resolution, met the trust target.

During inspection, we found the overall completion rate was 81%, which was worse than the trust target of 90%. Only three modules, moving and handling level 1, infection prevention and control level 1 and resuscitation level 1, met the trust target.

The trust told us they were taking action to improve mandatory training of maternity staff by sending reminder emails to managers, providing short notice training when training hit red flag warnings. Mandatory training figures were reported at governance meetings.

During inspection, the overall completion rate for medical staff was 84%, which was worse than the trust target of 90%. The senior doctors including consultants, had 94% compliance while the junior doctors had a 79% compliance. Only one module, adult basic life support level 2, met the target.

The trust provided doctors and midwives (including community midwives) with maternity specific skills training and signed off competencies in addition to mandatory training. This covered areas such as safe sleeping, fundal height measurement, cardiotocography (CTG) training, sepsis, bereavement update, maternity update and midwifery formulary, bereavement, mentorship update and reduced fetal movement. The trust submitted the maternity skills training attendance data for the period of April 2017 to March 2018 which showed 92% compliance. The practical obstetric multi professionals training (PROMPT) training were held six times in a year. During inspection, the service told us that 20 additional staff had completed the maternity skills training.

We saw that 81 maternity staff including the midwife and doctors had completed the perinatal mental health training. Also, the safeguarding midwife had completed the institute of health visiting mental health champion training.

Midwifery staff were required to undertake blood transfusion training and assessment every three years. This was in line with national recommendations (National Patient Safety Agency). As of 1 December 2017, 68% (118) of maternity midwives and seven nurses had completed the blood transfusion training.
Midwifery and obstetrics staff were also required to complete an e-learning fetal monitoring programme, which was designed to improve the interpretation of fetal heart rate monitoring in labour and its subsequent management. At the time of our inspection, maternity staff were required to complete this programme annually as part of their PROMPT training, which was in line with national recommendations (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirth, February 2016). Maternity staff received training in sepsis management, including the use of sepsis screening tools and sepsis care bundles as part of the PROMPT training. We reviewed the training record for the period of 1 May 2017 to 30 April 2018. We saw that 82% of midwives and 63% of obstetrician doctors had completed 6 hours of the theoretical part of the learning. However, 55% of midwives and 39% of obstetrician doctors had completed one or more simulation (practical) competency assessment of the PROMPT.

The overall competency compliance for the competency assessment was 46.6% for midwives and 33% for obstetrician doctors.

<table>
<thead>
<tr>
<th></th>
<th>4 or more chapters e-learning (score ≥75%)</th>
<th>1 or more simulation on K2 EFM (score ≥75%)</th>
<th>Overall compliance with both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td>100</td>
<td>90</td>
<td>77 (46.6%)</td>
</tr>
<tr>
<td>Obstetric Doctors</td>
<td>37</td>
<td>20</td>
<td>19 (33%)</td>
</tr>
</tbody>
</table>

The service introduced the K2 training package in June 2017 as a response to the incidents reported which identified a need for CTG training for all staff by June 2018. Staff were given seven hours protected time to complete the K2 training at home or on-site to help improve compliance. We noted that majority had completed the CTG training but not completed the competency assessment (K2). During inspection, the service told us that 31 more staff had completed the prompt training.

Staff could undertake the neonatal life support (NLS) training (level 3). The information provided by the trust showed 104 staff had completed the training and six staff had completed the Resuscitation Council NLS level 4 training.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all midwifery and medical staff had completed safeguarding adults and children training to the required levels.

There were clear systems, processes and practices in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. The safeguarding and child protection (CP) policy and systems were in-date and reviewed every two years in order to comply with national guidance. The safeguarding midwife and lead nurse for adult safeguarding were involved in the review of the domestic violence policy. The trust website had detailed information and useful for patients, visitors and staff on child and adult abuse and signposted them to the national domestic violence helpline, local authority, victims support and relevant women’s aid groups.

The maternity safeguarding annual report highlighted 30% of women who accessed the maternity service had high safeguarding concerns and high mental health needs. The service reported 217 safeguarding referrals were made by staff between January 2018 and March 2018 for children and unborn children. The main themes for referral were domestic violence (DV;14%), assault (12%), perinatal mental health (11%), child in need (4%) and patient not booked for maternal care (4%). The trust key areas of safeguarding work plan 2018/19 included DV, FGM and gangs. We saw evidence that all maternity safeguarding referrals were taken to
the weekly CP meeting or bi-monthly maternity link meetings where concerns were discussed among various multidisciplinary teams (MDT).

The service had an external youth worker who was based in the hospital and supported patients who were victims of violent crime.

The safeguarding team liaised with other professionals and agencies, such as social workers, the police, independent domestic violence advisors, family nurse partnership, and the perinatal mental health team, as needed.

The care of the teenage mothers sits under the safeguarding team following received referral from the midwife. The safeguarding team worked and accessed support from the family nurse partnership community nurses.

The service had a named specialist safeguarding midwife who was recently recruited following the business case approval and was a member of the local Multi-Agency Safeguarding Hub (MASH). The safeguarding midwife provided support, supervision, training and updates for staff. The named safeguarding midwife participated in serious case reviews and completed an individual management review (IMR) for the reviews of domestic homicide. Hospital and community midwives reported good support from the safeguarding team including the safeguarding midwife who visited women on the wards and supported staff on any issues. Comment from staff about the safeguarding midwife included “I can’t sing that woman’s praises enough”, “she is amazing”.

The service ran a clinic, known as Iris clinic for women who had undergone female genital mutilation (FGM) to ensure timely access to the specialist obstetrician, midwives and psychological support to ensure better birth planning. Staff used a FGM screening question proforma to assess and identify risk during contact. We saw that where FGM had occurred or women identified at risk this was recorded on patients’ notes.

The service used the LINK system to refer women to social services, health visitor and hospital safeguarding team. Details were documented in women’s hospital notes at booking. Women’s notes and patient record system will alert staff of safeguarding concerns. Women and their families with a child protection or children in need plan were followed up for 28 days after birth, in collaboration with the health visitor and GP. We noted that in each community team, one staff member was nominated weekly to attend the case conferences.

Staff had access to supervision individually or group session with the safeguarding team.

Midwifery and medical staff were required to undertake safeguarding children level three training; in line with national recommendations (HM Government Working together to safeguard children: A guide to inter-agency working to safeguard and promote welfare of children, March 2015; Royal College of Paediatrics and Child Health (RCPCH) Safeguarding children and young people; roles and competences for health care staff. Intercollegiate Document, March 2014).

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2017 to February 2018 for nursing/midwifery staff in maternity is shown below:
### Training Courses

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible Staff YTD</th>
<th>Number of Staff trained YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>110</td>
<td>84</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>9</td>
<td>6</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>119</td>
<td>90</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P18)

The overall completion rate for midwifery staff was 76% which was worse than the trust target of 90%. However, the junior medical staff achieved 92% on the safeguarding adult level 2 which was better than the trust target of 90%.

During inspection, we saw that the overall safeguarding completion rate for adult and children level 1 and 3 for medical staff had risen to 85% and 80% respectively. All clinical staff were expected to be trained to level 3 in Safeguarding Children.

We saw evidence that training was multidisciplinary and included scenario-based discussion and learning from local and national serious case reviews.

The level 3 safeguarding training was a half-day session and a plan was in place to change this to a full day in order to include perinatal mental health training. The level 3 safeguarding training was developed in compliance with the RCPCH Framework and was also implemented by GPs and maternity staff at a local hospital. We noted that the service involved senior social care practitioners in developing some aspect of the level 3 safeguarding training. The safeguarding training covered topics such as FGM, honour based violence, forced marriage, DV, mental health issue and substance misuse. Staff we spoke to gave positive feedback on the training received and we noted that the training covered serious case reviews, role playing and NICE guidance from the training material reviewed.

**Cleanliness, infection control and hygiene**

The majority of the maternity service we visited was tidy but not all areas were clean. We were not assured controls were effectively in place to prevent the spread of infection. Women we spoke with said the maternity department was not always clean.

We inspected all areas of the maternity unit including the delivery suite, obstetric theatres, wards and midwife led birth unit. In the maternity day unit, we noted there was no sluice so staff carrying out urine tests had to take samples to the antenatal clinic, which was some distance away. This caused delay as the maternity support worker (MSW) had to leave the unit and potentially increased the risk of infection.

In the antenatal clinic, we observed that the toilets taps were hard to turn off and five of the six taps were running. The bin in the disabled toilet had not been emptied and was overfull. Two patients we spoke to told us the toilets were not flushed and there was paper on the floor.

In the birth centre, we observed a baby changing mat had stained brown marks and had not been cleaned after use. Also, the blood pressure machine stands were not clean. We observed dust under the suction equipment on the resus trolley and dripping taps in the toilets and clean utility rooms. We noted two dirty birthing support ropes in two of the birth rooms, which were covered with body fluids, blood and meconium.

During our tour of the delivery suite, we noted a blood stain on the floor in one of the empty delivery rooms; this was promptly cleaned by staff although there was no sign indicating room was...
for cleaning. A patient commented the “delivery suite could need a bit of cleaning, there was dust everywhere”.

On the maternity unit, we observed the microwave in the breastfeeding room was stained and dirty. In the linen room, we saw fluff and dirt on the floor under the trolley. A patient we spoke to commented that at night, “staff seem not to care about cleanliness and there were dirty gloves and cups everywhere”.

There were cleaners assigned to the unit, however staff could not summon cleaners by bleep when needed urgently in the evening and night. Staff told us that the housekeeper only worked 7.30am to 3pm. Staff we spoke to told us that there had been a change of contract for the domestic staff which meant reduced hours and fewer cleaning staff which had impacted on the cleanliness of the maternity wards.

Monthly cleaning audits were carried out within the service. The cleaning audit covered three standards which were cleaning service, nursing and estates. The results of cleaning audits carried out on the antenatal area between February 2018 and April 2018, showed the average compliance score was 95%. The lowest compliance was reported for the 15 February 2018 which was 88%. During inspection we noted that the birth centre achieved 97% compliance in April 2018. The audits implied a higher standard of cleanliness than we observed.

As of May 2018, 75% of maternity staff had completed infection prevention and control training. This was below the trust target of 90%.

The service provided staff with personal protective equipment (PPE), to prevent and protect people from a healthcare-associated infection. We observed clinical staff adhere to the trust’s ‘arms bare below the elbow’ policy to enable effective hand washing and reduce the risk of spreading infections. There was access to hand washing facilities and a supply of PPE, which included sterile gloves, gowns and aprons, in all areas. This was an improvement from our inspection in September 2016 when staff did not always observe the bare below the elbow policy.

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas for staff, patients and visitors to use. We observed staff applying hand sanitising gel when they entered clinical areas. However, we noted an empty sanitiser dispenser outside the birth centre on the 23 May 2018 and was not refilled when we checked the next day. We observed staff washing their hands between patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE) Infection prevention and control: QS61, quality statement 3, April 2014). The IPC audit results for the period of July 2017 to January 2018, for all inpatient areas showed 97% compliance on average. The hand hygiene audit result for the period of November 2017 to March 2018 showed 99.6% average compliance on the labour ward and 96% on the maternity ward. Women we spoke with told us they saw staff wash their hands.

Women were offered screening for infectious diseases, such as hepatitis B and syphilis. Women were also offered influenza (flu) and pertussis (whooping cough) vaccination in pregnancy, which was in line with national recommendations (NICE Antenatal care for uncomplicated pregnancies: CG62, updated January 2017). The antenatal handheld records we reviewed confirmed this. Staff told us there was plan in place for the community midwife to be responsible for checking blood result two weeks after the test and recording in patients notes.

The service monitored postnatal readmission rates for infection. The trust reported 19 (2.4%) maternal readmissions within 42 days delivery for infection, for the period of May 2017 to October 2017, which was lower (better) than the national average of 3.2%. Infection was more common amongst women who had an emergency C-section, the majority being related to wound infection.
As of May 2018, there was zero cases of hospital acquired MRSA (antibiotic resistant bacteria) however, there was an incident of MRSA colonisation before admission in November 2017 for the maternity unit and one Clostridium difficile in the last 12 months. Clostridium difficile is a bacteria that can infect the bowel and cause diarrhoea.

Women who were booked for elective caesarean section (C-section) were screened for MRSA during their pre-operative assessment appointment. The medical records we reviewed confirmed that MRSA screening was completed when indicated. The theatre statistics for the period of December 2017 showed 100% compliance with MRSA screening and follow-up screening when indicated. During inspection, we noted 100% compliance in April on the delivery suite notice board.

Side rooms were available on the maternity wards, which could be used to admit women with a known or suspected infection. Staff we spoke with could describe what they would do if a patient required isolation due to infection. Staff had access to the sepsis six box on the wards.

There was an appropriate process in place for cleaning the birthing pools. Each birthing pool was cleaned and flushed daily and following every patient use.

**Environment and equipment**

The maternity service had suitable premises and equipment for women who accessed the service. There were effective processes in place to ensure equipment were maintained and tested for electrical safety, to ensure it was fit for purpose and safe for patient use. Although the service had systems to ensure emergency equipment was checked daily, compliance within the service varied.

The maternity unit was spacious and purpose-built. The spacious discharge lounge had reclining chairs, and was bright and clutter free.

There was good signage on doors of rooms to indicate whether occupied or not, and giving the name of the midwife caring for patient. However, midwife names were not on all the doors at night.

The environment (observation) audit covered areas such as equipment, PPE, fire exit, signage, medicines and hand gel. The environmental audit for the period of July 2017 to January 2018 showed an overall 96% compliance.

An external provider and ward managers were responsible for ensuring equipment such as CTG machines, infusion pumps and fetal blood analysers were serviced and maintained. As of May 2018, the equipment maintenance schedule showed all equipment (100%) items had been serviced as required. Therefore, we were assured equipment was safe for patient use.

Access to the delivery suite and maternity wards was by means of swipe card or an intercom buzzer system to gain both entry and exit from the wards. This meant staff could identify visitors and ensure women and their babies were kept safe. The theatres and neonatal unit were close to the delivery suite which allowed timely transfer when required.

CTG machines were available for women who required continuous electronic fetal heart rate monitoring. CTG machines are used to record both the fetal heart and uterine contractions during pregnancy and labour, which allowed early detection of fetal distress.

A fetal blood gas analyser and laboratory facility for bloods were available, which was in line with national recommendations (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

There were two dedicated obstetric theatres, which was in line with safe practice and had necessary equipment needed. The theatres were spacious in size. The service had access to the main hospital theatre if a third theatre was needed.
The delivery suite and birth centre met the Department of Health's recommendation that all birthing rooms should include ensuite facilities (Department of Health Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities, 2013).

There were arrangements in place, which complied with best practice, to safely manage waste and clinical specimens. Waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste and sharps. However, on one occasion in the antenatal clinic we observed the bin in the disabled toilet had not been emptied at 9am and was overfull. We observed sharps boxes were dated and not overfilled.

We observed fire exits were kept free from obstruction.

We spoke with the community midwives, who confirmed they had access to baby scales and sonicaid (a device used to listen to the fetal heart). We saw from the maintenance schedule reviewed that baby scales were calibrated regularly. Community midwives had access to carbon monoxide monitors, in line with national recommendations (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirth, February 2016).

The community midwives had access to equipped grab bags which were kept in the unit. However, staff told us they did not have personal safety devices such as panic alarms when they were working alone. They could all mention times they had been worried by aggressive behaviour on the streets. The lone working policy stated that appropriate equipment should be available to lone worker staff. The lone worker risk assessment template highlighted issuing of personal attack alarms to lone worker staff. However, community staff told us they would attend visits in pairs if they had any concerns. Senior staff and colleagues could access colleagues on the phone when they were working alone. Staff knew the process to follow if concerned about their safety in the community.

There was appropriate emergency equipment in the delivery suite, birth centres and theatres including resuscitation equipment, drug boxes for specific emergencies such as sepsis and cardiac arrest. Although the service had systems to ensure emergency equipment’s were checked daily, compliance was inconsistent.

We checked a range of consumable items from the resuscitaires, including syringes, airways and naso-gastric tubes all were in-date. Resuscitation trolleys were checked daily by staff to ensure the electrical equipment was in working order and tamper seals were in place. However, we observed some missing entries for the period of January to May 2018 on the maternity ward during our inspection. Also, the resuscitation trolley drawers were not secured with a tamper evident tag. However, when we visited at night we saw the resus trolley was secured with a tag.

On the delivery suite we noted six missing entries on the anaphylaxis trolley and the checklist had no headings. We noted dust and dirt on the suction bottle at the birth centre and immediate action was taken by staff when notified. In the delivery suite, the checklist indicated equipment were checked on only seven days during the period 6 March 2018 to 31 March 2018 and 19 days in April 2018.

We inspected the transitional care unit and saw large number of broken chairs in the waiting areas with a labelled sticker indicating awaiting repair. Although, the transitional care unit was not in use during inspection because the transitional service was provided on the ward, staff told us the area had been used about two weeks previously.
Assessing and responding to patient risk

Maternity staff completed risk assessments for women and babies from the antenatal to the postnatal period of the maternity pathway, in line with national guidance. Midwives said they documented on-going risk assessments at each antenatal appointment. The criteria for women planning to birth in the birth centre or wanting a home birth were in line with national guidance. A comprehensive risk assessment was completed at the initial booking appointment by midwives which covered medical history, previous birth history and complications, mental health, social needs, substance misuse, social services history, weight and age, risk of venous thromboembolism (blood clots), pre-eclampsia, high blood pressure and conditions such as gestational diabetes or high BMI, which was in line with national guidance. Women who were at high-risk of gestational diabetes were referred for glucose tolerance testing. The findings of these risk assessments were used to help women choose their preferred place of birth and plan future care provision. Women who were unsuitable for midwifery-led care were referred to the obstetrics team for review and management. This was confirmed in the patients’ records we reviewed.

Midwives we spoke to told us that not many women were booked by 10 weeks. Many late bookings were from recent arrivals to the area, including people seeking asylum or without rights to work. The service worked collaboratively with the GPs, health visitors, A&E, children centres and local community groups to improve earlier booking of mothers. Some community teams for example Tulip did group booking sessions for booking antenatal appointments for a maximum of nine women who must all speak English and were expected to below risk. Two midwives were present at these group appointments and they could see women individually following the sessions if risk or concerns were identified. The community midwives felt these worked well and have improved attendance and women liked these as they were able to engage with other women in the same situation.

The service used a perinatal mental health review tool to assess and monitor patients’ risk of depression and other mental health issues. We saw that the tool was developed in collaboration with the consultant midwife from a nearby hospital. Staff told us if they were concerned about a patient’s mental health, they would refer to the perinatal mental health team. The perinatal mental health team started in December 2017 and included a psychiatric nurse, psychologist, psychiatrist, consultant obstetrician, consultant midwife and safeguarding midwife. If staff had concerns that a patient was at risk of suicide or self-harm they would escalate immediately to a doctor. The perinatal multidisciplinary team (MDT) team met weekly to decide an appropriate pathway for patients and discuss individual cases that did not meet the perinatal service threshold. Low to medium risk cases were managed by the community services and linked with perinatal services when needed. The consultant provided support for women with moderate to severe mental health problems, including bi-polar disorder. There was a weekly psychosocial meeting were women identified at risk were reviewed and monitored.

A buddy system (fresh eyes) was in place for review of CTG interpretation, with guidance for escalation if concerns were raised. Fresh eyes involve a second midwife checking a CTG recording of a baby’s heart rate to ensure it has been interpreted correctly and appropriate actions taken when indicated. This was in line with national recommendations (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirth, 2016). The medical staff were also required to review the CTG traces of all patients during the ward round.

In the period of May to October 2017, the service audited compliance with ‘fresh eyes’ reviews as part of the external fetal monitoring (EFM) which had shown inconsistent practice. The audit showed 86% of patients had a CTG review documented on ward round, 76% of CTG were completed correctly, 46% had a documented hourly review and only 10% had evidence of buddy
system review during labour. We saw an action plan had been developed to improve compliance, which included a weekly CTG teaching review. The service had acted to address this and we observed during inspection that CTG peer reviews had improved and were carried out in line with trust policy and national recommendations. We reviewed four sets of CTG records and saw evidence that peer reviews were carried out two hourly during labour and CTG traces were appropriately escalated when indicated. The service planned to re-audit compliance with ‘fresh eyes’ reviews in October 2018 to ensure patient safety.

The service carried out risk meetings which were attended by relevant risk staff to identify, monitor and review other patient safety risk, incidents, root cause analysis, readmission audit. Two risk midwives were dedicated to assessing and responding to risk. A risky business newsletter was introduced in 2017 covered topics such as Vitamin K allergy checks, baby labelling (after an incident where a baby was labelled with wrong birth date), SBAR (situation, background, assessment and recommendation) handover tool, NEWTT early warning tool (newborn early warning trigger and track), emergency transfer and Duty of Candour. In March 2018, we saw a displayed message labelled ‘Highly Important Message’ on antenatal screening, which aimed at improving the screening process for women following recent incidents.

Women who were booked for elective caesarean section attended a pre-operative assessment clinic. We saw evidence that appropriate risk assessments were carried out, including MRSA screening, blood tests and anaesthetic review. Safety briefings were held before elective caesarean sections. The service blocked the theatre list from 8am to 9am, Monday to Friday for women with ectopic pregnancy. This ensured women who presented with ectopic pregnancy had the procedure done before the elective C-section.

The maternity service used an adapted version of the World Health Organisation (WHO) surgical safety checklist. This was in accordance with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist, January 2009). The checklist was used for women having a C-section or other obstetric surgical procedure, such as instrumental delivery, to prevent or avoid serious patient harm in the operating theatre. The results of the WHO surgical safety checklist audits for the period of January to December 2017 showed 90% overall compliance. We reviewed six WHO checklists during our inspection and no concerns were noted.

The maternity service used the modified early obstetric warning score (MEOWS), designed to allow early recognition and deterioration in pregnant and postnatal women by monitoring physical parameters, such as blood pressure, heart rate and temperature. The results of the audits completed from April to June 2017, showed 100% compliance on six of the eight standards audited, with completion and escalation, where indicated. However, we noted poor compliance on respiratory rate (65%) and 20% for alert, voice, pain and unresponsive (AVPU). The service carried out a re-audit in October 2017, which showed poor compliance on the completion and frequency of observation of women in antenatal, triage and admission. Staff generally monitored women observation on the postnatal ward but were not consistent on the planned frequency of the observation. Teaching and training session were given to staff following the audits to ensure compliance and safe care.

We reviewed 10 MEOWS charts during our inspection and found they were completed, scored and escalated, where indicated, in line with trust guidance. We also found medical staff responded promptly when requested and documented detailed management plans. Therefore, we were assured MEOWS charts were completed and patients were appropriately escalated, where indicated.
The service used the NEWTT, designed to identify babies at risk of clinical deterioration following birth and initiate prompt investigation and intervention. We reviewed three NEWTT during inspection charts and found they were completed, in line with trust guidance. We saw that the support worker had received training and teaching session on NEWTT and MEOWS.

Swabs used for vaginal birth and perineal suturing were counted for completeness by two members of staff, which was in line with national guidance. We saw from the notes we reviewed that two members of staff verified swab counts.

The community midwives had two on-call midwives after 5pm to give appropriate advice to women and assessing risk.

The service completed venous thromboembolism (VTE) risk assessments (used to determine a patient’s risk of developing a blood clot), in line with national recommendations. We saw that VTE assessment was included in the PROMPT training. The service completed a VTE audit for the period of 18 December 2017 to February 2018 which showed 86% of VTE assessments were carried out, but that 14% had no documentation of the assessment been carried out. The audit also showed that staff achieved 99% compliance on the correct thromboprophylaxis prescribed for the period of 18 December to 24 January 2018. Thromboprophylaxis is the prevention of thromboembolic disease. We noted that VTE risks were discussed at handover and team meetings to improve compliance, reduce risk and patient outcomes.

In the patients’ notes reviewed, staff completed VTE risk assessments and found they all had the initial antenatal, admission and postnatal VTE assessments completed. This was an improvement from our last inspection where we found no documentary evidence of VTE being assessed.

We saw evidence that staff routinely asked women about their baby’s movements at each antenatal contact to reduce the risk of still birth. Written information regarding this was also given to women by 24 weeks gestation. This was in line with national guidance (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirth, 2016). Staff advised women to contact the maternity telephone line, maternity day assessment unit (MDAU) or maternity triage unit if they had any concerns about their baby’s movements.

The service had a fetal medicine unit which supported women who had complications or abnormalities in their pregnancy.

A designated three-bedded maternity triage unit provided 24-hour assessment, review and ongoing care planning for pregnant women from 16 weeks gestation. Women could telephone for advice or present to the triage unit if they had any concerns or pregnancy related health issues such as pain, reduced fetal movements or vaginal bleeding. Patients could also be referred by their GP or antenatal clinic of they presented with risk such as palpitation.

Women who reported no fetal movements, imminent delivery, symptoms of severe pre-eclampsia or significant vaginal bleeding, were admitted directly to delivery suite from triage. The triage unit had birthing equipment available to facilitate safe delivery of the baby, if a woman could not be transferred to delivery suite in time for the birth.

Staff used the SBAR (situation, background, assessment and recommendation) handover tool when reporting incidents, escalating or handing over difficult cases. We saw evidence of this in the records we reviewed. SBAR is a structured method for communicating critical information that requires immediate attention and action, contributing to effective escalation and increased patient safety. We saw that staff received teaching sessions on SBAR and it was also included in the service newsletter.
Staff received training on sepsis as part of their PROMPT training. There was a pathway for the management of sepsis. Staff we spoke with could describe what actions should be taken when a patient was admitted with suspected or known sepsis and what treatment should be initiated, in line with national guidance.

Babies needing a higher level of care after delivery could be transferred to the hospital’s neonatal unit (NICU), level 2.

During inspection we saw that the transitional care unit was not in use and staff told us this was only used during winter pressure or overflow. Unwell neonates not requiring neonatal intensive care were admitted via the Caring together scheme (CTS) and transitional care unit on the maternity postnatal ward which was staffed by senior neonatal nurses and midwives. Staff told us that as a result of recent changes to the NICE guidance on the management of antibiotics for babies with potential infection, the trust increased the number of babies admitted to the neonatal unit as the number of births rose. This resulted in up to 15 babies a day being under the umbrella of the CTS scheme. These babies were discussed with the consultant on for NICU at the morning handover. The trust had a caring together scheme policy published on 21 May 2018 that advised staff on areas such as the criteria and responsibility of staff under the scheme. We saw the service had a new proposal in place for a band 7 nurse charge to be assigned to the caring together scheme 9am to 5pm. Also, the service was developing a caring together pathway with a local hospital to ensure women and babies are cared for in the region using a common pathway.

Staff told us the transitional unit was used two weeks ago however transitional service was carried out on the ward. Staff told us that if a mother was assessed as requiring additional support to manage her mental health, her learning disability or a substance misuse issue, both she and her baby would be cared for on the ward. During inspection on the maternity ward, we saw that three babies were cared for on the ward under the caring together scheme, although their mothers were fit for discharge. The babies remained under the care of neonatal unit and neonatologist. Neonatal staff came to ward to administer care such as antibiotics when required. However, the staff reported this can be challenging caring for mother and babies on the maternity ward.

There was security guard cover 8am to 8pm on the maternity ward, as a result of a serious incident that occurred in the service. Staff covered the reception after 8pm, however staff report been verbally abused by public and this had been escalated to managers. The reason for the abuse were guests not allowed to bring flowers unto the ward and not allowed more than two guests at a time on the patient bedside. We noted that the labour ward did not have a security guard.

The home birth midwives had agreed a protocol with the ambulance service to communicate an immediate life threatening maternal or paediatric emergency to reduce clinical risk.

Doctors undertook a daily ward round of all women who were inpatients in the maternity unit.

**Nurse and midwifery staffing**

Midwives worked a range of different shift patterns: early, late, night and long day. All staff had the same training and were expected to work flexibly between areas depending on demand.

Whilst staffing levels were often lower than planned, staffing levels and skill mix were regularly reviewed and actions were taken to meet patient acuity. The service used a national acuity tool, to assess staffing requirements based on patients’ needs. Staff were redeployed within the maternity unit when needed, to keep patients safe from avoidable harm and to provide the right care and treatment. The midwife to birth ratio was in line with national recommendations. A business case had been agreed for additional staffing and during inspection the funded establishment was 1:28, but this was only achieved using temporary staff. As part of their on-
going recruitment the service had vacancy post targeted for band 6 midwives and allowed flexible shift pattern and flexible contract for retiring midwife to help attract midwives to the service. The trust organised a recruitment event on the 12 May 2018 to recruit nurses and midwives, staff told us that 12 midwives were currently recruited. During inspection we saw that the service had recruited midwives from abroad.

An apprenticeship scheme was being undertaken to improve staffing and patient safety. We saw that band 3 staff had been developed to work in postnatal wars, in the community and delivery suite. Although community midwives we spoke did not like the scheme as band 3 staff did little clinical work. A business case was agreed for administrative staff in the labour ward, 8am to 8pm seven days a week. We saw that administrative cover was introduced in November 2017 in triage 9am to 5pm and there was planning to increase this to 8am to 8pm, seven days a week.

We noted that there were insufficient community midwives. Community midwives reported high caseloads and were not sure of their expected caseload figure or when the tool for calculating midwifery staffing levels (Birthrate plus) was last completed. Because of the high caseload and vacancies, team leaders had little management time. Staff told us that one of the community team has had no team leader for a year, and that post was covered by other team leaders. The community teams had four or five midwives and a MSW (band 3) shared between two teams. The MSWs were recruited as apprentices and their work was mainly administrative and gave them little clinical experience, so they could not provide the best support for midwives. Staff told us a team of four or five midwives saw 100 to 110 women in a month. Community midwives all worked on-call for home birth and some worked some birth centre shifts too.

Following the inspection, we asked the trust to provide us with the caseload figures for the community midwives. The trust told us currently the community midwives do not provide caseload midwifery, rather they provided group practice care, aimed at achieving continuity of care in the antenatal and postnatal period within the geographical area, with allocation to a named midwife clinic. The teams operated using a buddy system to cover the clinics and reduce the number of professionals a woman sees during her pregnancy. The annual average number of women having postnatal care varies from 700 to 900 women per team. The community midwives were also responsible for the care of women in Waltham Forest who chose to have their baby at the hospital and additional antenatal booking clinic, two antenatal follow up clinic as well as the provision of parenting education were run locally by the named midwife.

We found actual staffing levels were often lower than planned. The safer staffing return for February 2018, reported the average fill rate was 94% for the maternity staff. Not all shifts had been rated as being safe. See table below.

<table>
<thead>
<tr>
<th>Maternity service area</th>
<th>Day % midwife fill rate</th>
<th>Day % support worker fill rate</th>
<th>Night % Midwife fill rate</th>
<th>Night % Support worker fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour ward</td>
<td>76%</td>
<td>86%</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>Maternity ward</td>
<td>85%</td>
<td>85%</td>
<td>183%</td>
<td>65%</td>
</tr>
</tbody>
</table>

We saw that the night shift fill rate was 183% for the midwives on the maternity ward. This included staffing in transitional care.

Staffing incidents were reported via the electronic reporting system. The service reported 122 staff shortage incidents reported for the maternity service for the period of April 2017 to April 2018. The labour ward accounted for the highest staff shortage incidents (66%), 10% for maternity, 5% in birth centre and 4% in EPAU. We saw evidence that actions were taken, such as the redeployment of staff and activation of the staff escalation policy. The service introduced the safe
care meeting, which took place twice a day to give assurance to the senior leaders on safe staffing.

An escalation plan was in place to address staffing issues. This included the deployment of midwives from other areas and/or specialist roles, to support the unit when needed. Staff told us that a community midwife could be called into the birth unit and maternity ward by managers as part of the escalation. A senior member of staff (band seven or above) was on-call out-of-hours, seven days a week, to support effective working and patient flow within the unit. The service offered bank staff unfilled shifts to ensure establishment was met.

Staffing levels were displayed in the clinical areas for midwifery staff and maternity support workers. We observed the service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment on the days of our inspection.

According to national recommendations, all women should expect to receive one-to-one care in established labour (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007). At the last inspection not all women received one to one care. Since the last inspection, the service routinely audited the provision of one-to-one care in labour. The February 2018 dashboard showed 100% of women had one to one care in active labour.

A multidisciplinary handover took place at the change of each shift on the labour ward. Midwives and doctors from the maternity unit and staff from the neonatal unit attended the handover. Staff told us this had improved communication and ensured input from all staff including the junior doctors rather than a top-down decision approach. Midwifery staff told us they had good relationship with the medical staff and they heard their point of view and worked to the same guidelines. Handover included any safeguarding concerns, an overview of all high-risk women and/or their babies and the allocation of workloads. A detailed bedside handover of each patient took place between midwives.

A senior midwife coordinated the activity for each shift on the delivery suite and maternity wards. The coordinators were supernumerary, which enabled them to have oversight of ward activity and support staff as needed, in line with national recommendations. The coordinator was responsible for managing any issues within the unit, such as staffing and activity.

Ward managers and some specialist midwives were supernumerary, which meant they could support ward staff clinically when needed.

Student midwives were supernumerary and not included in the midwife-staffing establishment. We saw that every student was assigned a midwife to work with on shift.

The trust reported their staffing numbers below as of January 2018 for the midwifery staff.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>254.61</td>
<td>223.27</td>
<td>88%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab).

From February 2017 to January 2018, the trust reported a vacancy rate of 15.2% in maternity; higher than the trust target rate of 7.5%. However, we noted the vacancy rate had improved from 27% in August 2017. The overall vacancy rate for the maternity service (inclusive of medical staff) in April 2018 was 13.7%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Recent data received from the trust before the inspection showed an 11% vacancy rate in labour ward and 14% in the maternity ward; which was higher than the trust target rate of 7.5%.

During inspection we noted the overall nursing staff vacancy rate was 17.2% and maternity unit had 5WTE vacancy and there was on-going recruitment process in place.

From February 2017 to January 2018, the trust reported a turnover rate of 18.5% in maternity; higher than the trust target rate of 15%. Recent data received from the trust following the inspection showed an average 21% turnover rate for all maternity and medical staff. Senior staff told us the service was ensuring flexibility of staff working hours as well as improving the culture of the service to help improve the turnover rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From February 2017 to January 2018, the trust reported a sickness rate of 5.4% in maternity; exceeding the trust target rate of 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

During inspection, the trust reported a sickness rate of 3.7% in maternity indicating that sickness had reduced although it still exceeded the trust target of 3.5%. We saw that a fortnightly sickness absence board meeting was arranged with divisions to discuss individual cases of staff sickness.

Senior staff we spoke to reported good support from human resources and occupational health with sickness absence.

(Trust Workforce dashboard)

In the last 12 months before the inspection, maternity had 2766 shifts filled by bank and agency staff.

<table>
<thead>
<tr>
<th>Bank and Agency staffing - qualified nurses</th>
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<tbody>
<tr>
<td><strong>Core Service</strong></td>
</tr>
<tr>
<td>Maternity</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

For the period of 2017/18 the cost of the use of temporary staff in the maternity unit was £17,773 (8%) of the pay bill.

The service has an effective system in place for managing of the use of bank and agency staff. The trust had a local induction checklist and temporary staff policy that advised staff on the use, orientation and managing of all temporary staff. Where wards were short staffed, senior staff were required to consider help from other wards and contact the site manager before booking a temporary staff. The service mostly used the same agency staff and all agency staff were given an induction pack.

As of September 2017, the trust had a ratio of one midwife to every 30.8 women. This was worse than the national average of 26.82.

(Source: Electronic Staff Records – EST Data Warehouse)

During inspection the maternity service had funded establishment of one midwife to 28 women,
but staff shortages meant this often achieved through the use of temporary staff.

**Medical staffing**
The service had 15 consultants covering the maternity service with special interests in different specialities such as fetal medicine, diabetes, sepsis and infection control. All consultants worked in both obstetrics and gynaecology (O&G). The service had 12 senior house officers (SHO) that covered the maternity service. Since the last inspection and changes to practice following serious incidents the service now had dedicated registrars allocated to the triage and maternity day unit.

The service had two anaesthetics consultant covering the maternity service. During inspection we saw there was good registrar and SHO cover in the service including during weekends. The service had a separate SHO for the delivery suite and postnatal ward. As at May 2018, the service had 49.8WTE medical staff against a planned 51.8WTE. The average vacancy rate for medical staff was 3.8%, which accounted for consultant and specialist trainee staff.

During inspection, we noted the service were currently short of three middle grade doctors (17 in post). The posts were currently covered by locums. Senior staff told us it was difficult to recruit medical staff in UK and was faced with the challenge of recruiting prospective staff from abroad that will need to apply for visa to work in the country.

From February 2017 to January 2018, the trust reported a turnover rate of 18.5% in maternity, which was higher than the trust target turnover rate of 15%. The trust had a three-year (2018 to 2021) recruitment and retention strategy in place to improve the vacancy and staff turnover. This strategy included flexible working, retirement, return to practice career pathway, career clinic, rotational post, inter-departmental transfer, accommodation, adaptation, improving job adverts which include use of social media and use of targeted recruitment companies.

During inspection, the trust reported a sickness rate of 3.7% in maternity, exceeding the trust target of 3.5%. We saw that a fortnight sickness absence board meeting was arranged with divisions to discuss individual cases of staff sickness.

*Trust Workforce dashboard*

Staff we spoke to told us they used locum staff but rarely used agency staff.

The trust reported the use of 0.42WTE of medical agency staff and 1.96WTE use of medical bank staff for the period of May 2018. In December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.
Staffing skill mix for the 44.8 whole time equivalent staff working in maternity at the North Middlesex University Hospital NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>38%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>8%</td>
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<tr>
<td>Registrar group~</td>
<td>45%</td>
<td>45%</td>
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<tr>
<td>Junior*</td>
<td>4%</td>
<td>6%</td>
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^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records
Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and were available to all staff providing care. We noted that staff had access to patient information and could make informed decisions on patients’ care, management and treatment.

The maternity service used a mixture of paper and electronic records. Women carried their own handheld pregnancy records, which they were advised to bring to each antenatal appointment and any occasion when they attended the hospital. Antenatal screening results and ultrasound scan findings were included in the handheld records. This was in line with national recommendations (NICE Antenatal care for uncomplicated pregnancies: CG62, last updated January 2017; Nice Antenatal care: QS22 (3)).

The personal child health record (also known as the ‘red book’) was given to mothers on discharge. The red book is a national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life.

We found records were stored securely. We found computer terminals were locked when not in use. All patients’ records were locked away in the cupboards or with the patient, no records were seen unattended.

The clinical record audit for the period of July 2017 to January 2018 showed 92% compliance for labour ward, which met their target, compared to 75% (target not met) for the maternity ward.

The service carried out a clinical record audit in April 2018 which showed 91% compliance for maternity wards and 89% for the labour ward, which was identified as an improvement from previous month. The areas for improvement were identified as completion of breastfeeding assessments, food charts and repositioning charts. We saw that an action plan was developed and shared with staff during hand overs and message of the week emails, and as part of their safety huddle.

We reviewed 37 maternity records for women at different stages of the maternity pathway and found these were completed in line with national standards (NMC The Code: Professional
Standards and behaviour for nurses and midwives, 2015). Records were contemporaneous, and entries were legible, dated and signed. The named midwife and/or consultant was documented. We saw that regular clinical assessment was evidence in the maternity records we reviewed. Clinical assessments, such as blood pressure and abdominal palpation were documented. Relevant previous and current patient information was completed and risk assessments were evident, with details of actions taken where appropriate. We saw that discharge summaries were sent to health visitors and GPs. The summary included information about the woman’s pregnancy, labour and postnatal care, any medications they had been prescribed, and any ongoing risks and/or follow-up care needed. The patient records reviewed showed that staff communicated effectively with community staff where there was safeguarding, domestic violence and specific mother or baby concerns.

As of 24 May 2018, 85% of medical staff and 71% of midwifery staff had completed information governance training. This was slightly below the trust target of 95% compliance.

Discharge and care summaries were sent to the GP, community midwives, health visitors and other professionals to ensure continuity of care in the community. The summary included information about the woman’s pregnancy, labour and postnatal care, medications prescribed, treatment and procedures, follow-up plan and action, and any ongoing risks and/or follow-up care needed. A copy of the discharge or care summary was also given to the patient.

Medicines
At the last inspection the management of medicines did not comply with nationally recognised good practice. During this inspection, we noted there were still concerns on the storage and management of medicines.

Medicines were not always securely stored and within the use by date on the maternity ward we found an expired yellow paraffin tube (expiry date 2010) and this was escalated to staff who removed the tube. We also found loose tablets on trolleys and loose sheets of antibiotics tablets. Controlled drugs (medicines subject to additional security measures) were in date but were stored in an untidy box.

In the delivery suite we found nebuliser solution, anaesthetic spray and ultrasound gel in an insecure store room. We found emergency medicines such as EpiPen, Adrenalin, water for injection and other intravenous (IV) fluids including Saline, intrepid IV bags, Hartmanns and Volplex fluid not stored securely. We noted the ampoules of lidocaine 1% were kept on top of a trolley and staff told us they should not have been stored there. We also saw two ampoules of ephedrine hydrochloride on a trolley. Staff immediately removed this and handed over to the anaesthetist when we drew attention to it. Also, we saw skin cleansing lotion and a local anaesthetic spray unsecured on a trolley. The anaphylaxis trolley was kept in an unsecured area on the main corridor. We escalated this to staff, when we returned at night this had been removed and kept in a secured area.

We noted lots of dust on the medicines trolleys. We looked at the epidural trolley were medicines and equipment used for epidurals were stored, we noted six missing entries in May 2018 on two different epidural trolleys. We also noted eight missing entries for the period of November 2017 to May 2018.

In the birth centre we found three out of date blood bottles (expired March 2018) and five safety catheters (expired April 2018).

There was an up to date medicine policy which was reviewed in January 2018 that advised staff on the management and administration of medicines. There was a medicine safety group (MSG) and medicines management committee in place that discussed medicine incidents, medicine safety, reviewed local and national guidance on medicine and BNF. We saw evidence that's
storage and management of medicines were discussed and shared with staff. The MSG met bi-
monthly and was a sub-group of the medicine management committee. We saw that a controlled
drug audit, medicine errors and trends patient safety alert were discussed at the January 2018
meeting. The MSG reported to the medicine management committee (meet 4 weekly) which was
attended by the CCG and patient safety group.

The service was an active participant in the North Central London Joint Formulary Committee
where governance around medicines such as new drug applications and approved guidelines
were discussed. For example, we reviewed the September and October 2017 minutes and saw
that a newly approved guideline on the use of 5% lidocaine, new published NICE guidelines and
NHSI patient safety alert on IV lines and cannulas were discussed.

The service carried out a maternity drug storage audit in March 2018. The result showed 86%
compliance on drug storage and that staff were compliant on four of the 11 standards audited.
The compliance of the standard not met ranged from 50% to 92%. Antenatal and maternity triage
performed better than other part of the same service in the audit. Worst compliance was noted for
‘to take away’ medicines (TTA) (63%) and storage in a secured locker (50%). We reviewed the
action plan and saw that although the plan had been reviewed there was no expected date of
completion.

Most controlled drugs were stored correctly within wall mounted locked cupboards and staff were
required to check the physical stock against the stock level recorded in the controlled drug register
at least once daily in accordance with trust policy. We reviewed the controlled drug register on the
maternity ward and birth centre and found it was reconciled twice daily, at each shift change.

Medicines that needed to be kept below a certain temperature were stored in locked fridges. At the
last inspection, we found staff did not consistently follow trust processes for storing medicines at
the recommended temperatures, despite there being policies in place. On this inspection, we saw
the issues had not been fully addressed. Ambient and fridge temperatures were meant to be
checked daily to ensure medicines stored were effective and safe for patient use. We found that
the ambient temperature was generally checked but saw poor compliance on the maternity ward.
We reviewed the ambient and fridge temperature checklists for maternity ward from October 2017
to May 2018 and noted some missing entries in October 2017 (two), January to April 2018 (eight).
The birth centre medicines fridge was checked regularly but we noted one missing entry for the
period of February to May 2018.

On observation we found ambient temperatures were generally within the required range (between
15 to 25°C), and no occasions when the temperature had exceeded 30°C. We saw evidence that
actions were taken when temperatures exceeded the recommended range, in line with trust policy.

All medicines fridge observed were clean and locked.

We found medical gas cylinders used in the maternity units were stored appropriately in a locked
room, in line with national guidance.

Prescription charts were designed to prompt the medical team to review courses of antibiotics at
appropriate intervals, usually 48 hours for intravenous antibiotics and five days for oral antibiotics.
We looked at prescription administration charts for 10 women. All were signed, legible, and
medicines were given as prescribed. We found that patients’ allergy status was documented
appropriately. This is essential to avoid serious medication errors from being made.

Medicine incidents were reported via the electronic reporting system. For the period of February
2018, the dashboard indicated 28 medication incidents were reported for the division. We saw
evidence that actions were taken and learning from incidents was shared with staff via email,
message of the week, monthly risky business letter, risk folder, displayed risk board and staff handover.

On the last inspection, we had concerns on the non-luer-lock epidural infusion administration sets used 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. At this inspection we saw that the service now used a luer lock epidural infusion set.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported zero incidents which were classified as never events for maternity.

We saw that there was a never event seminar conducted for staff on the 1 May 2018 which was chaired by the NHS England with the aim to improve staff understanding and management of never events.

*(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from March 2017 to February 2018.

Of these, the most common types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with 11 (58% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with two (11% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only with two (11% of total incidents).
- Screening issues meeting SI criteria with two (11% of total incidents).
- Confidential information leak/information governance breach meeting SI criteria with two (11% of total incidents).

*(Source: Strategic Executive Information System (STEIS))*

During inspection, we saw that the trust reported 12 SI for the period of May 2017 to April 2018.
We reviewed the investigation report for three SIs reported in September and December 2017 and found comprehensive investigation, lessons learned, change in practice, duty of candour and actions taken to reduce the risk of recurrence.

The service held a weekly SI panel to review and monitor serious incidents reported as well as determine which incidents met the SI criteria before the external SI panel review. We saw that this meeting was attended by MDT staff, Clinical Commissioning Group (CCG), NHS England (NHSE) London screening team and a midwife from a partner hospital. However, we noted there had been delay in the investigation of serious incidents and drafting of the SI report. Senior staff we spoke to told us this was a result of the risk manager who resigned from their post and their previous interim risk manager was on long term sickness. At the time of inspection, the service had an advertised vacancy post for the risk manager position and an interim would take up post on the 30 May 2018. We were reassured by senior staff despite the delay in the comprehensive investigation of SIs, the service undertook rapid review of any SI and learning were disseminated to staff. We noted some delays in SI investigation were also due to patients been unwell and hospitalised. Staff told us that all finalised SI reports were reviewed every six months to ensure action plans had been implemented before they were closed.

Following the reporting of an incident, the executive team decided if it met the SI criteria then escalated this to an investigation conducted by a panel. The written report was then discussed at the serious incident location action group (SILAG) which was attended by CCG. A newsletter would then be produced and shared with staff for shared learning. We noted that the service reported two serious incidents in March 2018 and which related to fetal death and neonatal death. The trust identified in 2017 that 78 women booked had not been screened for haemoglobinopathy, which led staff to review all screening for the period July to September 2017. The lookback identified that a large number of women booked had missed screening. This was then declared as an SI and a SI meeting took place in February 2018 to mitigate the risk. A duty of candour letter was sent to all women who missed the blood test inviting them back to the hospital for the test. During inspection, we saw that the screening team were supported twice a week by a screening coordinator from a local hospital, as two of the screening staff were on maternity and sick leave. The post of the staff on sick leave was now been filled by an experienced bank 6 midwife for the last six months to ensure blood test had been taken and results reviewed. We saw that the screening midwife was currently receiving external training. The service aimed at having the screening test carried out for patients who had missed the screening.

Community midwives we spoke to were aware of the ‘screening incidents’ now. As a result of this SI, change was made to their practice by ensuring all blood test orders were checked by a second midwife before submission. The service introduced additional prompts for staff which included ‘partner details for haemoglobinopathy and a double check was done centrally.

The trust used an electronic system for reporting incidents. Staff we spoke with said they were encouraged to report incidents, and felt confident to do so.

The service managed patients’ safety incidents well. Staff recognised incidents and reported them appropriately. Incidents were investigated and lessons were shared with maternity team and wider service. This was an improvement from the last inspection, when we had concerns that staff were not recording incidents correctly and that action plans were in place. Also, staff were not confident their concerns were listened to or acted upon.

From April 2017 to March 2018, there were 1578 incidents reported for maternity through the national reporting and learning system, which was a 48% increase from the previous year (1065). Incidents were graded from no to low harm, or moderate to severe harm or death. The majority of
incidents were graded as having caused no or low harm (67% and 30% respectively). The remaining 3% were graded as having caused moderate harm (2.5%), severe (0.3) and death (0.1). *(Source: National Reporting and Learning System (NRLS))*

Incidents were reviewed at the weekly incident review meeting. Any potential serious incidents were escalated to the serious incident review and learning group. Staff told us there was a consultant on call who also accessed the incident system and closed incidents where appropriate alongside the matron. However serious incidents were investigated externally. Staff we spoke to told us that a red flag system was introduced to the electronic reporting system in 2017 to ensure compliance with the NICE (2014) guidance and identify staff shortages and identify any incident affecting patient safety.

Staff we spoke to reported a good reporting culture including near misses. Majority of the staff we spoke to had reported incidents and majority had completed one in the last three months. Staff told us they received feedback on incidents in a variety of ways, such as emails, staff noticeboards and the newsletter. Debriefing sessions were provided to staff individually and one to one sessions following a serious incident, which were chaired by consultants not involved in the incidents. Lessons learned from incidents were shared with the whole team and the wider service. This was an improvement from our previous inspection.

Perinatal mortality and morbidity (M&M) meetings for maternity services were held regularly and well attended. Learning from cases was identified and action plans were set up where indicated. The meeting minutes showed that staff discussed still births, audits including actions and recommendations and learning from serious incidents. The committee reviewed all deaths from 24 weeks and babies born with poor cord gases or needing cooling. The meetings were followed by a review of the dashboard every two months (i.e. after Mortality meeting). The perinatal M&M was linked to the mortality and morbidity, clinical governance and risk management committee.

The mortality review committee reviewed all deaths and was seen to be well-attended by the appropriate staff from the minutes reviewed. This meeting was held monthly and attended by MDT such as consultants, sonographers, neonatal midwife and midwives. The 11 December 2017 meeting minute showed that 35 deaths were reviewed in 2017 and highlighted the learning and the themes from the deaths were reduced fetal movement, DNA, late booking, communication and assessment between teams. We saw evidence of were changes were implemented as a result of learning learned from serious incidents and the M&M meeting. For example, because of a patient death with *clostridium difficile* (c. diff), junior doctors were trained on the choice of antibiotics and the c. diff policy was reviewed and updated. Also, we noted that two midwives and a registrar were allocated to the triage which was an improvement in the staffing level and a result of a SI in triage. Staff told us this had improved the safety and there have been no SI in 2018 since the change. An escalation policy was developed for the maternity service following the SI and RAG system in place for every admission which was introduced seven months ago.

Therefore, we were assured an effective system was in place to ensure learning from perinatal mortality and morbidity was shared, and actions were taken to improve the safety and quality of patient care.

We reviewed the coroners’ inquest data submitted by the trust for the period of 1 February 2017 to 30 January 2018. We saw that action plan was developed as a result of the inquest relating to the maternity service.

The trust had a duty of candour policy, which staff could access via the trust intranet. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When things went wrong, staff apologised and gave patients honest information and support. All staff we spoke with were aware of the importance of being open and honest with women and those close to them when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened.

Women and their families were involved in the investigation process after an incident or near miss and informed of the outcomes. We were told the investigation report was shared with the woman, her family and/or representative(s) on completion of the SI. The SI investigation report we reviewed corroborated this and we saw that patients received verbal apology and written duty of candour letter. We saw that the service introduced the duty of candour sticker as a prompt for staff in ensuring duty of candour compliance.

Safety Thermometer
The maternity service used the national maternity safety thermometer tool, which was designed to support improvements in patient care and experience. It records harm associated with maternity, such as perineal trauma, infection and women’s psychological perception of safety, and the proportion of mothers who have experienced ‘harm free’ care. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

The maternity service average combined harm free score was slightly worse than the England average for the period of June 2017 to April 2018. The maternity service average combined harm free score was 71%, which was slightly worse than the England average of 74%. Staff we spoke to told us that action was taken in response to the safety thermometer results, as needed. For example, on the proportion of women that had infection.

Recent data from March to April 2018 showed an improvement. The average combined harm free score was 86%, which was better than the England average of 74%, in a snapshot of the maternity safety thermometer.

Is the service effective?

Evidence-based care and treatment
There was an effective system in place to ensure policies, protocols and clinical pathways reflected national guidance. These were reviewed at least every three years, or when new national guidance was published or serious incidents occurred. For example, we saw that the abduction policy was recently updated following a serious incident in maternity.

Trust policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age. We reviewed the trust policies and 12 of their clinical guidelines and pathways, and found all were within review date and referenced national guidance such as that of the Royal College of Obstetricians and Gynaecologists (RCOG). However, we did find one patient information leaflet (vaginal birth after caesarean section, had passed its review date in November 2013. We raised this concern at the time of our inspection and observed that expired patient information leaflets were removed.

The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment. The service was involved in local and national audit programmes, and collated evidence to monitor and improve care and treatment when indicated. The audit team and guideline panel decides on the 2016 to 2018 audit programme in response to national audits, NICE guidance, best practice initiative, risks and trends from datix. The team also ratified guidelines and
There was a clinical audit and effectiveness committee that reviewed and monitored the local and national audits, policies, guidelines and performance. The meeting was carried out bi-monthly and we saw that audits were conducted by all staff groups. Result of audits were shared with staff via email, newsletter, shared drive, message of the week and prompt training when clinical practice are changed. We reviewed the last three committee minutes and saw that the meeting was very detailed and appropriate staff attended.

The service had updated protocols for reporting unexpected fetal outcomes which guided staff on the processes to follow where there are concerns on fetal movement; this was in line with the Fetal Anomaly screening programme (FASP) guidance.

The service used the wave two of the national bereavement pathway that looked at early miscarriage and ectopic pregnancy. We saw that forceps deliveries were carried out in the theatre which was in line with the RCOG guidelines.

We saw that staff followed the NICE guidelines on antidepressants in pregnancy. Staff told women about risks of stopping antidepressants abruptly, and risks of not treating depression but also risk factors for congenital malformation, preterm delivery, and perinatal mortality.

The service had guidelines for staff on the care of twins and screening, in line with the NICE guidance. Care and treatment of women with multiple pregnancies was provided in line with national guidance (NICE Multiple pregnancy: twin and triplet pregnancies, QS46, September 2013). For example, we saw evidence that women with a multiple pregnancy were cared for by a multidisciplinary team (NICE QS46: statement 3), and discussed the timing of birth and possible modes of delivery by 32 weeks (NICE QS42: statement 8).

Opportunities to participate in benchmarking and peer review were actively pursued within the regional network. The service was part of a clinical partnership group in the London North Central region and worked with other hospitals on developing standardised guidelines to ensure comparable and standardised care for the population, for example a guideline on the induction of labour.

Antenatal records showed that women received care in accordance with national guidance and standards (National Institute for Health and Care Excellence (NICE) Antenatal care: QS22). For example, handheld records contained a complete record of antenatal test results.

Women at risk of gestational diabetes were referred for glucose tolerance testing (NICE QS22: statement 6). Management plans for women who had gestational diabetes were developed and in place. Combined consultant led endocrine and obstetric clinics were available for women with diabetes, this was in line with NICE diabetes guidance.

Pregnant women with pre-existing diabetes were referred for retinopathy screening in the first trimester (weeks one to 12 of pregnancy). Diabetic retinopathy is a condition that can lead to sight loss. This was in line with national recommendations (NICE Diabetes in pregnancy: management from preconception to the postnatal period, last updated August 2015).

Maternity records and our discussion with staff showed that women who planned or needed a caesarean section were managed in accordance with national guidance (NICE Caesarean section: QS32, June 2013). For example, a vaginal birth after caesarean section clinic was offered to all women who have had a previous caesarean section (C-section), which was reflected in the C-section audit. This provided women with the opportunity to discuss birth options in their current pregnancy (NICE QS32: statement 1).

A consultant reviewed women who sustained a third- or fourth-degree tear at a follow up clinic in line with the RCOG guidance.
The service used cardiotocography (CTG) to enhance the delivery of effective care and treatment to support labour and birth. The CTG enabled medical and senior midwifery staff to have oversight of all CTG traces. This system has been shown to improve outcomes as it reduces the reliance on individual staff, which carries the risk of something being missed, and means senior staff can intervene as indicated, without waiting to be asked.

The service was one of the six UK participating hospital sites in the multi-centric CRN portfolio studies in pre-eclampsia (ASPRE, SPREE).

**Nutrition and hydration**

Patient’s nutrition and hydration needs were identified, monitored and met. Women had access to dietary and infant feeding specialists when needed. Women were offered light refreshment such as biscuit, sandwich, water and hot or cold drink during labour, after delivery or caesarean section.

Staff supported and advised women on breastfeeding their babies, including positioning and attachment, and hand expression. Breastfeeding initiation rates were monitored monthly. The breastfeeding rate for the period of April 2017 to March 2018 showed an overall 83% breastfeeding rate, 7% partial breastfeeding, 9% artificially feeding and 1% other type of feeding which was better than the national target. For the same period, an average of 60% babies were solely breastfeeding, 26% partially breastfeeding and 11% artificially feeding six weeks after birth. This was higher (better) than the national average of 44%. The service had achieved stage 2 accreditation in the UNICEF baby friendly scheme and was working towards achieving level 3.

During inspection we saw that the average breastfeeding initiation rates were 87% for maternity service. This was higher (better) than the national target of 74%. The display board on the birth centre showed an overall 90% compliance for the period of January to March 2018 which was better than national target of 74%. We saw evidence that an action plan was in place to improve breastfeeding initiation rates.

Babies at risk of hypoglycaemia were regularly monitored following delivery, to ensure they were well and maintained blood glucose levels within the normal range.

Women were encouraged to maintain their energy levels in the early stage of labour, by eating small, light meals containing carbohydrates. Women’s hydration levels were routinely monitored by staff and were corrected with oral or intravenous hydration techniques when indicated using the fluid chart. This was in line with national guidance (NICE *Intrapartum care for healthy women and babies: CG190*).

Women were given advice on fasting before their elective caesarean section. Women were also prescribed medicines to reduce stomach acid prior to surgery. This was in line with national guidance (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services, 2013*).

All women who underwent caesarean section received intravenous fluid to ensure they were kept well hydrated, unless contra-indicated. Following this operation women who were recovering well with no concerns noted by staff, could eat and drink as soon as they wished.

Women with pre-existing or gestational diabetes were referred to the dietitian. Advice on diet to help control blood sugar levels and weight was given by staff, in line with national guidance (NICE *Diabetes in pregnancy: management from preconception to the postnatal period*, last updated August 2015).
Pain relief

Staff provided pregnant women with evidence-based information about the availability and provision of different types of analgesia, in line with national recommendations (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013).

Staff assessed and managed women’s pain level regularly on an individual basis. Staff were given option and allowed to choose their methods of pain relief as part of their birth plan.

The delivery suite had four birthing pools for pain relief and water birth. For their period of April 2017 to March 2017, an average of 5% (235) of women who delivered had a water birth delivery.

The birth centre offered massage, breathing and relaxation techniques, mobilisation and Entonox (a mixture of nitrous oxide and air) as part of the pain relief. The delivery suite had sofa bed that patient’s partner can carry out massage for the women during labour.

The pharmacological methods of pain relief were readily available and included ‘gas and air’, opioids (such as pethidine and oral morphine) and epidural anaesthesia, which was available 24-hours a day, seven days a week. There was good anaesthetist cover which ensured timely access for pain management. The anaesthetist conducted a weekly clinic session for high risk women with raised BMI, difficulty with anaesthesia and com-morbidities. Epidurals were controlled via patient controlled epidural analgesia (PCEA), which is an established technique for pain relief during labour.

National guidelines recommend that the time from which a woman requests an epidural to the time they are ready to receive one should not normally exceed 30 minutes; this period should only exceed one hour in exceptional circumstances (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013). The June 2017 audit showed that the average time before women received their epidural was 23 minutes which was better than the guideline of 30 minutes.

From October 2017 to March 2018, 95% of women received regional anaesthesia for elective caesarean section and 89% for emergency caesarean section grade one, which was better than the national targets.

We saw that regular analgesia was prescribed for post-operative women, including opioids and non-steroidal anti-inflammatory drugs (NSAIDs). Women who had undergone surgery such as caesarean section, were given pain relief for use at home when they were discharged.

Patients we spoke with told us they had received good pain relief and were asked regularly if they needed analgesia. Also, patients that came to triage due to pain said they were seen quickly by doctor and anaesthetist.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve the service. Patient outcomes were generally in line with national averages. The number of unexpected term admissions to neonatal care facilities was consistently lower (better) than the national average.

The maternity service maintained a clinical performance and governance dashboard, which reported on activity and clinical outcomes. Performance was monitored for a range of outcomes, including normal vaginal, instrumental and caesarean section deliveries, unexpected term admissions to the neonatal intensive care unit (NICU), and the number of third- and fourth-degree perineal tears.

The trust’s maternity dashboard parameters had been set in agreement with the Clinical Commissioning Group (CCG) for the North Central London. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available (RCOG...
Maternity Dashboard: Clinical Performance and Governance Score Card (Good Practice No.7), January 2008). There were 38 performance measures detailed on the trust’s maternity dashboard, which covered birth activity, workforce, and obstetric and neonatal clinical indicators. A traffic light system was used to flag performance against agreed thresholds. A ‘red flag’ indicated areas that required action, to ensure safety and quality was maintained.

We reviewed the maternity dashboard from April 2017 to March 2018. On four indicators the service was successfully meeting national goals and three indicators were flagged as amber. The service was rated mostly red on one indicator. For example,

- The trust was within the agreed limits for number of postpartum haemorrhage (excessive blood loss).

- The service generally met the agreed threshold for instrumental deliveries, third- or fourth-degree perineal tear with an unassisted vaginal delivery, total bookings within 12 weeks and six days and neonatal unit admissions in obstetrics. The trust reported an average unexpected term admission rate of 4.2%. This was lower (better) than the national average of 5%.

- Clinical indicators where the service mostly scored a red flag was the still birth rate. One incident of maternal death (against a threshold of zero per month).

The number of elective caesareans carried out at the trust was 11.8% which was lower than the England average of 12.1%. The number of emergency caesareans was 18.9% which was higher (worse) than the England average 15.4%.

The February 2018 audit showed 100% of women had one to one care in active labour. This was an improvement from our inspection in September 2016.

For the period of May to October 2017, there had been 24 non-elective maternal readmissions which indicate a 3% overall readmission rate which was better than the RCOG standard of 5%. The audit showed that infection was cited as the most common cause of obstetric re-admissions—particularly amongst emergency C-section, the majority of which were related to wound infection. PPH, hypertensive disorders and abdominal pain were cited as other causes. The readmission rate varied according to the BMI. For a woman with normal BMI (<25), the re-admission rate was 0.3%. However, for a woman with a BMI≥35, the re-admission rate increased more than 10-fold to 4.6%. However, the audit result identified that only 39% (11) of re-admitted patients were either reviewed or discussed with the consultant on call within 24 hours of admission. We saw that an action was developed and reviewed regularly by staff following the audit. As a result of this audit, we saw that there has been a change in practice, for example all consultants on call were made aware of and reviewed all readmitted patients within 24 hours of re-admission.

In the 2016 National Neonatal Audit programme the trust performance was as follows:

Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?

The trust performed better than 94% of eligible babies had their temperature taken within an hour of birth, slightly under the England average of 96%.

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

The trust performed better than expected with 88% of eligible mothers falling into this category receiving steroids, which was above the England average of 86%.

What proportion of babies less than 33 weeks gestation at birth were receiving any of their own
mother's milk at discharge to home from a neonatal unit?

The trust performed better than expected with 79% of eligible babies receiving mothers milk, which was higher than the England average of 59%.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

The service carried out mother with baby on the neonatal unit audit for the period of April 2017 to June 2017. This audit was part of the baby friendly initiative where seven standards were audited. The result showed the trust achieved and performed better than their target on six of the standards. The scored did not meet their target (80) on the information given to mother about sources of help and support (67). We saw that improvements were made following the audit to improve the information given to mothers and signposting them to available support.

The service carried out on audit on the incident of motor block using low dose mixture for labour analgesia (epidural) in December 2017. The result showed that problems identified 17% of patient scored bromage 3 (patients unable to flex their knees) and while 56% scored bromage 2 (women able to partially flex their knees). The audit recommended the service should find out current practice in other hospital and using bupivacaine as an alternative which was in line with the NICE guideline. During inspection, we saw that the service was working towards meeting the recommendation.

The service conducted an audit of general anaesthetic (GA) for lower segment caesarean section (LSCS) in 2016. The result showed that the rate of regional anaesthesia for non-category 1 LSCS in hospital was 96%, which was better that the national average of 77%. Also, the rate of regional anaesthesia for category 1 LSCS in hospital was 48%, which was better that national average of 54%. The result showed that 42% of general anaesthesia had been required due to failed regional anaesthesia and this should have been 10% according to NSCSA.

The service carried an audit of the women that received one to one care during active labour for the period of January to March 2018. The result showed an overall 101% compliance on the labour ward and 98% for the birth centre. This was an improvement from the last inspection where we identified women in active in labour were not receiving one to one care.

The service carried out a scan detection of small age for gestational age (SGA) audit in January 2017. The audit identified 36 women with SGA foetuses, of which 33% were less than 10th centile, 56% was less than 5th centile and 11% was less than 3rd centile. Five patients had abdominal doppler, 75% women delivered after 37 weeks and two babies were admitted at neonatal intensive care unit. All women were given a rescan appointment which was in line with their policy and best practice.

An external fetal monitoring (EFM) audit was carried out for the period of May to October 2017 to evaluate fetal monitoring. EFM is most commonly recommended for the woman and her baby where there are complications, such as where a baby is compromised through poor placental function and the baby is growth restricted according to NICE. The result showed improvement in the service but required improvement in the use of buddy system, documentation and management plan. The result showed good performance on escalation to senior midwife and medical team (100), appropriate classification (98%), use of CTG sticker (96%), reason why EFM was recommended (86%), management plan (86%) and continuous observation (82%). However, there was poor performance on evidence of buddy system (fresh eye; 10%) and hourly CTG review (46%). As a result of this audit, CTG reviews were carried out every Friday morning.

The service carried out an audit of reduced fetal movement for the period of February to May 2018 against the RCOG guideline six standards. The result showed that:
• 80% of women reported that they were asked about fetal movements at all their appointments after 20 weeks.
• 58% of women reported that they received an information leaflet either in English or their own language about reduced fetal movements by 24 weeks.
• 100% of women were aware that they had to report to hospital if they felt no fetal movement
• 94% women were that they had to report to hospital if they felt reduced fetal movement
• 73% women were that they had to report to hospital if they noticed a change in fetal movements
• 54% women were aware that they had to report to hospital if they noticed less than 10 movements in a day.

The service had action plan in place to ensure the reduced fetal movement leaflets were available in all maternity areas and not just the antenatal clinic. Also, leaflets would be provided in other language languages for patients who do not speak English as their first language. During inspection we saw that leaflets were printed and available in different languages on reduced fetal movement for patients. The service aimed to re-audit this in July 2018 to see if there has been an improvement.

The service carried out a smoking assessment in pregnancy audit project for the period of October 2017 to April 2018, which was in line with the Saving Babies’ Lives care bundle, which was designed to reduce stillbirths. The result showed that 68% of women had their carbon monoxide (CO) level monitored while 28% of women did not. CO can slow the baby growth and increase the risk of miscarriage, stillbirths and sudden infant death. The result showed of those women whose co-level was monitored, 9% scored greater or equal to 4 parts per million (ppm)- this reading was consistent with someone who smokes or exposed to CO. The results showed 10% were current smokers and 21% of these women (current smokers) were not offered smoking cessation.

The service carried out the neonatal readmission audit for feeding issues for the period of July to September 2017. The result showed that there were 18 readmissions due to feeding issues of which four babies were born at another hospital and while two babies born elsewhere were receiving postnatal care by the trust. In 33% of the readmissions, another hospital was involved in the mother and baby care. Also, 83% of the mother were exclusively breastfeeding their baby on readmission and while 11% on discharge from the ward. The breastfeeding assessment tool (BAT) compliance falls below the 100% standard on ward (11%), first home visit (17%), day five (28%) and on ward after readmission (44%). Feeding supported in the hospital was 50% and while community was 22%, the hospital reported that the community figure might not be accurate due to inadequate documentation as there was higher use of BAT in the community. During inspection, we saw that staff were required to complete the feeding assessment tool to ensure breastfeeding was established before mothers were discharged.

From October 2016 to September 2017 the total number of caesarean sections was higher than expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections as expected.
### Standardised caesarean section rates

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>North Middlesex University Hospital NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.2%</td>
<td>570</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.5%</td>
<td>884</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.7%</td>
<td>1,454</td>
</tr>
</tbody>
</table>

In relation to other modes of delivery from October 2016 to September 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

### Proportions of deliveries by recorded delivery method

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>North Middlesex University Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,454</td>
<td>32.2%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>330</td>
<td>7.3%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>2,734</td>
<td>60.5%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,519</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

As of April 2018, the trust reported one active maternity outlier. This pertains to an emergency caesarean section in October 2017, which is currently been investigated by the CQC outlier panel.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected. They can provide a useful indicator of concerns regarding the care that people receive. Maternity outliers include puerperal sepsis and other puerperal infections, elective and emergency caesarean section, and neonatal and maternal readmission rates.

The trust carried out an emergency caesarean section retrospective audit in 2017, which showed the trust was an outlier among the region. The result showed five of the cases underwent general anaesthetic for the C-section, one of which was a category 1 and required further management due to massive bleeding. The trust review of the outlier showed that all the emergency C-section was done for the appropriate indication. Also, the diverse ethnicity and deprivation on the local area may have contributed to the higher rate of emergency C-section. The trust reported that the recent data from the 2017/18 quarter 3 North Central London CCG showed the elective C-section...
(ELCS) was persistently lower while the emergency C-section (EMCS) was comparable to other hospital in the region. The service reported that vaginal birth was encouraged for women who had C-section previously and which reflects the ELCS figures but higher in the EMCS. Following this audit, the service has changed their practice by ensuring that women who presented with bleeding near their delivery date were admitted into the delivery suite rather than triage.

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.29, which was slightly higher (worse) than the national average (5.19).

(Source: MBRRACE UK)

The service had an action plan in response to the MBRRACE audit report to improve care provision and patient outcomes. We saw 17 of the 39 recommendations had been met and the remainder were in progress. We were assured the service was taking action to reduce its perinatal mortality rate. Staff had completed a gap analysis against MBRRACE and this led to revising guidelines, introduction of safety huddles, birth options clinic, training in situational awareness and human factors, bereavement checklist and review of those guidelines.

The service carried out a stillbirth rate audit in 2017 in response to the requirement at the last inspection. The still birth rate was 7.07 per 1000 and reduced to 5.61 for medical top (MTOP’s), which was worse than the London region. The service developed a growth assessment protocol (GAP) implementation project plan in accordance with the Saving Babies Lives to help improved the still birth rate, which was one of the trust stillbirth action plan. We saw that staff attended a GAP plaining on the 13 March 2018 in line with their GAP action plan. The GAP was still in progress and a project manager and steering group are now in post. There is plan in place for the GAP to go live by 3 September 2018 and staff training schedule were scheduled from July to September 2018. The action plan also included training and discussion of fetal movement by staff, MDT working and engagement with the local community, improve early booking, develop better interpreter services carbon monoxide testing for pregnant women and smoking cessation referral, still birth annual audit and MDT review of still births with 24 to 48 hours.

We saw that the audit was shared with staff, discussed at team meeting and included in the message of the week. For example, the 2 April 2018 message highlighted the importance of fundal height measurement at every antenatal contact by identifying intrauterine growth restricted babies (IUGR) and small for gestational age babies (SGA) to ensure early surveillance, referral and intervention which will help reduce the still birth rate. Staff had developed a sticker label which was placed on patient’s notes to remind staff of measuring the fundal height. We saw that there had been an improvement in the still birth rate in January (2.513) and February (3.04) which was better than the trust target of 3.9%.

The service identified gap between the RCOG guidelines and trust guidelines on fetal movement, which might have resulted in fetal loss. We saw that the trust guidelines had been changed to reflect RCOG guidance fully. Other changes made by the service since the last inspection and as a result of the still birth included the implementation of mandatory still birth and bereavement training for the MDT, counselling and parent group, snow drop team (bereavement midwife champions), collaboration with the Muslim charity community and local hospice. However, this was an improvement from our inspection in September 2016.

Competent staff

The service supported staff to maintain their professional skills and experience. Staff told us they had good access to study days, external training and career progression. For example, two midwives were on a full-time scan course which included growth and anomaly. Midwives had also
attended training on Better births with NHS England, mother and babies in MIND and perinatal mental health. A support worker had been trained and developed to be a ultrasonographer. Two midwives were enrolled on the high dependency unit (HDU) course at the university. This was to ensure HDU was appropriately staffed by at least one person with training in HDU care.

Staff were trained on the assessment of fetal growth and used gestational related optimal weight (GROW) in their assessment. The service had plan in place for the growth assessment protocol (GAP) to go live by 3 September 2018 and staff training schedule were scheduled from July to September 2018.

28 midwives had received NIPE training and able to carry out the NHS newborn and infant physical examination (NIPE) screening programme.

Nurse sonographers at the EPAU and bereavement midwife were trained to give psychological support and discuss treatment such as medical management of miscarriage.

There were teaching and learning schedule in place for junior doctors, we reviewed the planned schedule for the period of October 2017 to September 2018 which took place in the hospital and external. We saw that medical staff including junior doctors attended different study days, national trainee conference, preventing burnout and promoting resilience, perinatal mental health, human factor training, research afternoon, consultant teaching, journal club, fetal monitoring, CV and interviews. The human factor training was accredited by RCOA and had been ongoing for two and half years and was carried out in partnership with British airway. This training was facilitated by MDT staff such as paramedics, physiotherapist, navy, patient advocacy officer and involved theoretical training and practical simulation. The human factor training was offered to maternity staff including students.

The service had a teaching rota (bi-weekly) for medical staff which include a monthly PROMPT training and human factor teaching on any on-going incidents case. We saw that medical students were involved in various journal publication and poster presentations. There was an updated junior doctor handbook which included orientation, medicines, list of medical staff and supervisor, consent, rota and brief teaching overview of the maternity areas.

We spoke to junior doctors and student midwives and they felt supported by MDT staff, and their mentors facilitated their learning in the unit.

Staff received training, teaching sessions and reviews of CTG to improve their competency. This was in line with national recommendations (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirths).

The consultant, matron and risk midwife carried out a quarterly learning road show, where they visited all the wards, taught and discuss risk messages with staff.

The service had three birth simulators that could talk and deliver babies which were used for practical training and simulation based on set scenarios. Staff reported good opportunity to attend this training.

The maternity service organised a band 6 development programmes in 2017 as a response to the midwives who were not passing the band 7 jobs interview they applied for. The programme covered topics such as leadership, e-roster, management, finance, specialist midwives job opportunity, interview session with HR and training opportunities in the local hospital. Staff we spoke to told us the band 6 programmes was successful and some band 6 staff had secured band 7 jobs. The service planned to continue this programme.

All staff underwent a trust induction programme, which included mandatory and role specific
training. Staff told us they had received a good induction for three days. All midwives who were new to the trust initially worked in a supernumerary capacity for a month alongside an experienced midwife. Midwifery staff including student had access to clinical placement facilitators and practice development midwives who operated an open-door policy.

Newly qualified midwives and oversee recruited midwives completed a year comprehensive preceptorship programme to support their development. The programme included regular progress interviews, reflections on practice, mandatory and maternity specific training, and competency assessments. Midwives could autonomously carry out tasks such as cannulation, perineal suturing and scrubbing for theatre when they had completed training and demonstrated competency. All staff including the preceptorship midwives were rotated every three months to work in all areas of the maternity service during their preceptorship programme. Staff told us they felt well supported during their preceptorship. During inspection, we saw that two midwives who had completed their preceptorship programme were enrolled on the mentorship course.

Poor or variable staff performance was identified through complaints, incidents and feedback. Managers supported staff to reflect, improve and develop their practice.

Midwifery and medical staff within the maternity service were up-to-date with their professional revalidation. This meant we were assured the service had appropriate measures in place to ensure all midwives and doctors were up-to-date and fit to practice.

Arrangements were in place for supporting and managing staff, such as annual appraisals. We saw that appraisal was also completed for midwife’s following the completion of their preceptorship. Staff told us they found the appraisal process useful to identify any learning and development needs. However, we found the percentage of staff who had received an annual appraisal was generally below the trust target of 90%.

From February 2017 to January 2018, 83% of staff within maternity at the trust had received an appraisal compared to a trust target of 90%. Senior staff told us the appraisal completion date was recently changed which might have affected the appraisal rate. A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of individuals required</th>
<th>Number completed</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>226</td>
<td>185</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>24</td>
<td>19</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>265</strong></td>
<td><strong>219</strong></td>
<td><strong>83%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The trust plan to improve appraisal rate included divisions and corporate heads to receive their respective staff lists of staff who required an appraisal during the appraisal window, and weekly communications on the intranet, face to face meetings and focused training for managers.

**Multidisciplinary working**

The maternity service multidisciplinary team worked together to improve patient care and outcome. Doctors, midwives and other healthcare professionals supported each other and were involved in assessing, planning and delivering women’s care and treatment.
Maternity staff worked jointly with a number of specialities, including neurology, psychologist, endocrinology, paediatrics, cardiology, urology and perinatal mental health, to deliver effective care and treatment.

A multidisciplinary handover which included the safety huddle took place twice a day on the maternity unit. We observed a detailed handover during our inspection, which was well attended by members of the multidisciplinary team (MDT) including the obstetric medical team, anaesthetists, medical student, delivery suite co-ordinator, unit co-ordinator, nurse, wars sister and nurse-in-charge of the neonatal intensive care unit (NICU). The team discussed the current acuity within the maternity unit and NICU, the planned caesarean section list, and high-risk patients. The team had good understanding of risk factors and able to raise question and concern appropriately. We saw that message of the week, risk board, VTE reminders, patient special requirement like interpreters where highlighted. Difficult cases were handed over to medical staff with the labour ward coordinator present, including prioritisation. Also, the medical team prioritise patients that needed to be seen before the ward rounds and junior doctors were signposted to check on patients while the handover was take place to plan their care.

The service was linked to The North London Partners Specialist Perinatal Mental Health Service (SPMHS), a community-based mental health team in the London Boroughs of Barnet, Camden, Enfield, Haringey and Islington that served the needs of pregnant and postnatal women with moderate to severe mental health needs). Staff reported good support and MDT working with the SPMHS.

Staff told us the communication between the community maternity teams and the hospital was good. Staff confirmed they were informed when a woman had suffered a pregnancy loss or had safeguarding concerns. Observation of practice, review of records and discussion with staff confirmed that all necessary. Community staff reported good communication and relationship with other professionals and agencies, such as health visitors, GPs, local authority safeguarding team, family nurse partnership, social services and the perinatal mental health team. We saw that staff involved health visitors on all high-risk cases and gave written and verbal handover on discharge. Staff reported excellent communication with the social services which was facilitated with the Haringey social services based in the hospital as well all safeguarding team were based in the same office.

Meetings minutes we reviewed confirmed that regular multidisciplinary meetings were held and were well attended. These included perinatal mortality and morbidity meetings, SI panel, risk meetings, and maternity governance meetings.

**Seven-day services**

Seven-day medical cover was provided with the minimum of a resident middle grade doctor. Dedicated consultant presence was from 8am to 9pm, Monday to Friday and 9am to 2pm, and 8pm to 9pm at weekends. On-call arrangements were in place out-of-hours.

Anaesthetic cover was available for emergencies on delivery suite and the maternity service 24 hours a day, seven days a week. This was in line with national recommendations (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services*, 2013).

There was 24-hour access to a dedicated obstetric theatre, and a theatre team was also available 24 hours a day, seven days a week.

The maternity triage unit was available to women 24 hours a day, seven days a week and managed by two midwives on each shift. There was a dedicated registrar cover from 8am to 8pm since April 2018 and while two on-call gynaecology registrar covers 8pm to 8am at night. This was
an improvement since the last inspection. Women could telephone for advice or present to the unit if they had any concerns or health issues.

The maternity day assessment unit was open from 7.45am to 8.15pm, seven days a week for booked appointment. The unit were staffed with two midwives, a support worker and doctor (available 9-5, then on call obstetric team after 5pm). Out of these hours, women could self-refer to triage.

Community midwives offered seven-day services for home births. On-call arrangements were in place 24 hours a day, seven days a week to facilitate the home birth service and provide any other advice or care to women at home, as needed. We saw that two community midwives were on call at night to cover home births.

The discharge lounge was available to women and their relatives 8am to 10pm, seven days a week. This was staffed by a band 3 support worker, a midwife with NIPE training and staff on the maternity ward.

There was seven day a week access to the early pregnancy assessment unit (EPAU), which was part of the women’s ambulatory day unit (WADU). The EPAU was opened between 9am and 3pm at weekends and 7.45am to 8pm on weekdays. There were two sonographers assigned to EPAU at weekend and supported by doctor on call to ensure timely and safe care of patients.

The women’s ambulatory day unit (WADU) was open seven days a week. It had scanning facilities on site and we noted the service was the only hospital in the region whose WADU opened seven days a week. The unit only accepted referrals from GPs, midwives, the emergency department or an urgent care centre, and aimed to see patients on the same day or within two days of receiving the referral.

Patients had access to the phlebotomists and interpreting service seven days a week.

**Health promotion**

Staff supported women that accessed the maternity service to live healthier lives and manage their own health, care and wellbeing.

The service offered women influenza (flu) and pertussis (whooping cough) vaccinations, in line with the NICE guideline on antenatal care for uncomplicated pregnancies.

Midwives recorded the smoking status for each pregnant woman at the booking appointment and offered smoking cessation advice to women who smoke.

Women diagnosed with gestational diabetes were empowered and supported by staff to manage their own health, care and wellbeing.

Women with a body mass index greater than 35 were referred to a local agency for support and advice with weight loss, healthy eating and exercise.

The hospital had achieved the United Nations Children’s Fund (UNICEF) baby friendly initiative level 2 accreditation. This meant the service was committed to supporting mothers to breastfeed, whilst also supporting parents who chose to bottle feed. Breastfeeding information was displayed throughout the maternity service, including breast feeding rate, guidance on the health benefits, positioning and benefits of attachment. Midwifery gave breastfeeding support and advice to mothers both in the hospital and community.

The midwives and obstetricians gave health promotion advice on the importance of fetal movements to women at each antenatal contact as a method of fetal surveillance, in line with the current RCOG guideline (Green-top Guideline No. 57) and MBRRACE-UK guidance.
Other health promotion information and leaflets seen during inspection included Bacillus Almette–Guérin (BCG) vaccine, avoiding cot death, jaundice and sudden infant death syndrome. During inspection, we saw on the notice board that the health promotion theme of month was reducing risk of blood clots.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards
The trust had up-to-date policies regarding consent and the Mental Capacity Act 2005 (MCA). Staff could access these via the trust intranet. Staff receive training on MCA and DOLS as part of their level safeguarding training.

Staff understood their responsibilities regarding consent. Medical staff informed women about the risks and benefits of obstetric procedures, such as caesarean section. We observed this during our inspection. Written consent was obtained from women prior to surgery and we saw evidence of this in the maternity records we reviewed.

We saw midwifery and medical staff asking for consent before they provided care or treatment, such as obtaining blood samples and performing clinical observations. The women we spoke with confirmed that staff asked them for their consent before proceeding with care and treatment. They also told us they were given enough information to enable them to make informed decisions about their care and treatment.

Patient we spoke to told us that “staff sought their permission before they do anything, I think it is very good”. Doctors took their time to explain the benefits and risk of procedures fully before given be the consent form to sign. A patient commented that staff asked several times about their name and procedure they were having done to ensure their understanding.

Staff had access to specialist midwives, nurses and other professionals who had expertise in dealing with women in vulnerable circumstances, such as those with learning disabilities and mental health concerns. The psychiatric liaison team supported staff with MCA assessment when necessary.

Is the service caring?

Compassionate care
Staff cared for patients with compassion, respect and dignity. Feedback from patients and those close to them was positive. Staff treated patients well and with empathy.

We saw many positive comments in letters and cards to the staff. This included, “I received phenomenal care” and “you have made everything much bearable and for that we are eternally grateful”. One woman wrote “to all the previous midwife who made a difference in my life, you have been a blessing and joy”.

We spoke to 20 women and their relatives during the inspection. The comments received included; “staff were friendly”, “polite”, “nice”, privacy always respected (staff shut the curtain around by bed when necessary and happy to come back”, reception staff were helpful and friendly”, privacy have been maintained and respected, “service was excellent” staff were kind and caring. “I have been respected throughout my stay”.

We observed medical and midwifery staff interacting with women and their relatives in a polite, friendly and respectful manner. Staff introduced themselves to women and their relatives and made them aware of their roles and responsibilities.

Staff recognised and respected the women’s holistic needs. Staff confirmed that when they assessed patient’s needs they considered their personal, cultural, social and religious needs. Patients we spoke with and patient records we reviewed corroborated this.
Patients’ privacy and dignity was respected by staff. We saw that staff closed curtains and doors to protect patients’ privacy and knocked on doors before they entered. There were curtains as well in the delivery suite and single rooms which ensured women could use them when undressing while staff were in the room. The rooms also had a notice on the door to advice staff and visitors when a patient was occupied. All women we spoke with felt their privacy and dignity was maintained.

Women told us they had a named midwife. We saw evidence of this in the patient records we reviewed and patient feedback.

From January 2017 to January 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

During inspection, we saw that the FFT performance for the period of April 2018 was 97% and similar to the England average of 97%. We saw that FFT result was displayed on the wards and available on the trust website.

From January 2017 to January 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally worse than the England average.

During inspection, we saw that the FFT performance for the period of April 2018 was 94% and worse than the England average of 97%.

From January 2017 to January 2018 the trust’s maternity Friends and Family Test (postnatal
ward) performance (% recommended) was generally worse than the England average. No data was reported from July 2017 to September 2017.

During inspection, we saw that the FFT performance for the period of April 2018 was 96% and better than the England average of 95%.

During inspection, we saw that the FFT performance for the period of April 2018 was 100% and better than the England average of 96%.

(Source: NHS England Friends and Family Test)

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>7.8</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>About the same</td>
<td>9.2</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>Worst performing trusts</td>
<td>7.3</td>
</tr>
<tr>
<td></td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.2</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>9.0</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>Worst performing trusts</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>If attention was needed, did a member of staff help within a reasonable amount of time?</td>
<td>About the same</td>
<td>8.2</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>8.6</td>
</tr>
<tr>
<td>Area</td>
<td>Question</td>
<td>RAG</td>
<td>Score</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>6.5</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>7.3</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same</td>
<td>8.6</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>Worst performing trusts</td>
<td>7.5</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

The overall response rate was 27% (88) of women who delivered their babies in February 2017. Overall, women reported positive experiences of maternity care and there were small improvements in results across almost every question. Compared with the last survey in 2015 a greater proportion of women said that they were offered the choice of giving birth in a midwife-led unit or birth centre, saw the same midwife at every antenatal appointment and could ‘always’ get help from a member of staff within a reasonable time while in hospital after the birth. However, the trust performed worse than other trusts for three out of 16 questions in the CQC maternity survey 2017. The trusts performed about the same as other trusts in the remaining 13 questions.

The trust had five positive improvement areas from the previous survey. However, the trust scored worse than national average for questions relating to labour, which were ‘did you have skin to skin contact with your baby’, ‘spoke to in a way you could have understand’ and ‘treated with kindness and understanding’. We saw that the result and action plan were reviewed monthly on each North Central local maternity system (LMS). We saw that the trust benchmarked this result to four local hospital in the region. On the maternity survey, the trust performed similar to other hospital in the region for ‘care in hospital after births’ and ‘staff during labour and birth’ but worse for ‘skin to skin contact’. During inspection patient we spoke to told us that staff encouraged them to have skin to skin contact with their baby. A patient commented that the best of their day was “when I was given my baby to hold on my chest, I was over the moon”. We saw displayed pictures on the picture notice board of mother and babies with brief message of the benefit of skin to skin contact.

Emotional support
Staff provided compassionate care and emotional support to patients to minimise their distress. Staff involved patients and their relatives in assessing and meeting their emotional and social needs, which was understood as being crucial in the patient care. Specialist support for bereaved women and their families, and women in vulnerable circumstances was available and personalised to meet their individual needs. Women and patients felt really cared for, treated with respected and dignity and involved in their care.

There was ongoing assessment of women’s mental health and well-being during the antenatal to the postnatal period. The maternity service had access to psychologist, psychiatrist and perinatal mental health specialists, who provided additional care, support and treatment for women with mental health concerns as needed. Staff also had access to the safeguarding midwife who was also the perinatal health nurse.

Women were offered emotional support when trying to establish breastfeeding. Patients we spoke to told us staff explained about mental wellbeing and supported them with breastfeeding issues.
The service introduced three clinics a week in November 2017 for access to psychologist and psychiatrists from antenatal to postnatal period. A mental health nurse would visit relevant women postnatally. Staff referred women with emotional or mental health issues to the health visitors and a senior social worker who specialized in mental health for additional support.

The service had access to Let’s Talk Improving Access to Psychological Therapies (IAPT), which had a range of treatment programmes including one to one therapy, counselling and group work. The service covered Barnet, Haringey and Enfield.

The maternity service offered a debriefing service, which provided women and their partners with the opportunity to discuss any unresolved concerns, anxiety or issues they had regarding their pregnancy or birth experience. The debriefing service was held by one the consultant obstetrician.

Bereavement policies and pathways were in place to support parents in the event of a pregnancy loss, such as miscarriage, stillbirth or neonatal death. The trust carried out a bereaved cared audit for the period of November 2016 to November 2017. The result showed overall satisfaction in the level of support given to patients' relatives and care received from staff. Positive comments received included; “at a very difficult time all hospital staff were very caring and allowing us to time to remain after death”, “the team on the ward were understanding of the patient’s need”. Negative comments were related to communication, care plan and empathy. We saw that the trust has included feedback from the audit in the teaching and training for staff to nurture an empathic care culture. Also, the trust had increased the chaplaincy team to improve support given to patients and their relatives. The action plan included improving ethnic and religious variety of responses through translation in top languages and creating groups for English-speaking minority groups.

The trust had a chaplaincy service, which provided spiritual care and religious support for patients, partners and relatives as needed. Multi-faith options were available. The chaplaincy service was available for support 24 hours a day, seven days a week.

A specialist bereavement midwife provided training for staff and supported families from their initial loss, throughout their time in hospital and their return home. The bereavement midwife advised and gave support to parents and families following still-born, miscarriage and neonatal death on the wards and clinic. The bereavement midwife had their own case load which included supporting with bereaved women during consecutive pregnancy at the blue bell clinic. The service had links with health visitors and signposted parents with charity bereavement support, Muslim charity community, hospice and local Muslim Chaplin. The support given to patients included counselling, parent support group, option for funeral, psychological support, memory making (boxes), ensuring parents spent time with the deceased baby or foetus and signposting them to charities and local community. Staff could contact the bereavement nurse out of hours or bleep them during the day. Home visits from the bereavement midwife were available for women as needed. Monthly coffee mornings were run by the bereavement midwife to help Early Pregnancy Assessment Unit (EPAU) patients

We saw that the service had trained some midwives with interest with bereavement to be a bereavement champions (snow drop teams). The snow drop teams also supported families and gave them bereavement information and schedule follow-up appointment with the bereavement midwife.

There was access to national and local advisory groups such as Sands (stillbirth and neonatal death charity), to offer both practical advice and emotional support to women and their families. The trust organised an open event for support to the bereaved patients and their families on 24 May 2018, with the local community, MP, mayor, public and staff in attendance.
Understanding and involvement of patients and those close to them
Staff treated women who used the services and those close to them as active partners in their care and treatment. Staff were fully committed to working in partnership with women, and encouraged women in making decision about their care and birth choices.

Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care; they understood the choices available to them and were given options of where to deliver their baby if considered low risk.

All the women and relatives we spoke with felt staff involved them in their care and had received the information they needed to understand their treatment, which enabled them to make informed decisions about their care.

We saw many examples of positive feedback from patients, which corroborated they felt involved in their care and treatment. Examples included; “everything was explained to me, was assured and received help all the way which helped prepare them for their C-section”, “the anaesthetist was helpful and took their time to explain the procedure before undergoing C-section”, “staff made sure I know what was going on, I was given information about the plan and when I would be having my operation”, “Doctors and consultant came to explain what was going to happen during the caesarean section”, “all my questions was answered”.

During inspection, we observed staff were very thorough, answered all patients question, spoke quietly and had good interaction with the patients loved ones.

Birthing partners were involved in the care of their partner (or loved ones) and newborn baby, including being offered the option to massage their partner during labour and cutting their baby’s cord at delivery. Birthing partners could attend caesarean section deliveries carried out under regional anaesthesia and were able to sit beside their partner and support them throughout the procedure.

We saw that staff gave written information to support information given verbally. There was plenty of information available in other languages for women and those close to them who accessed the service. Women had access to interpreters, telephone translation and link workers (Turkish and Romanian).

Is the service responsive?

Service delivery to meet the needs of local people
The service planned and delivered care in a way that met the diverse needs of the local and surrounding population. The patient’s needs and preferences were considered and acted on to ensure services were delivered to meet those needs. The service had a business plan in place to ensure continuity of patient care.

The service was working closely with local stakeholders, neighbouring trust and the local maternity system (LMS) to improve maternal and neonatal safety across the clinical network as laid out in Better Births, Saving Babies’ Lives and Maternal and Neonatal Health Safety Collaborative.

Representatives from the service attended the local maternity voices meeting to work in partnership with women to plan, monitor and improve the maternity service provision.

Antenatal care was provided and easily accessible to pregnant women and tailored to meet the needs of women and the local community in line with the NICE guidance on antenatal care. Women could access maternity services via their GP, self-referral, local children’s centre or by
contacting community midwives directly. Women could tour the whole maternity unit in advance of giving birth.

The service provided postnatal follow up care as part of the discharge process with community midwives and, where necessary, doctors. A discharge letter was sent to women’s GPs, health visitors following discharge from the hospital, to facilitate continuity of care.

The service offered a vaginal birth after caesarean section (C-section) appointment, to women who have had a C-section to explore birth choices for their current pregnancy in line with national guidance.

A named midwife and/or consultant cared for women throughout their pregnancy. This was confirmed from the maternity records we reviewed and women we spoke with. This was in line with NICE guidance on Antenatal care.

Women were given an informed choice about where they gave birth, in conjunction with consideration of their potential risk. Midwifery-led care were offered to women with an uncomplicated pregnancy. This included a home birth or delivery in the birth centre, which provided midwifery-led care, which was in line with national guidance (NICE Antenatal care for uncomplicated pregnancies: CG62). Women with previous medical condition, complication of pregnancy or had experienced previous complications in pregnancy or labour, were advised to have their baby on the delivery suite, which was obstetric-led and provided for all women over 28 weeks gestation.

The service had four birthing pools in the birth centre which meant women could use water for labour and/or birth if they wished.

Women’s partners could stay with them throughout their admission and stay overnight.

The trust’s website contained a virtual tour of the maternity unit. There were pictures of the maternity unit on the trust website which ensured patients who were unable to visit the hospital prior to their visit and appointment had the opportunity to view and have a feel of the maternity service provision. Patients and their relatives could book a tour of the maternity units twice a month in the evening. This ensured that working parents were able to attend the tour.

The service provided patients and professional relevant information on the trust website which included on line booking, pregnancy, antenatal, having your baby, safeguarding information, after your baby is born and maternity frequency asked questions. Women could read the information on the trust website in other languages. The trust website also had information leaflets for pregnant women on smoking in pregnancy, flu vaccines, chicken pox, gestational diabetes and healthy eating in pregnancy.

Meeting people’s individual needs
The needs and preferences of patients were considered when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs.

Care and treatment was coordinated with other services and providers, to ensure the needs of women and their families were met.

The maternity ward environment was spacious and had a welcoming big and colourful sign; ‘welcome to maternity ward’. There were butterfly and flower designs on the wall and visual display of staff which gave the environment a relaxed, cosy and homely feel. There was wheelchair access to the wards, antenatal clinic and delivery suite.
The maternity service had ensuite rooms with accessible toilets and showers which were suitable for people with reduced mobility. The birthing unit had a sofa bed for patients and their loved one to use and relatives could give the patient massage during labour.

The service ran a weekly multiple births clinic which was consultant led and was supported by a midwife with special interest in multiple births. This meant women who attended the clinic had continuity of care.

Antenatal and parenting classes were held every day of the week in the community for women 30 to 34 weeks. Women were able to choose the day that met their needs. The service offered parent education classes to women and their birthing partners at the hospital and community. These classes included preparation for labour, parenting and bonding. In addition, two breastfeeding workshops were provided each week in the hospital. The service also provided an alternative birth education programme (hypnobirthing) which covered specific self-hypnosis, relaxation and breathing technique for better births. There was a charge for this.

The maternity service had arrangements in place to support women with complex needs such as learning disability, diabetes, sickle cell, HIV, mental health, blood disorder, genetic disorder, hepatitis b, previous C-section and high BMI. These were managed by specialist midwives and/or consultants and included a joint clinic held for women with diabetes, perinatal mental health services, fetal medicine clinic, and joint cardiology and obstetrics clinic. A designated consultant was responsible for perinatal health and ran a clinic for women with mental health needs. Medical staff told us they had had joint clinics were patients were seen by two consultants with different specialities such as obstetric and mental health and obstetric and neurology. Staff we spoke to were happy about the support for women with HIV and this was evident in the 600 women who gave birth without any case of cross infection.

The safeguarding lead and specialist safeguarding midwives provided care, support and treatment for women in vulnerable circumstances, such as those with learning disabilities, mental health, substance misuse, teenagers and travellers. They could refer to other health care professionals or agencies for additional support and advice as needed, such as the trust’s learning disability health liaison team and family nurse partnership.

We saw that the trust implemented a carer passport information booklet, which was a scheme for carers who supported vulnerable patients. Staff we spoke to told us that the trust was the first hospital to introduce the carer passport scheme.

The service provided debriefing service to any woman who had delivered at the hospital if they wanted this. This offered women and their partners the opportunity to discuss any unresolved concerns or issues they had regarding their pregnancy or birth experience.

Bereavement care provision was in place to support families from their initial loss, throughout their time in hospital and return home. The service employed a bereavement midwife, whose role was to develop bereavement care, provide support for parents and training and education for staff.

The bereavement midwife worked alongside various local communities to meet the diverse needs of the population. We saw that the service had made changes to the provision of Muslim families following the loss of their child based on feedback received. This include ensuring parents were able to take the baby remains the same in order to ensure timely burial in line with the Muslim religion. Staff told us the change was crucial as it was important for parents to carry out the funeral in a timely way according to their faith. The service had a dedicated bereavement room which had a cold cot to ensure bereaved parents had time with their baby. Bereaved mothers who wanted to spend more time with their deceased baby or foetus before funeral were discharged to a flat in a
local hospice. We noted that this was an improvement since the last inspection and staff said these changes were made as a result of feedback received from families and collaboration with local charities and community groups.

The bereavement midwife supported women with making funeral arrangements and arranged counselling services where necessary. The hospital had a chaplaincy service, which offered spiritual and/or religious support to parents who faced the loss of their baby. Chaplains of various denominations and faiths were available on request.

A memory box, which included photographs and hand and foot prints, was given to parents who had suffered a loss. This ensure bereaved parents were kept away from celebrating families and the sound of live babies, and was in line with national recommendations (Sands *Stillbirth: how professionals can make a difference*, 2015).

Women were offered fetal anomaly screening, in line with national recommendations. Women identified as high risk for a fetal abnormality, such as Down’s syndrome, were seen in the fetal medicine antenatal clinic for on-going treatment and support. During inspection we saw that the fetal medicine board had information written in different language as well as printed information.

Interpreter services were available for women for whom English was not their first language. The service had three full time interpreters who worked 9am to 5pm. These were provided face-to-face or via a dedicated telephone translation service. There was a website translation icon on the trust website which can translate vital information on the website to 11 languages such as Chinese, Turkish, Japanese and German. The trust reported Polish, Romanian, Turkish, Bulgarian and Spanish were the top five requested language in 2016. British sign language accounted for 4% of all request received. The maternity service had a Turkish and Romanian link worker. Patients we spoke to told us they had been offered an interpreter.

Community midwives told us that some midwives speak the languages spoken by their local population and these midwives were often allocated to women who speak that language to help develop a trusting and collaborative relationship.

The services used the British sign language alphabet and Makaton symbols (a language programme which uses signs and symbols to help people to communicate) to support women communication.

There was a dedicated breastfeeding room in the maternity ward for women and visitors to breastfeed their baby. The room also had a microwave that was used for sterilising pump attachments.

The women’s ambulatory day unit had a quiet room for women who were unwell and awaiting assessment to sit or lie down and for breaking bad news.

Women had a choice of meals, which took account of their individual preferences, respecting cultural, nutritional and personal choice. Patient could order food at any time and outside of set meal times for patients in maternity. The maternity ward audit for the period of March 2017 to November 2017 showed 100% of women commented they were offered choices of meals. Patients feedback included; “whenever you are hungry, snacks and drinks are always available”, “staff asked, if they needed help with feeding”.

We saw that staff responded promptly to patient call bell. A woman told us “staff answered quickly when I call”. The maternity ward audit for the period of March 2017 to November 2017 showed 100% women commented that they had their call bell within their reach.
There was a free Wi-Fi for patients and visitors and a radio station available for patients 24 hours a day, seven days a week.

There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services such as the neonatal intensive care unit.

**Access and flow**

Women could access maternity services via their GP, local children’s centre or by contacting community midwives directly. Patients could also self-refer to the service by the phone or completing a booking form on-line.

From April 2017 to March 2018, an average of 89% of women had accessed antenatal care by 12 weeks and six days gestation, which was better than the England average of 81%.

From the patients notes reviewed we saw that routine antenatal care appointments for women who have never given birth and women who have given birth were scheduled in line with national guidance.

Women were referred to the early pregnancy unit by the midwife, GP, A&E and other fertility clinic were mostly seen on the day or next day. GP’s could refer online, or call for advice, answerphone monitored promptly. The unit was open seven days a week for women up to 16 weeks gestation. There were two scanning rooms and a quiet room in the unit and staff told us that 95% of scan results were available within a day.

Women could telephone the maternity hotline (Maternity Direct) for advice Monday to Friday, 10am to 6pm. Calls were answered by a senior midwife. Women could access the maternity day unit for review, if indicated by the symptoms or concerns they described. Women who attended the maternity day assessment unit or triage unit were prioritised according to their clinical needs and/or symptoms. Staff aimed to assess all patients within 15 minutes of arrival, and audited this.

The trust provided staff with a patient flow and escalation policy and procedure that advised them on process to follow to ensure timely access and flow of the service.

The trust data showed the antenatal clinic saw a high activity of patients with an average of 85 deliveries per month. The service held 13 clinics a week to meet the demand and needs of the population. Approximately 20 women were booked by midwives each day and approximately 25 women seen in each consultant clinic. High risk women were seen in the antenatal clinic setting with care provided by midwives, specialist midwives and obstetric consultants.

During inspection, we observed the antenatal clinic was very busy. At one point, there was a queue of about 12 women to register with one of the two receptionists. Staff we spoke to told us the clinics were well organised but sometimes run late, particularly when consultations involved a translator. Clinics also overran due to late arrival of women and missing notes (patient leaving their hand-held notes at home). Staff told us that they overbooked the clinics because the transient population meant some people ‘did not attend’. Staff told us when the clinics were busy this could be chaotic for staff and patients. There were procedures and processes in place for dealing with patients who did not attend (DNA) but staff told us some patients were lost to the system especially when they relocated abroad. The DNA policy ensured that staff offered patients subsequent appointments and responded to any safeguarding concerns.

An audit of the antenatal clinic carried out in September 2017, showed 70% of women waited 30 to 60 minutes to be seen by staff, 15% waited 20-30 minutes and 15% waited 60 to 90 minutes. The main reason for the waiting time was shortage of doctors (43%). In the outpatient, patient waited around four to five minutes before been seen by the receptionist and commented that staff
came to check who had not yet been seen. The service planned to carry out a re-audit in July 2018.

Waiting times were shown on a whiteboard as people came in to the clinic but this was not visible from the seating area. The waiting time information on display was not reflective of some patients’ experience. On one occasion we saw that the displayed waiting time of 30 minutes was not updated for two over hours and we noted some patient had been waiting for two hours.

Patients we spoke to in other areas of the maternity unit told us they were seen within 20 minutes by the consultants. For example, a patient commented they were seen immediately by the doctors in the recovery. Two other patients commented been seen between 10 to 20 minutes on the antenatal ward.

To improve flow, we saw that sonographer capacity was currently being boosted by the ASPRE fellows in obstetrics who were involved in a joint ASPRE and aspirin for evidence-based pre-eclampsia prevention trial. The fellows were running two obstetric scanning rooms 9am - 5pm, five days per week, but staff were concerned about scanning delays when the project ended.

At times during our inspection the labour ward was very busy and some women experienced delays in transfer to the labour ward following induction. Staff we spoke to told us the delay rarely affected women in established labour. When we inspected at night, we saw three women waiting to be transferred to labour ward Staff told us they had had a few deliveries in triage in the past while patients were awaiting transfer. We saw that the triage was staffed with two midwives and one support worker day and night. A four-bedded bay in triage was used for the ambulatory induction service. Women were looked after by one midwife. From April 2017 to Match 2018, 1.1% of babies were delivered in triage and 0.1% in A&E, which were areas not designated as delivery suite, theatre or the birth centre.

The service conducted an audit of the waiting time in triage for the period of March 2017 to December 2017. The service aimed for women to have their first assessment within 15 minutes to risk assess and prioritise women to be seen first. The result showed 89% overall compliance and we noted that the figures fluctuated monthly between 83% and 94%. The service achieved over 90% for the period of July to December 2017. Changes were made in practice following this audit by having a registrar presence 8am to 8pm seven days a week. A follow-up audit for January 2018 showed that 96% of women were seen within 15 minutes and no patient (0%) waited longer than 30 minutes. The service reported that 46% that attended triage needed to be seen by a doctor and of which 42% were seen by them within 30 minutes of arrival. Thirty three percent waited less than an hour to see a doctor and while 25% waited for more than an hour to see a doctor. This was an improvement from our inspection in September 2016. A patient in triage commented that they were seen immediately in triage by midwife when they arrived due to pain and within 15 minutes by the doctor.

The service had a discharge lounge for patients and their relatives to wait while awaiting their paper work or take-home medicines. The midwife would bring the paper work, medication and relevant information to the patient before they were discharged. Staff told us this had improved flow of the service, reduced the delays in discharge and improve the communication with the pharmacy.

For the last 12 months, the maternity service had not suspended the service. Contingency plans were in place if the unit was required to close due to lack of capacity. The service had an updated maternity unit and escalation closure and diverts policy in place that advised staff on topics such as factors for escalation, closure of the unit, guidance for matron, escalation flow chart and risk assessment in triage.
Bed Occupancy

From July 2016 to December 2017 the bed occupancy levels for maternity were generally higher than the England average, with the trust having over 75% occupancy in Quarter Q3 2017/18 compared to the England average of 60%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Staff told us the high bed occupancy rates were related to the complexities of the women needs that accessed this service. Reasons were mainly related to safeguarding issues, social needs, still birth and emergency C-section.

Learning from complaints and concerns
The service had processes in place to ensure complaints were dealt with effectively. Information were provided to women and their families on how to report concerns and make a complaint. Information on the patient advice and liaison services service (PALS) were available on the maternity unit. PALS provided advice and support to women (and those close to them) who wished to raise a concern or complaint. Information on how to complain was also published on the trust's website. Patient we spoke to knew how to make a complaint if they want to.

Patients and their partners were offered local resolution meeting to address complaints and the outcome once it had been investigated. This was attended by the complaints team and staff we spoke to told us that patients have found the face to face resolution helpful to address their concerns as well as receive an apology in person.

From January 2017 to May 2018 there were 50 complaints about maternity. The trust took an average of 36 days to investigate and close complaints; this was not in line with their complaints policy, which states complaints should be resolved within 30 days. Although we saw that complaints investigation was comprehensive and staff gave verbal and written apology to patients and family. The service also offered a face to face resolution meeting to patients to speak to senior staff about their complaints during and after the complaints investigation. The main themes of
complaint were staff attitude, medical explanation, test appointments, information and care package.

Staff we spoke to told us that complaints have dropped (improved) dramatically because of actions taken to improve the service such as addressing staff communication and culture and debrief sessions.

From June 2017 to May 2018, zero complaints were referred to the Parliamentary Health Service Ombudsman.

(Source: Provider Information Request P55)

Is the service well-led?

Leadership

The maternity service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

In the last inspection, we had concerns on the leadership of the service. Since the last inspection we saw that changes were made to the leadership structure and teams. The maternity service was under the women children’s and clinical support services division and had a clear management structure with defining lines of responsibility and accountability.

The trust had appointed new substantive leadership team for the service. A divisional director of operations, divisional director of clinical services and head of midwifery had overall responsibility for the division. The maternity services leadership team consisted of a clinical director for obstetrics and gynaecology, service manager and the head of midwifery (HOM). A consultant midwife, consultants, risk midwives, matrons, ward managers and specialist midwives supported the senior management team. We met with the senior management team who demonstrated knowledge of the service’s performance, challenges they faced and actions needed to address them. The leadership team had direct access to the trust board and reported good support. We saw from the minutes of board meetings that the trust board had oversight of the service.

Members of the leadership team and maternity staff told us they had worked collaboratively with stakeholders to improve the service through the maternity improvement plan. The senior management team spoke with pride about the work and improvement that had been made to the service particularly around culture and safety.

The delivery suite was co-ordinated by an experienced senior midwife who, wherever possible, was supernumerary to the staffing numbers required for the provision of one-to-one care in labour. This meant they had oversight of ward activity and could support staff as needed.

Staff spoke positively about the senior management team. They told us they were visible and they felt well supported by managers. During our inspection, we observed senior staff were visible and attended clinical areas to support staff, discuss activity and issues that had arisen.

The new head of midwifery (HOM) had been in post for two weeks. The HOM had access to the Trust Board and felt supported by the board and triumvirate.

Staff told us that the HOM had introduced herself at a recent study day and emailed all staff. Staff we spoke to told us they were pleased the head of midwifery sent her picture and gave brief background of her professional and family background (number of children), which they felt was positive and kind gesture.
Leadership at all levels were known by staff and visible and approachable. Staff had met executives such as the director of nursing and midwifery. Staff spoke positively and gave positive feedback about the matrons, consultant midwife and service manager. Staff told us they received support from the senior leaders and felt respected and listened to.

The senior staff service provided ongoing support to the matrons and staff in addressing the actions from the maternity improvement plan.

The practice development midwives (PDM) and consultant midwife replaced the former supervisors of midwives, since statutory supervision had ceased to exist in April 2017 to help support the new midwives employed in the service. The PDM were visible in the unit and wore a distinctive uniform.

**Vision and Strategy**

The service had a strategy and vision of what it wanted to achieve and workable plans to turn it into action. The trust vision was to provide outstanding care for local people. The service vision was to provide the best support and high standard of care for local women.

The service had a 2016-2019 strategy and business plan 2016-17 in place. These were underpinned by the trust’s core values and developed by staff and shared with staff to ensure positive patient experience and excellent clinical outcomes. The 2016-2019 strategies for maternity services were: to be the provider of choice to both the local population and to new areas, to ensure services support the national maternity review’s vision for the future of maternity care; to increase the number of deliveries to ensure the unit was viable, ensure all aspects of a woman’s pathway from booking to postnatal care are seamless and place the woman at the heart of care and to ensure more women delivered in the midwifery-led service through new models of care and to introduce new technology and new ways of working to support 21st century care.

The current strategy was in place till 2019, the new senior leaderships including the head of midwifery intended to review and develop a new strategy and present to the board when this ran out.

The clinical director for maternity was the co-chair of the local maternity system LMS and we saw that some guidance and risk governance were shared on LMS. The LMS objective included looking at developing midwifery clear pathway. There was not a designated non-executive director (NED) with responsibility for maternity services during inspection.

**Culture**

At the last inspection we had concerns around the culture of the service and staff experiencing bullying and harassment. At this inspection, we saw that the service had carried out major work to improve the culture and staff morale. Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. We saw that staff were committed to improving the quality of care and patient experience. Staff told us they felt valued, wanted and involved in the improvement and development of the service.

Senior staff told us that the bullying culture which had been a risk to patient safety had been much improved by rotation of staff to break up friendship groups, less hierarchy and much inclusive culture. Staff we spoke to were happy about the rotation and believed it had helped improve staff culture, morale and skills.

Staff felt the reputation of the unit was changing and students now wanted to work in the trust following their training. Student doctors and midwives told us the service had a good learning atmosphere, morale had greatly improved and ‘it’s a whole different place’.
Some staff who had been working in the trust for years reported major improvement in the culture, staffing levels management support and no more cliques and bullying in the service. We saw staff including agency staff who had left the trust due to the culture, or who had experienced racist elements in the culture had come back to work in the unit. New midwives felt supported and told us they had never experienced or witnessed bullying. Staff felt the improved culture had improved the staff turnover of the maternity service.

Staff told us there were good opportunities for learning, career progression and new posts were advertised and open to everyone, which ensured equal opportunities.

We saw that the service had developed a CUSS (I am concerned, I am uncomfortable, this is not safe, stop) escalation tool to encourage staff and teams to raise issue, concerns and poor practice to improve the service culture. Staff commented that the service had improved in last 18 months and they were able to challenge colleagues and raise issues without been victimised. Staff respected and valued by their managers and MDT and encouraged to share ideas they had for service improvement.

Medical and midwifery staff felt there was a positive working culture and reported collaborative and effective team working to provide safe care and provision. Medical staff told us they never felt alone and “if you needed three consultants at night, you will get it”.

Staff comments on the culture and working relationship included; “it’s amazing working here”, “no hierarchy of medical or midwifery staff”, “we support each other to give safe care”, “friendly and approachable staff”, “always looking forward to coming to work”, “able to talk about concern with line manager, colleagues, practice development midwife”, “I love working here”, “a team feel and environment”, “feel quickly part of the team”.

The culture encouraged openness and honesty. Duty of candour was implemented in the service and we saw that cases that met the duty of candour were reviewed and monitored at the divisional monthly performance meeting. We saw in the 21 November 2017 meeting minutes that all duty of candour for the previous month had been completed (100%).

The maternity service celebrated staff success. Since our last inspection, the service had introduced ‘greatix’ for recognising staff and team for excellent care of service. The greatix was set up by a maternity doctor and anyone could nominate a staff or team. We saw that since this had been implemented staff and team had received 26 greatix certificates. Staff we spoke to told us there was possibility that greatix will be implemented by other services in the trust.

The trust also had a star of the month scheme which was introduced in October 2017. The star of the month winner was announced at monthly performance meeting and displayed on the wards. Staff told us there was a plan to introduce a voucher scheme to be awarded to star of the month.

We saw that staff had nominated a matron for supporting them during a difficult birth delivery. The service rewarded staff with a star mentor award who had made a difference to student learning experience.

The bereavement midwife received a Royal College of Midwives award for bereavement care, support and debrief session given to staff and patients. The bereavement midwife was also nominated by a patient for a national award due to the difference made to the patient and relative during a difficult time. The bereavement midwife also received a runner up award in the British journal of midwifery award February 2018. The child protection lead was nominated for BASCAN and NSPCC Award for Child Protection trainer of the year and reached the top three in the country.
As part of the international day of midwife, the service displayed thank you in different languages to identify and celebrate the diversity of staff in the service.

Staff told us there were more midwives activities and the service now celebrated staff including those retiring. Also, staff had monthly coffee meeting where issues such as culture and concerns were addressed. Staff we spoke to felt their concerns were listened and acted upon. However, this was an improvement from our inspection in September 2016.

The trust had a freedom to speak up guardian who was appointed in July 2016 and staff we spoke to were aware of who their guardian was. The speak up guardian attended training and network with other hospital and guardians in the London region. The guardian worked with mediators and bullying and harassment facilitators to improve the culture and whistleblowing in the trust. The freedom to speak up guardian reported to the executives and attended board meeting. We noted in the January 2018 board report that the speak up guardian recommended appointing two more speak up guardian and train staff to be speak up ambassadors. We saw displayed posters on the wards, staff toilets and staff rooms of the freedom to speak up guardian with their details. We saw that the service had carried out various work to improve staff confidence in raising concerns which was also include in their maternity improvement plan. This was an improvement from our inspection in September 2016.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. The arrangements for governance were clear and operated effectively. Staff understood their roles and accountabilities.

The service sought reassurance through various governance meetings such as the divisional management meetings and the clinical audit and effectiveness committee which reported to the trust board. The clinical audit and effectiveness committee covered areas such as local and national audits, divisional structure, IT and quality improvement. Senior team reported good and robust governance support from the trust board.

The medicine management committee and the North Central London Joint Formulary Committee addressed governance around medicines.

The monthly divisional meeting addressed governance and clinical and clinical risk. Serious incidents were discussed at the division monthly performance meeting and we noted that there were five new SI in February 2018 for maternity. The meeting also highlighted 23 overdue 48 hours report and 17 SI actions from the action plans were still outstanding for maternity.

The maternity service used a clinical performance and governance dashboard to monitor activity, outcomes and performance. The dashboard was used to help identify patient safety and quality issues. This was in line with national recommendations (RCOG Maternity Dashboard: Clinical Performance and Governance Score Card, Good Practice No.7, 2008). The dashboard tracked monthly performance against locally agreed performance measures. We saw evidence that actions were taken to review and address areas where locally agreed performance standards were not met. The maternity dashboard was regularly discussed at departmental, divisional governance meetings and trust board.

There were clear responsibilities, roles and systems of accountability to support good governance within the service. The trust had an up-to-date risk management policy and strategy, which staff could access via the trust intranet. Staff were aware of how to complete incident reports and were encouraged to do so. Staff we spoke to have completed incidents and received feedback from managers.
The service engaged actively with the local maternity system board which was attended by other hospitals in the local region, CCG as well as service maternity staff such as the risk lead, consultant and head of midwifery. From the minutes the trust provided we saw that perinatal mental health, recruitment, projects, dashboard and the national and London maternity transformation project update were discussed at the meeting to ensure improvement, learning and benchmarking.

The maternity improvement board reported quarterly to the clinical quality review group (CQRG). Maternity risks and incidents were discussed and reviewed at this meeting.

The maternity improvement action plan was implemented in 2017 as a result of external review of the service and which contained 237 actions. The plan was huge and was being implemented in sections by the maternity team. We saw that 24% of the actions had been completed and others were still being implemented. The actions included reducing the still birth rate, introducing GAP/GROW, third degree tear, leadership, appropriate staffing on HDU and saving babies lives bundle. The service had submitted a business case to have dedicated HDU rooms. The maternity improvement plan committee met every two weeks to review the plan and feedback to the executives.

The trust introduced a service called Schwartz rounds which was run by a psychologist where staff could attend and discuss any issues they had experienced or going through such as bullying and bereavement. Staff we spoke to told us this had helped improved the culture, morale and mental wellbeing of staff.

Management of risk, issues and performance

The service had processes and systems in place for managing performance and identifying and mitigating risks. There was a maternity dashboard and a systematic programme of clinical and internal audit, which were used to monitor risks and quality to identify where action should be taken. The maternity audit programme was informed by national audits, incidents, complaints and clinical outcomes. Findings from audits were shared with staff through emails, safety huddle, meeting and newsletters. The maternity dashboard was benchmarked with other hospital in the region and we noted the trust took actions with the aim to improve the still birth rate and emergency caesarean section rate where they were outliers among their peers.

Incidents were reviewed at various governance meeting such as SI panel, perinatal mortality and morbidity meeting. The risk midwife also reviewed incidents and other risks identified within the service. Minutes of meetings held showed that serious incidents and complaints, and quality audit updates were discussed. Actions taken to reduce recurrence and improve service provision were detailed. Any potential serious incidents were escalated to the divisional serious incident review and learning group.

The maternity service had arrangements in place for identifying, recording and managing risks. The divisional risk register included a description of each risk, with mitigating actions and assurances in place. An assessment of the likelihood of the risk recurring, its possible impact and those responsible for review and monitoring were highlighted on the risk register. There were 199 items on the women, children’s and clinical support services divisional risk register and which included shortage of junior doctors and vacancy rate of 35% for the division. Risks specific to maternity included and not limited to CTG training, GROWTH chart project, ANNB screening, security cover, staffing, electronic maternity information system, backlog of SI and incident response in a timely manner and abduction. The top three risks were antenatal screening, CTG compliance and SI backlog. Staff we spoke with were aware of the main risks within the service.
However, we noted that the risk register did not highlight the risk of infection from poor cleaning we identified during inspection.

We noted on the divisional monthly performance meeting minutes that there were overdue risks on the risk register. For example, 73 risks were overdue as at 1 March 2018 and 16 risks were awaiting approval at divisional or executive level. The 27 April 2018 highlighted that 68 risks have all been reviewed but not updated on datix and 16 risks were awaiting approval at divisional or executive level if graded 15 plus. During inspection, senior staff told us the risk register had been reviewed the previous week and all risk identified were initially reviewed rapidly by the divisional governance leads to identify trends and mitigate risk. Risks were then finally reviewed at the governance meetings.

Information Management

The maternity service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service had clear performance measures, which were reported and monitored. These included the maternity safety thermometer, maternity dashboard, FFT results and social media. Performance results were discussed at divisional and board level to improve care and patient outcome.

The maternity dashboard parameters had been set in agreement with the CCG, and were in line with national targets where available. A traffic light system was used to flag performance against agreed thresholds. Senior staff at governance and risk management meetings regularly reviewed the dashboard.

The service submitted data to external bodies as required such as MBRRACE-UK, which enabled the service to benchmark performance against national outcomes.

Community midwives had access in the community to trust computer systems. Staff told us that 50% of community midwife had tablets but these had to be shared by staff in a team. Community midwives also had access to laptops to access relevant corporate and patient information.

The service used a digital electronic system to receive feedback from patients on the birth unit.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The service obtained and acted on people’s views and experiences to shape and improve the services and culture. We saw evidence that service user feedback was sought to inform changes and improvements to service provision.

Posters on the walls across the maternity services contained feedback for patients. During inspection we saw a patient safety alerts poster which informed patients and visitors of missed booking of bloods by the service and there was ongoing monitoring and action been taken to address this. Outside the delivery suite was a ‘Listening Tree’ display with positive statements about how concerns had been addressed. For example, you wanted sofa beds for partners in the delivery suite – we will soon provide them; you thought there were not enough staff, we have ongoing recruitment.

During inspection, we saw that the service had started a parent support group for bereaved families which was launched on the 24 May 2018 as an open day event in collaboration with Sands (stillbirth and neonatal death charity) for bereaved families. We saw that the event was attended by bereaved families, staff, the local community, charity organisation MP and mayor.
The service gave feedback to women and families through ‘you said, we did’ posters. The service engaged with staff through various means such as newsletters, walk arounds, notice boards and staff meetings. Staff told us the clinical director and NED had visited the maternity service and this borne out by data submitted by the trust. Staff told us the feedback was used to improve the service for example, the recruitment of administrative staff on labour ward to improve staff and patient experience. Feedback from complaints and survey findings were also reported to staff during meetings.

Monthly performance newsletters were sent to staff and covered areas such as the divisional achievement, risk register, clinical governance, maternity improvement plan, duty of candour, serious incidents action plan and risk register.

The service held a maternity voices meeting in April 2018. This meeting was held as a kick off process to have a more formal feedback from women using the service.

The service was developing strong links with the local Maternity Voices Partnership (MVP), which is an independent multidisciplinary committee made up of user representatives, maternity professionals and other stakeholders. There were plans to engage local women in the service design and improvement by going out to community groups seeking their support to improve maternity service provision.

Women who used maternity services were encouraged to give feedback on the quality of service they received. Information about the complaints procedure and patient advice and liaison services was available in clinical areas. Feedback was also gathered through FFT, birth reflections and social media forums, such as NHS Choices, Facebook and Twitter. We reviewed the feedback received on social media in 2018 and noted that majority of the feedback were positive.

There were positive and collaborative relationships with external partners and stakeholders to build a shared understanding of challenges within maternity and the needs of the local population, and delivery of services to meet those needs. The service was working collaboratively with service users, neighbouring trusts and commissioners via the LMS, to ensure national recommendations for maternity care were implemented across the region. This was evident in the partnership working with Royal Free hospital, CCG, NHSE and other stakeholders to improve the service through the maternity implementation plan.

In the 2017 annual National NHS staff survey, the trust scored 3.76 (out of five) for an overall indicator of staff engagement. This was slightly worse than the national average of 3.8. We saw that an improvement action plan had been developed to address concerns raised in the survey, which included addressing culture, bullying, harassment and discrimination and staff recommending hospital as a place to work. Improvement made was evident from feedback received from staff about the culture and staff engagement. The trust also introduced the BME staff network in spring 2017 and staff held their first meeting in November 2017.

Learning, continuous improvement and innovation

The service had focused on continuous learning and improvement and was addressing the concerns we reported at the September 2016 inspection. We found many improvements had been made, but some further work was still required.

Senior leaders were committed to improving services by learning from when things went well and making changes in practice through shared learning, external reviews, promoting training, research and innovation.

The trust conducted an external review in January 2017 since the last inspection to understand what factors contributed to the findings on the culture of maternity and if the issues were
widespread across the Trust. There were four recommendations which included a focus on service integration and collective responsibility for the service, rotation of midwives across the service and build on the success of the ‘bleep’ initiative and review its approach to issues that staff have found difficult to manage. During inspection we saw that these recommendations were being actioned. For example, the rotation of midwives and a bleep holder who managed managerial issues and a midwife on call 24 hours, seven days a week.

A new management team were appointed to lead on the urgent actions identified from the CQC inspection and external review. A comprehensive assessment of the maternity services was undertaken by the Director of Midwifery Services from the Royal Free Hospital for the period of March to June 2017. This analysis covered all aspects of maternity services. The assessment considered the standard of service provision, and areas for improvement which developed in the comprehensive maternity improvement plan. The assessment highlighted improvement in the leadership team and which resulted in the director of maternity been appointed to work with the service in delivering the maternity action plan.

The trust carried out an external review of the maternity service KPI in 2017. The report highlighted that the issues in the service had been largely resolved and found good aspects of risk management aligned to SI such as CTG interpretation but improvement was needed on the review of the risk register. The junior medical clinical supervision validation ranked the service among the highest performing in the London region. The FFT result had shown improvement in the maternity service by up to 76% and the service performed better than the national target on maternity booking within 13 weeks. However, the reviewed highlighted there had been recent flags on the timely review of serious incidents.

The trust was one of the nine trusts identified as high risk and supported by the NHS Improvement (NHSI) Maternity Safety support list with a focus on improving the maternity service and patient experience.

The service was one of the six UK participating hospital sites in the multi-centric CRN portfolio studies in pre-eclampsia (ASPRE, SPREE).

The service was involved in the joint ASPRE and aspirin for evidence-based pre-eclampsia prevention trial.

The snowdrop bereavement service won the Sands Award for Bereavement Care, at The Royal College of Midwives (RCM) Annual Midwifery Awards 2018.

Staff including students told us there was a drive towards improvement of the service and they all felt involved. Midwifery staff said they were encouraged and supported to complete additional training such as, HDU, mentorship and sonography.

The trust also worked on quality improvement (QI) programme and developed a project group which was tasked with addressing the findings from staff survey. Staff told us the service was looking at maternity and neonatal collaborative as part of the QI project.

The substance misuse clinic was run jointly by consultant obstetrician and safeguarding midwife and with links to the community services. There was also a vulnerable women clinic which was run weekly by the safeguarding midwife to support women and offer continuity of midwifery service.

We saw that the trust implemented a carer passport information booklet, which was a scheme for carers who supported vulnerable patients. Staff we spoke to told us that the trust was the first hospital to introduce the carer passport scheme.
The perinatal mental health started in December 2017 and the team included psychiatric nurse, psychologist, psychiatrist, consultant obstetrician, consultant midwife and safeguarding midwife.

The women’s ambulatory day unit (WADU) was open seven days a week. It had scanning facilities on site and we noted the service was the only hospital in the region whose WADU opened seven days a week.

There was a website translation icon on the trust website which could translate vital information on the website to 11 languages such as Chinese, Turkish, Japanese and German.
Facts and data about this service

The trust has 52 inpatient paediatric beds located across three wards.

(Source: Routine Trust Provider Information Request (RPIR) – Sites)

The trust had 11,195 spells from December 2016 to November 2017.

Emergency spells accounted for 73% (8,193 spells), 26% (2,925 spells) were day case spells, and the remaining 1% (77 spells) were elective.

We spoke with 41 members of staff including nurses, doctors, health care assistants and administrative staff. We spoke with 23 parents/guardians and children across the different areas of the service.

Percentage of spells in children’s services by type of appointment and site, from December 2016 to November 2017, North Middlesex University Hospital NHS Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Middlesex Hospital</td>
<td>11,194</td>
</tr>
<tr>
<td>This trust</td>
<td>11,195</td>
</tr>
<tr>
<td>England total</td>
<td>1,099,209</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to February 2018 for nursing staff in children’s services is shown below:
<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>79</td>
<td>72</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>79</td>
<td>70</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>79</td>
<td>68</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>79</td>
<td>62</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>45</td>
<td>31</td>
<td>69%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>79</td>
<td>43</td>
<td>54%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff in services for children and young people was 78% which did not meet the trust target of 90%. At the time of inspection, data provided by the trust showed that the compliance rate for mandatory training had improved slightly. It was 80% for Rainbow ward nurses, and 88% for Starlight Ward and Sunrise Neonatal unit nurses.

During inspection managers told us that mandatory training was a key priority for improvement within the division. The clinical director told us they had some issues with oversight of mandatory training rates due to problems with the system they were using. Managers told us that the mandatory training compliance was a risk for the service.

During our last inspection data provided by the trust showed 70.9% of the paediatric staff had completed paediatric intermediate life support (PILS) training against the trust target of 90%, and only 44.4% of nursing staff on Rainbow ward had completed this. The clinical director told us that PILS training was still an issue for nursing staff and they were still not meeting the target. Data provided by the trust showed that Rainbow Ward and paediatric junior medical staff were still not meeting the target, with 72% and 73% compliance respectively.

The neonatal mandatory training compliance rate was 89% overall. This was almost in line with the trust target. Mandatory training for neonatal staff included newborn life support training (NLS).

There was a structured induction programme for new staff. One member of staff who had started in their role two months before the inspection said they thought the induction was good.

The clinical director told us that all middle grade doctors and consultants were trained in advanced paediatric life support. We were told that the service aimed to have all anaesthetists in advanced paediatric life support (APLS) trained by August 2018. The consultant urologist who operated on children was Basic Life Support (BLS) trained.

**Safeguarding**

The safeguarding team for the women and children’s division was made up of a safeguarding lead (a consultant paediatrician), a named nurse and a named midwife. They were supported by two safeguarding advisers, one of whom was a midwife and the other a paediatric nurse. The paediatric safeguarding adviser dealt with safeguarding cases relating to both adults and children. There were vacant positions for two administrators to support the team and recruitment was currently in progress.

A quarterly child safeguarding meeting was held which was attended by a representative from social services. Children safeguarding information was cascaded up to the board through governance meetings, which included the director of nursing and the deputy director of nursing. At board level, the team was represented by the director of nursing or the deputy director of nursing.
The team worked closely with social services. The deputy director of nursing represented the trust at multiagency safeguarding meetings.

There was an advice line and there was always someone available by phone or bleep. Multiple contact numbers were on display on notice boards. Out of hours, safeguarding referrals went through to the on-call consultants (up to 22.00 hrs) or through the paediatric registrars on duty.

The safeguarding team provided mandatory safeguarding training for all staff. All new staff attended a day of safeguarding training as part of the induction programme. All other clinical staff, including junior doctors, nurses, healthcare assistants and students, attended a half day safeguarding level 2 training. All nurses working with children undertook a whole day of safeguarding level 3 training. One nurse commented that the level 3 training they attended was “good and very interactive” with a range of professionals, and good practice was shared. The safeguarding lead told us the in-house training was based on guidelines issued by the British Association for the Study and Prevention of Child Abuse and Neglect. Staff told us the training included child sexual exploitation, gangs and female genital mutilation (FGM).

Staff demonstrated a good understanding of safeguarding procedures and told us they were well supported by the trust’s safeguarding team.

Staff told us that children with safeguarding concerns notes were kept in yellow folders so that they were easily identifiable.

Staff told us they frequently saw children under 16 who were pregnant, and that they were always referred to the safeguarding team.

The safeguarding lead told us they sat on a child sexual exploitation subgroup with the local authority. As part of the bi-borough initiative there were two youth workers (crime officers) based at the hospital and they worked with young people who were in gangs. This was because of the rise in the number of gang stabbings in the area.

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2016 to March 2017 for nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>79</td>
<td>71</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff in services for children and young people was 90%, which meets the trust target of 90%.

The completion rate for safeguarding level 2 was 94% for junior medical staff and 100% for paediatric senior medical staff.

Cleanliness, infection control and hygiene
Cleaning was undertaken by an external company. Staff told us they had regular morning and evening cleaners which they said was good as they knew the wards. Staff said they were happy with the standard of cleaning. At the time of inspection, the wards appeared clean and the environment was tidy and uncluttered.

In Starlight Ward we saw the domestic cleaner cleaning the waiting room, which was also a playroom for children. We were told there was a cleaner on site from 7am to 7pm. Outside these hours, there was an on-call team available.
A member of staff confirmed that the toys in the waiting areas were cleaned every night by designated night staff.

Hand washing facilities and sanitising gel were available throughout the paediatric and neonatal departments, including in corridors, by ward entrances and in clinical areas. There was prominent signage reminding people of the importance of hand washing.

Staff wore appropriate personal protective equipment. Staff wore aprons and gloves before giving personal care to patients and these were changed in-between patients. We observed staff washing their hands before attending to patients. All staff we saw were ‘arms bare below the elbow’ in clinical areas, in line with national guidance.

We noted the hand hygiene audit in the neonatal unit for February 2018 was 95% and this was displayed on the noticeboard. In the neonatal unit we saw the result of the cleaning audit for April 2018 was 100% and was displayed on a notice board. The display boards in the unit had key infection prevention and control messages. Colour-coded cleaning equipment was used for different areas, such as the toilets and kitchen.

Nursing staff cleaned and maintained specialised clinical equipment, such as the resuscitaire, the baby ventilator and incubator. The trolleys for various procedures were visibly clean and were labelled appropriately to indicate if they had been cleaned.

In the CQC Children and Young People’s Survey 2016, the trust scored 7.89 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was worse than other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Environment and equipment
In our last inspection we found that a resuscitation grab bag was missing vital equipment and there was no difficult airway box on the neonatal unit. The service now had these in place and it was trust policy to conduct daily checks twice. The clinical director told us that the paediatric service did regular simulations and had found that the checks were not always being completed properly so had started doing the checks weekly.

Rainbow Ward had seven single rooms, three double rooms, and three four-bedded bays. Staff told us there were capacity issues with the high dependency unit (HDU) which was located on Rainbow ward. They also said there were bays with two beds in that were used for infectious patients, but this then meant that only one patient could be in the bay. Two of the side rooms were reserved for oncology patients and were equipped with ensuite facilities.

Starlight Ward had five ensuite cubicles used as isolation rooms and for children under six months old. In addition, there were two bays each with two beds and a shower room with toilet facilities. Three of these beds were allocated for day surgery patients.

The door to Rainbow ward was meant to be secure but did not always close properly, which meant that anyone could enter the ward.

The entrance to the neonatal unit had CCTV in operation and the main entrance door was locked at all times. The unit required visitors to communicate with clinical staff over an intercom before gaining entry. From 8.30am to 4.30pm, there was a ward clerk by the reception desk at the main entrance to the unit. The administrator ensured visitors’ identification was verified before they were directed to the neonatal ward.
The theatre recovery was a combined adult and child recovery area. However, there was an allocated bed space for children which was out of sight of the adult area and separated by a curtain.

In Rainbow ward, all equipment was regularly serviced. The date of the service and the due date for the next service were clearly labelled on the equipment. For example, the weighing scale was last serviced on 28 November 2017 and was due for its next service in November 2018.

The housekeeper in Rainbow ward regularly checked all equipment, including monitors and infusion pumps and consumables such as saline solutions, needles, syringes and nasogastric tubes, to ensure they were in date. They also checked to ensure all consumables, including hand gels, disposable gloves and aprons, were in constant supply.

On the day of the inspection, servicing of clinical equipment was up to date. A number of items of older equipment, such as the continuous positive airway pressure (CPAP) machine were due to be replaced. Staff said 15 new syringe infusion pumps had been delivered to the ward. The old infusion pumps were still in use until they were ready to be replaced.

Staff said the Medical Physics Team promptly handled the repair of equipment. The hospital had an equipment library where spare equipment was kept. Staff could access the library for spare equipment, such as a monitoring machine.

The neonatal unit was spacious and uncluttered. All equipment was in good working order. Each item of equipment had been cleaned, clearly labelled with the date and time of cleaning and had been covered for cleanliness. The equipment was placed in a spacious room and organised efficiently for easy access. In the storage room, all consumables were alphabetically coded and kept in storage units, with prices on display so that staff were aware of costs.

Clinical equipment, such as the cardiac monitors, incubators and the resuscitaire and baby ventilator were serviced and in date. They were checked daily and there were no gaps in the checklist.

Since the last CQC inspection, the t-piece resuscitation device was used for the newborn (instead of ambu bags) in the intensive care unit, and one was available by each cot.

The neonatal unit had two full time housekeepers (band 2). They worked Monday to Saturday and their responsibilities included stocking up consumables such as syringes and needles, nasogastric tubes and disposable gloves and cleaning equipment. They also checked that all clinical equipment had been serviced and was in date.

The fracture clinic where children were seen had a small waiting area with a section for children, where there were toys.

**Assessing and responding to patient risk**

The paediatric service used the paediatric early warning score (PEWS) tool to monitor patients and detect signs of deterioration. PEWS were designed to help health care professionals to recognise ‘at risk’ children and to trigger early referral to medical staff, so that early intervention could be implemented to prevent deterioration. Staff used the situation, background, assessment, recommendation (SBAR) tool for handovers.

There was not always an adequate number of nurses on shift who were trained in advanced paediatric life support (APLS). Managers said that ideally there was always one member of staff on shift within the whole service who was APLS trained, but that this was not part of a rota and so was not always the case. This was not in line with guidance from the Royal College of Nursing which stated, “At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need.”
The service used a sepsis care bundle for management of patients with confirmed or suspected sepsis.

The service used the London Neonatal Transfer Service (NTS) or the Children’s Acute Transport Service (CATS) to initiate a retrieval for babies or children requiring intensive care.

There was no neonatal early warning tool in use to detect deterioration of a newborn baby’s condition. Instead, staff carried out frequent monitoring of a newborn baby’s condition and charted the results, looking for signs of deterioration. We spoke with two neonatal nurses in the intensive care unit. They were able to recognise when a patient’s condition had deteriorated and understood when to follow the escalation process.

Staff told us that there were issues with security staff responding to requests for assistance, and it often took four or five bleeps for them to come to the ward. Staff said they had had to call the police on several occasions where they had to deal with aggressive patients.

Children presenting with mental health conditions were risk assessed on their safety to see if a registered RMN was required, and support was also provided by HCAs and play specialists. Managers said they had seen an increase in the admission of children requiring mental health care. They said staff coped well with the challenges this presented. They told us they were planning to organise an in-house training day on mental health.

We attended a doctors’ huddle on the neonatal unit, which took place three times a day. Those in attendance included the shift co-ordinator, the consultant, five doctors and a neonatal outreach nurse. The team discussed staffing, patient safety, discharges, potential admissions and a safeguarding referral.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.43 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.69 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>7.89</td>
<td>Worse than other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>20</td>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.43</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>36</td>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.69</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Nurse staffing

The trust has reported their nursing staffing numbers below as at January 2018:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Young People</td>
<td>178.99</td>
<td>144.45</td>
<td>81%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Staff told us that covering other departments was a problem, for example, ward managers and nurses having to move between Rainbow and Starlight wards. To address staffing problems, the service had started a rotation system for new nurses, where they spent 6 months each in the paediatric emergency department, the neonatal ward, Starlight and Rainbow wards and paediatric outpatients. Managers told us this had been successful and all the nurses in the first round had stayed on in permanent positions. There were 12 more nurses due to start in September 2018. On the day of our inspection one nurse had been moved from Rainbow Ward to the paediatric day assessment unit due to short-staffing there.

The ward nurse in charge was supernumerary. There was a bleep rota for out of hours cover which staff could use to contact a paediatric senior nurse if required.

Staff told us that during winter pressures they had to stop taking admissions at one point due to staffing issues, as they were unable to fill day shifts.

The wards displayed the staffing levels for the day on a notice board. A ward manager told us that Rainbow Ward was well staffed at the time of inspection and only had vacancies for two band 5 and 0.5WTE band 6 nurses. Rainbow Ward had five health care assistants (HCAs). This was the policy since 2017, and staff said it had made a big improvement in the running of the ward.

The neonatal unit employed eight band 7 nurses, who all had lead roles. These included an education lead, a neonatal outreach nurse, and an infection control lead. The planned number of staff was seven on both day and night shifts. On the day of our inspection, the neonatal unit had seven nurses (one band 7, four band 6 and two band 5) on duty. We were told additional nurses were deployed if the neonatal unit had a baby in the isolation room or if the workload was such that Bay 4 was in use.

Staff said that the paediatric outpatient department and paediatric day assessment unit were often understaffed, with just one nurse on shift covering both areas. Cover for breaks had to be provided by nurses from the wards or by the community nurses.

If more staff were needed, the staff could contact the nurse with the bleep-holder role to attend, who would be a senior paediatric nurse. However, the bleep-holder often had other wards to attend to and could not always provide the assistance required.

Staff said that there was often an issue with skill mix as most of the band 6 nurses worked in the day. They said at night there was always a band 6 who could administer intravenous drugs but they had to swap between the wards depending on where they were needed. Staff gave an example of where they had to report a staffing issue related to this in March 2018.

From February 2017 to January 2018, the trust reported a vacancy rate of 18.4% in children’s services. This is higher than the trust target of 7.5%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Managers told us that recruitment was in progress to fill vacancies. There were three band 5 nurses starting work at the end of July and a further four in September 2018. Three candidates were being interviewed for the band 6 posts in May 2018. We were also told that four nursery nurses (band 4) would commence working in the neonatal unit by the end of July 2018.

From February 2017 to January 2018, the trust reported a turnover rate of 24% in children’s services. This is higher than the trust target of 15%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Managers said staff turnover tended to be due to people relocating, and that pay was also an issue as the trust was just outside London, so there was no inner London high cost area allowance (HCAS). They were working on ways to retain staff, including the rotation program described above.

From February 2017 to January 2018, the trust reported a sickness rate of 4.1% in children’s services, higher than the trust’s target rate of 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust has not provided total shifts including those covered by permanent staff. This data will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

The table below shows the numbers of shifts in services for children and young people that were covered by nursing bank and agency staff or left unfilled. This data relates to qualified nurses only.

<table>
<thead>
<tr>
<th>Bank and agency use – qualified nurses</th>
<th>Core Service</th>
<th>Bank</th>
<th>Agency</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Young People</td>
<td>2,383</td>
<td>2,007</td>
<td>588</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Staff told us that there were a higher number of agency staff on night shifts. Managers said they tended to use regular bank and agency staff where possible and that this helped as they knew the department.

Medical staffing

The trust has reported their medical staffing numbers below as at January 2018:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Planned Staffing WTE</th>
<th>Actual Staffing WTE</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Young People</td>
<td>55.82</td>
<td>54.93</td>
<td>98%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Staff told us that they thought there could be more doctors at night. They said doctors often went through the whole night shift without a break. They covered the paediatric ward and the paediatric emergency department (ED), and so in an emergency the needs of the ED would come first. We noted that medical staffing at night was also an issue found during the last inspection.
From February 2017 to January 2018, the trust reported a vacancy rate of 6.3% in children’s services; this is lower than the trust target of 7.5%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From February 2017 to January 2018, the trust reported a turnover rate of 10.6% in children’s services; this is lower than the trust target of 15%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From February 2017 to January 2018, the trust reported a turnover rate of 1.2% in children’s services; this is lower than the trust target of 3.5%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The table below shows the numbers of shifts in services for children and young people that were covered by medical and dental bank and locum staff or left unfilled.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Young People</td>
<td>94</td>
<td>115</td>
<td>196</td>
</tr>
</tbody>
</table>

(Source:Routine Provider Information Request (RPIR) P21 Medical Locums)

In December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the 47 whole time equivalent staff working in children’s services at North Middlesex University Hospital NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>38%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>56%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

We found that there were issues with the quality of documentation in the paediatric wards. The divisional audit log included details of the 2017 paediatric records audit and highlighted issues such as the patient’s name not being recorded on each page, NHS numbers being less
frequently used than hospital numbers, and names of staff being illegible. It also stated that block writing meant dates were not recorded for multiple time entry points. The action plan included writing page numbers on each page, providing staff with name stamps and advising locum/agency staff to write their names with a signature in legible hand writing.

We reviewed five sets of records on Rainbow Ward and found that drug charts were all appropriately completed with no omissions noted, nursing entries were completed with date and signature, and PEWS scores were recorded. However, we found safety briefings and risk assessments had not been completed or reviewed consistently.

There were systems to flag on records where a child had particular needs including child protection and is this was widely understood.

We reviewed the records of a young person with a learning disability. We saw that multidisciplinary meetings and best interests assessments had been recorded. We found that all relevant documentation had been completed and there was a hospital passport detailing the specific requirements of the patient.

We reviewed a set of notes for a patient who had undergone day surgery and found documentation had been completed appropriately, including operation notes, recovery notes, consent, anaesthetic records and medication.

We looked at three sets of notes in the paediatric day assessment unit (PDAU). We saw that all relevant documentation was present and completed, including medical history, pain assessments and medication. The records were mainly electronic, with a paper record for observations and admission information.

We checked five sets of medical notes on the neonatal unit. They were in booklet form and all clinical professionals documented their reviews of each patient. We saw the handwritten notes from doctors, nurses, the dietician, allied healthcare staff and other professionals. They were filed in the case notes folder and kept in a locked cabinet when not in use.

We looked at five sets of neonatal nursing observation records in the intensive care and high dependency unit. These were recorded throughout the 24-hour day and included equipment checks, plans of patient care, evaluation records, observation charts, apnoea and bradycardia, pain score, tissue viability, fluids and nutrition and charts of intakes and outputs. All the handwritten notes were in black ink and were legible, signed and dated.

On Rainbow Ward we saw that observation charts were not kept by the child’s bed but in the nursing station. This presented a potential risk in the event of sudden deterioration. There was also nowhere showing the child’s name around the bed space.

**Medicines**

At the last inspection, we found that the trust needed to improve drug refrigerator temperature monitoring and ensure medication was safely stored. Medication fridge temperatures were now part of the ‘perfect ward’ audit, and were checked weekly as part of the environmental audit. A senior member of staff told us there had been instances where the temperature was documented as too high but that this had been followed up with ward managers to ensure they were dealing with the issue. A nurse in the neonatal ward told us they would escalate to the nurse in charge and to the pharmacist if any fridge temperature was incorrect or if the fridge was faulty.

We saw that medicines were stored in lockable drug cupboards. All controlled drugs were stored in a separate controlled drug cupboard. We observed the storage fridges were locked when not in use. This had ensured the safe storage of all medicines.
We checked a sample of two of the controlled drugs in use on Rainbow Ward and found the drugs in stock balanced the recorded balance in the inpatient controlled drug register. The entries in the register were clear and signed by two registered nurses on each occasion.

We observed two nurses checking the drugs for intravenous infusion for patients who needed them. On each occasion, we saw that both nurses signed the drug chart accordingly, prior to one of the nurses administering the drug through the infusion pump.

We were told a pharmacist visited the ward every morning to review each patient’s prescription charts. During inspection, we saw that the pharmacist checked the prescribing charts and checked medicine management to confirm medication reconciliation had been done and was correct.

We checked a sample of three prescription charts on the neonatal unit for the name, date of birth and weight of the baby, the case number, the consultant, the drugs and whether oxygen was prescribed. The details were completed and double signed and the drugs had been prescribed correctly.

The pharmacist conducted monthly audits on all drugs in stock. The audit involved checking if each drug was in date and was not overstocked, that controlled drugs were reconciled and that the drug cupboards were kept locked at all times when not in use. In the pharmacy audits in February and March 2018, the action plan had emphasised encouraging staff to store each patient’s own prescribed drugs in the patient’s own drugs storage facility in Rainbow ward instead of keeping them in the general stock cupboard.

We were told any prescribing errors by doctors would be picked up during the pharmacist’s daily checks and such errors were reported using a system accessible by pharmacists and consultants. The designated paediatric consultant would raise the issue with the doctor concerned. Medicine errors were also reported through the trust incident reporting system.

There were three reported medications errors in the last 12 months. They were reported on the trust’s incident reporting system and investigated. Senior staff told us that they had introduced a penalty system as a result of the errors. If staff made three errors their competency was taken away and they had to undergo retraining.

**Incidents**

We viewed the incident log and saw that 133 incidents had been reported from October 2017 to April 2018. Of these, three were rated at the highest severity level. Incidents relating to paediatric surgery were reported under the surgery division.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported no incidents classified as never events for children’s’ services.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England from March 2017 to February 2018.

These incidents were:

- One slips/trips/falls meeting SI criteria
• One sub-optimal care of the deteriorating patient meeting SI criteria
• One disruptive/aggressive/violent behaviour meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with knew how to report incidents, which was done via the trust-wide electronic reporting system. Some commented that they thought incidents might not always be recorded consistently due to time constraints. Doctors said they reported incidents and received feedback, including learning and actions.

Incidents were discussed in the morning ward meetings. Staff gave an example of a change because of an incident, where the bathrooms on the ward had been made ligature-safe. Another example of learning from an incident involved an inpatient who was awaiting child and adolescent mental health services (CAMHS) transfer. Staff told us that one of the lessons from the incident was the need to have the confidence to escalate concerns. However, some staff commented that they did not always receive feedback or lessons learned about incidents they had reported.

In the neonatal unit, we saw evidence of lessons learned when babies had been given the wrong expressed milk. As a result, changes in storage and nursing practice had been made. All expressed breast milk was now stored in a lockable fridge and the containers were clearly labelled for each baby. Two members of staff were required to check and sign the log book before the milk was given to each baby. This had ensured the correct mother’s milk was given to each baby.

A hospital-wide incident review meeting was held daily and was led by the director of nursing or the medical director and attended by matrons from all clinical divisions.

The service held mortality and morbidity meetings in paediatrics and held joint ones with the neonatal and maternity units and with the emergency department.

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 to provide reasonable support to that person. Staff were aware of the duty of candour policy. Staff we spoke with gave an example in which parents had been notified when a medication error occurred and were kept informed at various stages of an incident investigation. A ward manager said that, following a medication error, a meeting had been held with the child’s mother to discuss the outcome of the investigation.

Mandatory training on the duty of candour was delivered as part of risk and safety training in the trust induction and in the annual refresher training for all staff.

Safety Thermometer
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

The trust told us they did not use a safety thermometer in services for children and young people.

Is the service effective?

Evidence-based care and treatment
In Rainbow ward, a ward manager was assigned to review all paediatric clinical guidance policies to ensure they were up to date with national guidelines, such as those from the National Institute for Clinical Excellence and Health (NICE). For example, the high dependency unit (HDU) clinical
guidance policy had been rectified and had been made available for all staff to access on the intranet since December 2017. The Nasal Gastric and Nasal Jejunal policy was completed recently and was waiting to be approved by the trust.

During the last inspection, we identified that 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. The clinical director told us that the previous head of nursing had undertaken an informal version of the audit and found that many of the criteria had not been met, such as the provision of information for young people.

The service participated in local and national audits, including the National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12), the National Paediatric Diabetes Audit (NPDA) and the National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP).

The trust did not provide Mental Health Act (MHA) training to its staff as a separate module and staff told us that they had not received MHA training. Staff we spoke with told us that they were frustrated by their lack of knowledge around the MHA because they often had to care for patients who had mental illness.

**Nutrition and hydration**

Age appropriate nutrition was provided. Staff told us they recently changed the menu as a result of patient feedback, and that they now had a simpler menu to cater for children’s preferences.

Meals were available to cater for religious and cultural requirements, and for children with food allergies. Staff said that when children had more specialist requirements they sometimes had to ask parents to bring something in, at least temporarily until the hospital could organise appropriate food to accommodate their needs.

Staff said there was good input from the ward based dietician, who also attended the doctors’ handovers in the mornings.

The neonatal unit had a locum paediatric dietician who was on site Monday to Friday from 8.30am to 4.30pm. The dietician regularly reviewed each baby’s nutritional and hydration needs, according to need. The feeding regime was in accordance with guidelines from the European Society for Parenteral Nutrition and Gastroenterology, Hepatology and Nutrition for neonates (ESPGHAN). The nurses followed the dietician’s recommendations. This had ensured all babies in the neonatal unit had adequate nutrition and hydration.

In the neonatal intensive care unit, newborn babies who were on ventilation were given feeds when their condition became stable. Each baby was given a strict feeding regime. Milk feeds commenced when the mother had made her choice either to use breast milk or artificial milk.

There were three fridges and a freezer used for the storage of expressed breast milk (EBM). Only staff could access these fridges. The fridge temperature was checked twice daily by the nurse in charge. We checked the log book for fridge temperatures and found no gaps in the recording. The EBM administration check form was kept at the cot side and two nurses were required to check and sign the form before giving EBM to the baby. We saw that this procedure was followed.

A parent commented that food and drinks were available for breast feeding mothers.

Breast feeding was promoted in the neonatal unit, which had achieved Stage 2 UNICEF
accreditation. Stage 2 accreditation was achieved when a service demonstrated that all staff had been educated according to their role, and the training had prepared staff to care for mothers and babies effectively.

**Pain relief**
The neonatal infant pain scale (NIPS) was used to assess pain in the newborn. This was following the recognition in a ‘perfect ward’ audit in 2017 that no standard pain assessment tool was being used. We saw that the neonates’ pain assessments were recorded on the observation charts.

We saw that pain assessments were completed in the records we reviewed. The service used the smiley faces universal pain assessment tool, where children were asked to point to the faces to help indicate their level of pain.

The pain management guidelines included guidance on pain scoring and prescribing of analgesics for children of different age ranges. It included MHRA guidance, for example codeine related products not being suitable for patients who undergo adenoidectomy and/or tonsillectomy for obstructive sleep apnoea. We saw that the guidance was due for review in 2021.

**Patient outcomes**
The neonatal unit was involved in the baby friendly breastfeeding support audit, which was part of the neonatal national audit programme (NNAP). The result for 30 April 2018 for babies less than 33 weeks showed that, of 7 babies discharged, 5 were on mother’s milk. 71.4% of discharged babies were on expressed mothers’ milk and 57.1% of mothers were breastfeeding.

‘Perfect Ward’ Audits based on five specified ‘domains’ were carried out regularly. We saw the results of the local audits that were completed in April 2018 for Rainbow ward. The results were broken down into the five domains - clinical patients (92%), clinical records (84%), clinical staff (88%), environmental observation (94%) and infection prevention and control (not recorded).

In the neonatal unit, the results of the “Perfect Ward Audits” for April 2018 were broken down into five domains, namely, clinical patients (92%), clinical records (96%), clinical staff (100%), environmental observation (70%) and infection prevention and control (95%)

The National paediatric diabetes audit 2015/16 showed the percentage of crude proportion of patients receiving all key care processes annually at the trust was 11.8%, which was a negative outlier. The national aggregate was 35.5%. The figure in the 2014/15 report was 40%.

This indicated that patients living with diabetes were receiving appreciably worse treatment than average.

The trust’s performance in the standard ‘Blood glucose diabetes control (HbA1c): Organisation compared with nationally: Case-mix adjusted mean HbA1c (mmol/mol)’ was 66.9, which was within the expected range. The national aggregate was 68.3. The figure in the 2014/15 report was also within the expected range.

The trust’s performance in the standard ‘Organisational performance compared between years: Median HbA1c (mmol/mol)’ was 63, which was a clinically significant improvement. The national aggregate was 65. The figure in the 2014/15 report was 70.5.

*(Source: National Paediatric Diabetes Audit 2015/16)*

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.
The data shows that from September 2016 to August 2017 in the paediatrics speciality there was a lower percentage of under ones readmitted following an elective admission compared to the England average and a lower percentage of patients aged 1-17 years old readmitted following an elective admission compared to the England average.

### Emergency readmissions within two days of discharge following elective admission among the under 1 age group, by treatment speciality (September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Middlesex University Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>0.7%</td>
<td>1,205</td>
</tr>
</tbody>
</table>

### Emergency readmissions within two days of discharge following elective admission among the 1-17 age group, by treatment speciality (September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Middlesex University Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>0.5%</td>
<td>1,230</td>
</tr>
</tbody>
</table>

The data shows that from September 2016 to August 2017 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average and lower percentages of patients aged 1-17 years old readmitted following an emergency admission in both paediatrics and general surgery compared to the England averages.

### Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment speciality (September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Middlesex University Hospital NHS Trust</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
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</tr>
<tr>
<td>Paediatrics</td>
<td>2.4%</td>
<td>3,330</td>
</tr>
</tbody>
</table>

### Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment speciality (September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Middlesex University Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.2%</td>
<td>4,828</td>
</tr>
<tr>
<td>General Surgery</td>
<td>3.4%</td>
<td>327</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

The trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and diabetes. The trust performed better than the England average in epilepsy.

### Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>North Middlesex University Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td>18.3%</td>
<td>-</td>
</tr>
</tbody>
</table>
### Diabetes

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
<th>Count</th>
<th>No.</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30.8%</td>
</tr>
<tr>
<td>1-17</td>
<td>18.6%</td>
<td>199</td>
<td>37</td>
<td>16.4%</td>
</tr>
</tbody>
</table>

### Epilepsy

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
<th>Count</th>
<th>No.</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>31.1%</td>
</tr>
<tr>
<td>1-17</td>
<td>22.6%</td>
<td>53</td>
<td>12</td>
<td>27.9%</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

In the 2017 National Neonatal Audit the trust’s performance was as follows:

#### Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5°C and 37.5°C

The trust’s performance was 60.9% which was within the expected range; the national aggregate was 61%.

The trust did not meet the audit’s recommended standard of 90% for this measure.

#### Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission

The trust’s performance was 90.9%, which was within the expected range. The national aggregate was 90.5%.

The trust did not meet the audit’s recommended standard of 100% for this measure.

#### Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity

The trust’s performance was 96.8% which was within the expected range; the national aggregate was 94.2%.

The trust did not meet the audit’s recommended standard of 100% for this measure.

#### Babies with gestation at birth <30 weeks who had received documented follow-up at two years gestationally corrected age

The trust’s performance was 29.6%, which was worse than expected. The national aggregate was 61.2%.

The trust did not meet the audit’s recommended standard of 100% for this measure.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Competent staff**

The last inspection found that children’s services failed to meet the play requirements of children as set out by the National Association of Health Play Specialists. The service now had one qualified play specialist and two play leaders, and were recruiting for a third. Managers said they found this was a more robust team than previously and that they aimed to get the play leaders to become qualified play specialists.
At the time of our last inspection, only 56% of the nurses in the neonatal unit were qualified in speciality (QIS), this was less than the 70% recommended by the British Association of Perinatal Medicine (BAPM) guidelines. This had not improved and was 54% at the time of inspection. However, regular experienced bank and agency nurses were used to make up the numbers if required. The matron confirmed most of the permanent staff also worked as bank staff, so the staffing level and skill mix were adequate.

There was a practice development nurse (PDN) who covered all paediatric services, and another for the neonatal department. They had been working to raise the profile of children’s services within the trust, make links with other departments and improve training opportunities for staff, for example a recent cannulation study day (focussed on children) at another hospital run by a trust that NMUH has clinical practice group partnerships with. Staff commented that opportunities for training and development had improved since the PDN started.

The neonatal unit had an education lead (a band 7 nurse) who liaised with the trust education team for mentorship and newborn life support training. They review guidelines, staff competencies, staff training and organised equipment training for staff. This ensured staff maintained their competencies in clinical practice.

Staff told us that the system of rotation between children’s departments (including neonatal) for new nurses worked well. It meant they learned a wide range of skills and could provide support to different departments as needed.

It was not clear that there were adequate HDU trained staff on Rainbow Ward. A ward manager told us four nurses had completed HDU training and that two were currently on the course.

On the day of inspection, five of the seven nurses in the neonatal unit had qualifications in speciality (QIS) in neonatal nursing.

From February 2017 to January 2018, 85% of staff within children’s services at the trust had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of individuals required</th>
<th>Number completed</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>17</td>
<td>16</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>149</td>
<td>127</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Senior staff told us the appraisal rate on Rainbow ward was at 50%, and that this low rate was due to recent staff sicknesses. The neonatal appraisal rate was 100% at the time of inspection.

**Multidisciplinary working**

The service held regular complex care meetings, which included discussions on the transition of patients from children to adult services. Some staff commented that they felt some children were not appropriate to be treated as adults, such as complex sickle cell and oncology patients, but that the trust would not do anything to change this.

There were good transition pathways for young people within some of the outpatient clinics, including sickle cell, diabetes and haematology.
The service had one play specialist and two play leaders. They covered the children’s emergency department, children’s wards, the paediatric assessment unit, outpatients and the paediatric day assessment unit. There was also a teacher who worked Monday to Friday 9am to 12pm. The play specialist attended handover every morning and planned the day’s programme according to the workload that day, such as assisting children with special needs and offering support to anxious children waiting for surgery.

We found there was good internal multidisciplinary team (MDT) working between the neonatal unit and the maternity service, the community team, the pharmacists and other professionals. There was an MDT ward round every Wednesday at 2pm. The consultant of the day, doctors, lead nurse, allied healthcare professionals, speech and language therapist, dietician, community outreach nurse and other relevant professionals attended. The team discussed chronic issues affecting patients, including the feeding regime, longer term medication and discharges. There was good external MDT working with other trust hospitals, the North Central London network, the Neonatal Transfer Service (NTS) and others.

A parent whose baby was transferred to the neonatal unit from another hospital commented there had been good communication between the two hospitals.

The community neonatal outreach nurse worked 0.8 WTE in the community and 0.2 WTE in the neonatal unit. The outreach nurse attended the handover every morning at 7.30am and also the doctors’ huddle. They also attended the ward round and MDT meetings on Wednesdays.

The outreach nurse also attended discharge planning meetings. This ensured continuity of care in the community for babies discharged into the care of the outreach nurse, who would have met the parents and knew the progress of the baby before discharge.

In the CQC Children and Young People’s Survey 2016, the trust scored 8.17 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Seven-day services
The play specialist and play leaders were only available on weekdays from 8am to 4pm, and not at weekends. This was the same finding as our previous inspection.

There were no paediatric outpatient clinics at the weekends. Only the HIV clinic offered early and late weekday appointments, so that schoolchildren could attend before or after school.

There were psychological support services for children during the working week but not at weekends.

Health Promotion
Staff told us the ward-based dietician was involved in health promotion. The neonatal unit promoted breast feeding. The unit had achieved UNICEF Baby Friendly Accreditation Stage 2. This meant the unit was committed to supporting mothers to initiate breastfeeding and encouraged them to exclusively breastfeed for the first six months, while at the same time also supporting parents who chose to bottle-feed.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards
We saw that appropriate consent was gained and that this was recorded in patient records.

We reviewed a set of notes for a patient who had a learning disability and saw that a best interests assessment had been completed and that the form for patients unable to consent had been completed.
The trust has not provided any Mental Capacity Act training completion data for medical or nursing staff in children’s services. This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust performed about the same as other trusts for three questions relating to effectiveness in the CQC Children and Young People’s Survey 2016, worse than other trusts for two questions, with one question having no score.

CQC Children’s Survey questions, effective domain, North Middlesex University Hospital NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>7.82</td>
<td>About the same as other trusts</td>
<td>E3</td>
</tr>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>7.01</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.02</td>
<td>Worse than other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>23</td>
<td>Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.17</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>33</td>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>5.97</td>
<td>Worse than other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>54</td>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP</td>
<td>No Score</td>
<td>No Score</td>
<td>E4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service caring?

Compassionate care

In April 2018, the friends and family test showed 91.7% of parents would recommend the neonatal service to their relatives and friends.

Four parents said the doctors and nurses were very good in caring for their baby. One of the parents said that the doctor (a paediatrician) was in the ward every day to check their baby (in the intensive care unit) and added that the doctor was courteous and respectful to parents. A baby’s father said both doctors and nurses had provided perfect care and added that they provided 100% excellent care. Both parents said they would recommend the service to their relatives. One parent said the care was “fantastic” and that communication with staff was very good.

There was positive feedback written by children alongside drawings on a board in Rainbow Ward. Comments included “Nice nurses and doctors” and “What is really good about this hospital is that they really care about you and that there are some play areas to play in.”
Parents spoke with on Rainbow Ward were mainly positive about the care provided. However, one commented that a small number of staff were not compassionate.

Parents spoke with in the paediatric day assessment unit were positive about the staff and said they were friendly and one commented that the doctors were very kind when they spoke to their child. A parent of a child on Starlight Ward commented that they felt the care was very good. Another whose child was having day surgery stated that staff were “excellent”. A parent of a child being seen in paediatric outpatients said the doctor they saw was “really good… caring and supportive”. Another parent commented that the doctor their child saw was really good, that they had seen the same doctor a couple of times and that they were really happy with the doctor.

The trust performed about the same as other trusts for six questions relating to compassionate care in the CQC Children and Young People’s Survey 2016, and worse than other trusts for four questions.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.26</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>14</td>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.22</td>
<td>Worse than other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>22</td>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.32</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>42</td>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>8.36</td>
<td>Worse than other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>43</td>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>8.36</td>
<td>Worse than other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>44</td>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>7.33</td>
<td>Worse than other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>58</td>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>5.93</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>64</td>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>7.95</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>74</td>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 CYP</td>
<td>9.05</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>75</td>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 CYP</td>
<td>8.43</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

There were a range of clinical nurse specialists in post and psychological support services for children were available during the week to respond to the emotional needs of children with mental health conditions.

Parents spoke with on the neonatal unit commented that staff attitudes were excellent and that they felt well supported. Staff showed respect and dignity to parents. One parent said that the neonatal unit allows parents and grandparents to visit their baby at any time without restrictions, except during ward rounds.
We observed the staff interaction with parents and noted that staff were understanding and compassionate.

There was a weekly neonatal parent support group which was attended by the neonatal outreach nurse.

The trust performed worse than other trusts for four questions and about the same as other trusts for the remaining question relating to emotional support in the CQC Children and Young People’s Survey 2016.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>8.41</td>
<td>Worse than other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>29</td>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>7.85</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>45</td>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>8.65</td>
<td>Worse than other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>65</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>8.10</td>
<td>Worse than other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>67</td>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>7.57</td>
<td>Worse than other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them
Parents we spoke with on the neonatal unit said the staff kept them informed and explained the procedures before providing care and treatment for their baby. There were four ensuite bedrooms for parents and one of which was used as an isolation room. These rooms could accommodate parents and babies and used prior to the baby being discharged home. Staff supported the parents for a few days in learning how to care for their baby before going home.

Privacy for parents had been maintained in the neonatal ward. During a ward round, all other parents and family members were requested to wait in the parents’ waiting room except for the parents whose baby was being seen by the consultant and their team. This ensured total privacy and confidentiality during discussions with the baby’s parents.

Parents said they knew who to speak to if they had concerns. However, they had not had any concerns.

Parents we spoke with on Rainbow Ward said staff were very polite and didn’t rush them out at the end of visiting times.

Parents we spoke with said they were given information about their child’s condition and what to do if symptoms recurred. Parents of children who had had surgery said they were given instructions on post-operative care, what to look out for and when to bring the child in.

The trust performed worse than other trusts for six questions and about the same as other trusts for 12 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. Three of the questions had no score.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>8.53</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>12</td>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.57</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>8.42</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>15</td>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>7.52</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>16</td>
<td>Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.12</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>17</td>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.12</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>18</td>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>8.60</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>31</td>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.40</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>32</td>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>8.82</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>34</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.38</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>39</td>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>0-15 adults</td>
<td>7.25</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>41</td>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.19</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>59</td>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 CYP</td>
<td>8.40</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 CYP</td>
<td>7.95</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>61</td>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 CYP</td>
<td>9.02</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>62</td>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 CYP</td>
<td>9.57</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>63</td>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 CYP</td>
<td>5.85</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>66</td>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
<td>C2</td>
</tr>
</tbody>
</table>
Before the operations or procedures, did hospital staff explain to you what would be done?

<table>
<thead>
<tr>
<th>CYP</th>
<th>Score</th>
<th>C2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-15</td>
<td>No Score</td>
<td>No Score</td>
</tr>
</tbody>
</table>

Afterwards, did staff explain to you how the operations or procedures had gone?

<table>
<thead>
<tr>
<th>CYP</th>
<th>Score</th>
<th>C2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-15</td>
<td>No Score</td>
<td>No Score</td>
</tr>
</tbody>
</table>

When you left hospital, did you know what was going to happen next with your care?

<table>
<thead>
<tr>
<th>CYP</th>
<th>Score</th>
<th>C2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-15</td>
<td>7.65</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The trust policy for young people age 16 and over was that they were treated as adults. During the last inspection, we found that the trust did not have sufficient oversight of the care and treatment of these young people, particularly in relation to them as inpatients. However, the trust now included the identification of these patients as part of the daily bed meeting, and staff told us that paediatricians and children’s nurses would attend them if required. Staff also told us that the adult wards had new guidance in the form of a poster to ensure that staff knew what to do should they require support from paediatric staff. We noted from the meeting minutes of the children’s board in May 2018 that these were very recent changes.

Staff told us that there were exceptions where patients aged 16 and over might be allowed to stay on the children’s ward, such as if 16-year olds were taking their exams. Some staff also said that consultants were able to use their discretion if they felt a young person should remain under the care of the paediatric team.

Managers told us that the trust had considered having an adolescent ward but found that there was not enough demand to make this an efficient option.

Staff told us they faced challenges in providing care and treatment for children who presented with mental health conditions. There was often a delay in accessing child and adolescent mental health services (CAMHS), particularly at weekends as they only worked 9am-5pm Monday to Friday. Staff said if a child was admitted on a Friday afternoon they would be likely to be there until at least the following Monday. The divisional risk register detailed this risk, stating that “The London Emergency standards state that a child with a psychiatric illness must be reviewed by a CAMHS professional within 12 hours of referral. There was a 9-5 service, 5 days a week. This results in a child waiting from Friday evening to Monday morning for review, putting themselves and other patients and staff at risk. This means that care is suboptimal, bed usage is increased and the chance for useful therapeutic intervention may be lost.”

The trust was working with the local clinical commissioning groups (CCGs) and mental health trust to address the issues. They stated that the risk was mitigated by all children with a mental health problem being seen by a paediatric registrar or consultant within 4 hours of admission and all children being reviewed by a consultant paediatrician within 12 hours of hospital attendance, or within 12 hours of admission to the paediatric unit. All children with mental health problems were to be admitted to the paediatric ward until a CAMHS assessment could take place and, if advice was required in the interim period, their needs were to be discussed with the CAMHS on-call consultant if advice was required in the interim period. There was an on-call rota of child psychiatrists available for telephone consultations.

During our last inspection we found 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. There was now an additional whole time equivalent (WTE)
allergy nurse who had been in post for 6 months in addition to the 0.8 WTE nurse. The service also had two GPs with a special interest (GPSIs) in allergies on the team. However, patients were still experiencing long waits for allergy appointments. The service had worked with a local CCG to get funding for the allergy nurse and was doing the same with two CCGs to look at additional funding for asthma nurses.

The trust had a community children’s nursing team. This included clinical nurse specialists - four for diabetes, two for sickle cell, one for HIV, two for allergies, one for asthma and one for epilepsy. They undertook home visits and school visits and held community outreach clinics. The community nurses had strong links with the paediatric consultants and many also held joint clinics and nurse-led clinics at the hospital.

The trust performed better than other trusts for one question, worse than other trusts for two questions and about the same as other trusts for the remaining 14 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.90</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>5</td>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child’s physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.26</td>
<td>Worse than other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>25</td>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>7.36</td>
<td>Worse than other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>26</td>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>3.32</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>28</td>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.19</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>55</td>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>9.32</td>
<td>Better than other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>6.91</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>24</td>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>4.87</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>37</td>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.00</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>38</td>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>7.84</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>40</td>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>6.93</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>56</td>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>6.21</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
</tbody>
</table>
57 | Did you like the hospital food? | 8-15 CYP | 5.73 | About the same as other trusts | R2
71 | Did a member of staff tell you who to talk to if you were worried about anything when you got home? | 8-15 CYP | 6.62 | About the same as other trusts | R2
73 | Did a member of staff give you advice on how to look after yourself after you went home? | 8-15 CYP | 7.99 | About the same as other trusts | R2
2 | Did the hospital give you a choice of admission dates? | 0-7 adults | 5.40 | About the same as other trusts | R3
3 | Did the hospital change your child’s admission date at all? | 0-7 adults | 8.09 | About the same as other trusts | R3

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Meeting people’s individual needs
Ward managers said they tried to group patients by ages. They said they were normally able to do this but sometimes it was not possible.

There was no learning disability lead nurse for paediatrics, however, the trust adult learning disability nurse provided advice and support for young people with a learning disability when required. Staff told us patients with a learning disability had an “all about me” poster above their bed with information on their specific personal requirements and preferences.

We reviewed the records of a young person with a learning disability who was on an adult ward. We saw that the learning disability nurse was involved in the patient’s care. We also saw that there was information on how to communicate with the patient.

Young people who were pregnant were seen by the maternity team. Staff said that they might be admitted to the paediatric ward if it was appropriate for the individual patient.

The service provided retinopathy of prematurity screening to babies born prematurely. Babies who required treatment would be referred to another London hospital and the follow-up treatment would be in the neonatal unit as a ward attender.

Babies with complex needs received a paediatric passport in case of readmission. The doctor working in the paediatric assessment unit was informed when the child presented at the accident/emergency department. We were shown a green passport for a baby.

Babies born at less than 30 weeks gestation were seen by a consultant specialising in neuro-development. Subsequent follow-up meetings took place at 6-8 weeks, four months, 12 months and two years post discharge. This was in line with the neonatal audit programme (NNAP) standard. However, the 2017 audit showed that the trust performed significantly lower than the national average for the two years follow up.

The community neonatal outreach nurse supported mothers whose baby had been born prematurely or at under 30 weeks gestation, as well as babies with complex needs or requiring oxygen and feeds through a nasogastric tube. The outreach nurse visited these babies until they were six months old. The outreach nurse also visited any baby referred by the medical team and any baby requiring a blood test. They were able to order oxygen for the baby at home if required.

The service had access to interpreters, including the three permanent, trust employed Turkish interpreters.
There were televisions available on the ward but some parents commented that they were out of reach and there was no remote control.

Nursing staff did not all have visible name badges on.

The lift to access the ward had a voice announcer, Braille and was tactile for those who are visually impaired. The wards were also bright which can aid children who are visually impaired. The corridor had guard rails so children could hold on or pull themselves along if they were in a wheelchair.

**Access and flow**

The service had a high number of patients who required follow up appointments in paediatrics but who had been placed “on hold” because there was no clinic capacity in which to see them. This was on the divisional risk register which detailed that there were 287 patients “on hold”. The largest cohort was endocrinology patients (150) “where patients often cannot be discharged before being transferred to adult services. Numbers have recently increased due to the departure of a locum endocrinologist from whom additional follow ups requirements were generated”. The next largest cohort was allergy with 100 patients. The trust had recently employed an additional allergy nurse and had two extra GPSIs to help reduce this. Senior leaders told us they were mitigating risk as consultants were reviewing their ‘on hold lists’ and ensuring that patients were prioritised accordingly. They said patients also had consultants’ email addresses and secretaries’ phone numbers if they needed to contact them urgently. Additionally, staff were calling allergy patients a week ahead of their appointment in addition to the text message reminders to minimise did not attend (DNA) rates.

The trust provided us with ‘referral to treatment’ (RTT) information for April 2017 to March 2018. This showed that most patients were being seen within the 18-week national standard. Over the 12-month period, 97% of patients had been treated within 18 weeks of referral.

The service manager told us that the DNA rate for children’s outpatients was high compared to the national level. It was 17.8% at the time of inspection. They said it was particularly high for new patients, and that part of it was due to the transient population, and that patients had to wait a long time for their first appointment. They tried to address this with additional registrar clinics. The service manager told us that part of the problem was that referrals for children’s services were handled centrally by the trust, and that a lot of delays could be avoided if it was managed locally due to the nature of the subspecialist clinics. They said the trust had an outpatient improvement team who was going to visit another trust to see how they had changed their referral system by making it locally managed and had significantly reduced waiting times as a result.

There were issues with capacity in the paediatric outpatient department. Managers told us they did not have enough space to accommodate all the doctors. However, there were also times when several rooms were not in use, such as Friday afternoons. They said this was due to the consultants preferring certain days and times for their clinics.

The short stay unit, Starlight Ward, was for stays of up to 48 hours. Rainbow Ward was used for patients requiring longer-term admission. Rainbow Ward had a fast track pathway for certain patients, including oncology and sickle cell patients. This allowed them to be admitted directly to the ward rather than going through the paediatric emergency department and/or the paediatric assessment unit.

Whilst the service did not routinely admit young people aged 16 and over, staff told us that Rainbow ward took two young people age 16-17 in January 2018 to help with problems of flow within the hospital.
The paediatric assessment unit (PAU) accepted patients through a triage system. Children coming through the emergency department were assessed by a paediatrician in PAU before being admitted to Rainbow ward.

A parent we spoke with on the paediatric assessment unit, whose child had undergone day surgery, commented that they thought the service was good and they never experienced delays.

**Learning from complaints and concerns**

From January 2017 to December 2017, there were seven complaints about children’s services. The trust took an average of 19 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be resolved within 30 days.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Senior staff told us that the level of complaints for children’s services was very low. They said most concerns raised were dealt with and deescalated before they reached the formal complaint stage. Complaints themes included waiting times in the paediatric emergency department and communication regarding information about care. They said the service was working to improve communication, for example new paperwork included prompts for staff to ensure all information was given.

At the time of the inspection, there were no complaints pending investigation. A manager had confirmed all complaints had been dealt with appropriately within the timeline specified by the trust’s policy. However, we were told one of the complainants had expressed dissatisfaction with the outcome of the investigation of a recent complaint.

The trust had their own version of the Friends and Family Test on tablets on the wards and in outpatient areas for patients and relatives to provide feedback. Managers told us that response rates were low for children’s services.

**Is the service well-led?**

**Leadership**

The service was led by a divisional director (Women, Children’s and Clinical Support Division), a clinical director, a service manager and a divisional head of nursing. There was also a paediatric matron, a neonatal matron and a community paediatric matron.

Staff said leaders were supportive and approachable, and felt their concerns were listened to. Some commented that there was a clear structure within the service, but that it was not clear how things were raised above the level of the divisional leadership team.

The neonatal unit had a new matron who started in February 2018. We noted there had been positive changes and improvements since the matron had been in post. The leadership team had addressed issues highlighted in the previous CQC report and improvements had been made. The new matron had commenced monthly staff meetings and disseminating the message of the week to all staff.

**Vision and Strategy**

Senior leaders told us they were proud of the service and that they were delivering good care. They told us they had moved on from where they were at the previous inspection and were able to identify weaknesses. They said that key improvements needed were transitional care, interaction between neonatal and maternity care, and patient engagement. However, there was no clear strategy for the service.
Culture
Staff we spoke with told us they felt supported by their managers and colleagues. They said it was a friendly team and they felt listened to if they raised concerns. Some staff commented that the team was like a family and they prided themselves on good teamwork. Junior doctors said they felt well supported by consultants.

Staff in the neonatal unit said they felt there had been improvements in the way the unit was managed. The matron operated an open-door policy and was visible and accessible Monday to Friday.

Staff spoke positively about the “Greatix” system, which was used to recognise staff achievements and good practice. Anyone could add positive feedback about any staff member on it. Staff felt the system worked well and helped improve morale.

The trust had a team of the month system which Starlight Ward and Rainbow Ward had won in the two months prior to inspection.

Governance
Since the last inspection the trust had created a children’s board which reported to the clinical quality and patient safety committee. We reviewed the minutes for the last three meetings of the children’s board, which were held in January 2017, June 2017 and May 2018. The terms of reference stated that the board should meet quarterly, but this had not happened. The clinical director told us that they had had issues with changes in senior leadership changes but that they planned to ensure that the board met quarterly from now.

Staff told us that historically children’s service was quite self-contained and that issues tended to be dealt with within the division without needing to be escalated to the trust leadership team. However, they said that this was changing and gave a recent example of a situation that was escalated to senior leaders, including the CEO.

Staff told us they were not aware that there was an executive lead for children’s services but that one of the non-executive directors had recently helped them with arranging redecoration of the wards.

The paediatric team were not part of the trust bed meetings and managers told us that site managers did not get involved with paediatric bed issues.

Governance meetings were held to discuss risks, and any compliments and concerns. Senior managers, clinical managers and directors attended these meetings and information was cascaded down to ward level. Departmental risk and safety meetings were held every two weeks. In the neonatal unit, a monthly staff meeting was held, chaired by the matron. However, nurses on the wards and in outpatients said there were no regular team meetings other than the daily huddles.

The neonatal matron and a consultant paediatrician (and others) attended the labour ward forum, in which the obstetrician, antenatal matron and postnatal manager and others were present. This had improved liaison and awareness of maternal issues that had an impact on neonatal care and outcomes.

Management of risk, issues and performance
Mandatory training compliance was below target in some areas, and whilst managers told us this was a risk, we saw that it was not included in the risk register. Managers did not have sufficient oversight of mandatory training compliance rates and told us there were issues with the online system used to track staff training.

Senior staff told us that the low numbers of children in surgery was a concern as it made it
difficult for anaesthetists and surgeons to maintain their skills. This was not on the risk register.

We saw that other risks identified on inspection were on the risk register, including access to CAMHS services and delays in providing follow up appointments. It also included the nursing staff shortage with actions including active recruitment and a focus on retention with engagement in education and development possibilities.

There was a systematic programme of clinical and internal audit. We viewed the audit tracker which detailed the lead for each audit, action plan, and RAG rating.

**Information Management**

Most records in the service were paper-based, except for outpatients which was partly electronic.

Generally, staff had access to accurate and up-to-date comprehensive information on patients’ care and treatment. Staff were aware of how to use and store confidential information.

Referral to treatment (RTT) information was reliable and accurate and it gave management and staff the assurance of knowing the day-to-day position for those patients awaiting an appointment.

The learning disability lead nurse told us the trust had a system to flag patients who had a learning disability, which enabled them to have oversight of any young people who were inpatients and might require their involvement in their care.

The community nursing team used paper notes and found that this was time consuming as they had to go on visits then return to the hospital to write up their notes on the computer system. They commented that mobile devices would be far more efficient and would allow them to see more patients each day.

**Engagement**

During our last inspection we found that public engagement was limited. Managers told us that the patient experience survey take-up was low in paediatrics, and few children responded, it was mainly parents. However, Rainbow Ward had started a ‘tops and pants’ board to get children involved, so they could give their feedback using pictures as well as words. They were looking at how to feed that back in to patient experience committee.

Parents we spoke with during the inspection said they hadn’t been asked for any feedback about their child’s care at the hospital during their visit.

The weekly ‘perfect ward’ audit included parent feedback. Staff asked five parents each week. Staff told us the food had recently been changed as a result of feedback on the trust patient experience tracker and via the Rainbow ward ‘pants and tops’ feedback. They now served a simpler menu to cater for children’s preferences.

Staff showed us that Rainbow Ward was in the process of being decorated and that a local artist and children were involved.

During our last inspection it was not always evident that all staff groups were listened to in relation to their concerns. Since the last inspection there had been several changes in the executive leadership team. Staff said that the team in place at the time of our inspection was engaged and patient focused. There was also a children’s board which reported to the executive team so any concerns within the service could be channelled appropriately.

The staff survey engagement score for the women’s, children’s and clinical support services division was 3.76 in 2017 which is similar to the national average of 3.78. There was no further information available specific to staff working in services for children and young people.
The paediatric matron told us they wanted to hear staff feedback and to get staff to lead and give ideas. They also wanted to improve on getting feedback from young people using the service and were looking into working with local community organisations and schools.

There was a neonatal parents group which met weekly to enable parents to discuss their baby’s care with staff. In response to feedback from parents at a previous meeting, staff organised a massage demonstration and a positioning for sleeping and feeding demonstration, given by a physiotherapist. Safe sleeping advice was given at the last meeting, in May 2018.

**Learning, continuous improvement and innovation**

The clinical director told us that the children’s board had a work plan, which included providing more paediatric surgery. This would be better for paediatric surgeons and anaesthetists as currently numbers were low so it was difficult for them to maintain their experience.

The divisional director told us the service was trying to make other areas where children were seen outside of paediatrics more child-friendly. For example, radiology would have a dedicated children’s x ray room.

The neonatal service was involved with the North London Neonatal Network, working to develop guidelines for a neonatal early warning tool.

Staff in the neonatal unit were involved in the ‘caring together scheme’ and were currently developing the ‘keeping mothers and babies together’ pathway. This was shared across the North Central London Network. This was a best practice initiative by the Royal College of Midwives.

The neonatal team was working on helping neighboring trusts with developing a pathway to have a late preterm pack for a 34 weeks old baby to stay on in the postnatal ward.
End of Life Care

Facts and data about this service

The trust provides end of life care (EOLC) at North Middlesex hospital. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

There were 515 inpatient beds within the hospital and two designated end of life care beds on Podium ward. All other end of life care and palliative care patients were nursed on other wards. Patients that were coming towards the end of their life were accommodated on wards and side rooms, if they were available, and in line with the patient’s preference. Palliative care is offered to patients that have a terminal or life limiting illness, and require medical assistance and symptom control to improve their quality of life. EOLC patients are those entering into their last year, days or hours of life.

EOLC and palliative care patients are cared for by ward staff, however, if their needs are complex, the patient is referred to the Specialist Palliative Care Team (SPCT). Not all EOLC and palliative care patients are referred to the SPCT, as the wards have EOLC Link nurses; this enabled the wards to manage patients’ symptoms and pain.

The SPCT was a team of three consultants 1.6 whole time equivalent (WTE) and three clinical nurse specialists (CNS); the team was available Monday to Friday, 9am until 5pm. There was no out of hours cover.

The reporting structure for this team was under the surgical service.

For consultant cover, the clinical lead reported to the clinical director of oncology and palliative care; they then reported to the divisional director of clinical services.

For nursing, the matron of haematology, oncology, sickle cell, stroke, radiotherapy and palliative care reported to the divisional head of nursing.

Within the mortuary, the lead consultant for histopathology reported to the service manager, who reported to the divisional director of operations and then the medical director. The medical director then reported to the chief executive.

The trust reported 1094 deaths between April 2017 and March 2018, 244 of which were seen by the SPCT.

The trust had 897 deaths from December 2016 to November 2017.

(Source: Hospital Episode Statistics)

The Specialist Palliative Care Team is working towards providing a seven-day service.

(Source: Routine Provider Information Request (RPIR) – Context Acute)

Our inspection was announced and lasted for three days; we spoke with three palliative and EOLC (End of Life Care) consultants and three palliative and EOLC CNS’s (clinical nurse specialists). This made up the SPCT (specialist palliative care team).

We also spoke with eight doctors, 11 registered nurses, one healthcare assistant (HCA), three chaplains, five members of the Speech and Language Therapist (SLT) team, six Occupational
Therapists (OT’s), two physiotherapists, two bereavement staff, three porters and four patients. We did not get to speak with any relatives or friends of patients, as they were either unavailable or did not wish to speak with us at the time.

We visited all wards within the hospital, the mortuary (including the two viewing rooms), the chaplaincy including the chapel, multi-faith room and Muslim prayer room, the Patient Advice and Liaison Service (PALS) office and the porter’s office. We also spoke with the infection prevention and control (IPC) lead, the mortuary interim lead and the lead health and safety officer.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training
The trust set a target of 90% for completion of mandatory training.

The trust provided evidence to show that the SPCT nurses had achieved 100% compliance for mandatory training. Mandatory training included information standards, equality, diversity and human rights, fire safety, health, safety and welfare, information governance, moving and handling level 1, conflict resolution, preventing radicalisation, infection prevention and control, basic life support, adult immediate life support, safeguarding adults levels 1 and 2, safeguarding children levels 1 and 2 and display screen equipment. We were also provided with data to demonstrate that the lead consultant had completed her yearly appraisal and clinical supervision sessions. We were aware the lead consultant had completed a large amount of training, as recorded in the continuing professional development (CPD) plan as well as their mandatory training, however, there was no evidence of any mandatory training attended by other SPCT consultants as this was not provided to demonstrate compliance.

Mandatory training included safeguarding for adults and children to the appropriate levels as well as basic life support. A comprehensive and up to date list was provided.

The SLT team had a mandatory training rate of 96%. This was via a mixture of online and face to face training. We do not have evidence for the SLT team.

We requested the training information for porters, however this was not provided by the trust.

We requested mandatory training data for medical or nursing staff with end of life care. The trust did not provide data for medical staff.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding
The trust set a target of 90% for completion of safeguarding training.

The trust has not provided any safeguarding training data for medical staff within end of life care.

All staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults. Staff were able to demonstrate how they report incidents to the safeguarding team. We saw training records for the SPCT CNS’s to show that they were all up to date with their safeguarding adults and children training however, we were not provided with any safeguarding training data for the consultants within the SPCT

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Cleanliness, infection control and hygiene
We visited all the wards within the trust and found them to be visibly clean and tidy. Some were more modern and spacious than others (newer parts of the building), but in general, the wards were well lit and comfortable for patients and relatives. They contained sinks for handwashing with the appropriate elbow taps and paper hand towels to dry the hands. We observed and used the hand gel on wards and in some corridors.

The trust had a service level agreement with a third party to provide domestic and portering services to the trust. The mortuary was cleaned and maintained by the third-party provider on a regular basis. The flooring was in a good state of repair and visibly clean. The post-mortem area floor was hosed down daily and deep cleaned once per month. This was in line with HBN 00/10 Part A Flooring.

The wards that we visited as part of our inspection were visibly clean and tidy.

We visited the mortuary and the two hospital viewing rooms during our three-day visit. We found some concerns within the mortuary. The viewing rooms were clean, tidy and no issues were identified. The mortuary was visibly clean and tidy, although some splashes of fluid were observed on the fridge doors. The splashes were due to the use of cleaning fluids.

The finger taps that we found in the post mortem storage room in 2016 were still there. The IPC lead for the trust was able to demonstrate their mitigation for this. The IPC lead stated staff were able to use a disposable hand towel to turn the taps off, or use their wrist, instead of turning it off by hand.

The other concern was that there were two rooms within the post mortem suite. We were informed by the mortuary staff that both rooms were semi-clean/semi-dirty utility. We asked the IPC lead to explain this situation. Trust representatives stated this was incorrect and would be rectified.

We observed a phenolic cleaning fluid in use that was subject to a European Union (EU) directive, that specifically removed this type of fluid from use.

Equipment used for post-mortems was washed in a phenolic solution by hand. This is contrary to the HSE mortuary standards, paragraphs 114 and 115, which state reusable equipment should be stored appropriately, decontaminated and sterilised in an appropriate solution and autoclaved. We were informed by the mortuary staff this did not happen, and that reusable equipment was washed by hand; this included items classed as sharps.

We brought this to the attention of the IPC (infection prevention and control) lead, and these items were immediately removed from use and replaced with an alternative; we were assured that all items of equipment that were available as single use disposable items would be used to replace multi use equipment.

Once a body had been collected from the mortuary, staff cleaned the trays with cleaning fluids. The rest of the fridge was also cleaned by mortuary staff at regular intervals. We looked at fridge trays and found these were visibly clean.

We also observed specimens that had been collected, stored in formalin and kept in unlocked metal cabinets inside the post mortem suite. The main door that led to these specimens was kept locked. Formalin is a flammable liquid. The nearest fire extinguisher was located outside of the post mortem suite.

There was no ventilation for these metal cabinets or extractors within the storage room. Formalin is a highly toxic substance that can be absorbed easily when breathing. We pointed these issues out to the trust during our inspection. The risk assessment officer for the trust stated that it was
their practice for the specimens to be stored without ventilation in the locked room, as the specimens were sealed prior to being stored, therefore he stated there was very little risk.

We spoke with the interim mortuary manager and the IPC lead for the trust. They were both recently in post (approximately one month and six months respectively), and had not yet created a Mortuary IPC or Mortuary Standard Operating Policy. We were told creating and implementing those policies would be a high priority. However, not having such policies is contrary to The HSE (Health and Safety Executive) mortuary standards set out under the document ‘Safe working and the prevention of infection in the mortuary and post-mortem room’. Paragraph 111 states ‘Disinfection procedures need to be drawn up specifying which types of disinfectant should be used where, and for what purpose. These procedures should be compatible with hospital trust policy.’

We spoke with the mortuary technicians and were told that if they were unsure as to what to do in a certain situation, they would speak with other mortuary technicians at other trusts, corroborate their findings and then decide on how to proceed. This was due to the fact that there was no standard operating procedure (SOP). This is also contrary to the HSE mortuary standards.

At the time of our inspection, the trust did not carry out any IPC audits within the mortuary or specifically for palliative and EOLC patients. The IPC and mortuary lead stated that they would be carrying out a risk assessment of the mortuary and putting changes in place as soon as possible. As described above, some measures and changes were made with immediate effect.

The trust conducted handwashing audits. Although there was no specific audit for palliative or EOLC, we were provided with a handwashing audit for Podium 1 (Oncology ward) that showed a varied performance. For the past 12 months, four months had a 100% compliance rate, three months reached over 90% compliance, and five months were between 68% and 80% compliance. We were not aware of any action plans created to increase compliance.

All SPCT clinical staff we observed were bare below the elbows.

During our inspection, we observed infectious patients prioritised for a side room, to prevent the spread of infection throughout the ward. Barrier nursing would be used in these instances.

**Environment and equipment**

The trust used syringe drivers for palliative and EOLC patients. We saw evidence of syringe drivers being maintained and serviced on a regular basis. The medical devices department had a spreadsheet to indicate which syringe drivers required servicing and cleaning, as well as the date they were last serviced.

The hand gel that we used within the mortuary was out of date and had congealed. The mortuary staff changed this immediately. The mortuary housed 32 fridges for deceased patients; this included four spaces for bariatric patients. There was also a separate area for stillbirths.

The fridges, post mortem tables, sinks and lights were maintained by a third party. The trust was not responsible for their maintenance, other than routine cleaning after use.

The mortuary contained yellow sharps bins in the storage area that had not yet been labelled or used. They were only placed in the post-mortem suite when a post-mortem or other procedure took place, therefore we did not see any in use at the time of our inspection.

Consumables were stored off the floor in compliance with HBN 00/09 in the first utility room. We inspected and found that the mortuary was in compliance with EU waste Directive 2008/98/EC for The Safe Management and Disposal of Healthcare Waste DH 2013.
We found that the three post-mortem tables were clean and free from limescale, as were the sinks within the mortuary. This was an improvement from the previous inspection, when we did find a build-up of limescale in these areas. We saw staff had worked to rectify this situation.

We did not see any evidence on the electrical equipment within the mortuary that portable appliance testing (PAT) had taken place. There were no labels to confirm this.

We observed a battery charging pack within one of the post mortem rooms had wires that were not securely in place. These were wrapped with electrical safety tape. There was no evidence that this piece of equipment had been tested since 2010. The mortuary staff informed us not all equipment was PAT tested. They said the trust decided on the equipment that required testing.

We are unaware as to how this decision was made and any risk assessment that was used. PAT testing at the hospital was carried out by a third party. No evidence of PAT testing was available for the mortuary or the post-mortem suite.

Mortuary staff kept a log of fridge and freezer temperatures. The log showed the range of temperatures that were acceptable. There were a number of occasions that the fridges and freezer did not meet the specified criterion. We asked the staff and the mortuary leads what action they had taken on those occasions. Porters or the member of staff that checked the temperatures told the mortuary technicians of the change in temperature. Once they were aware of this, they went and checked the fridge/freezer themselves. They then checked the temperatures again 20 minutes later and found they were within normal range. Mortuary staff stated that if there was an issue with the fridge or freezer temperatures, they would call out the fridge/freezer engineer and they would rectify the issue if it had not resolved after they had rechecked these. This was also brought to the attention of the mortuary and IPC lead.

There was no evidence available to show that further checks or action had been taken on these occasions.

During our last inspection, we found that out of date consumables were being stored and used within the mortuary. These had been disposed of, and we only found one box of nitrile gloves that were out of date. The department disposed of these immediately.

The mortuary also included a waiting room for relatives and a viewing room for friends or relatives wishing to view the deceased.

**Assessing and responding to patient risk**

The Individualised Priorities for End of Life Care (iPELC) document was used for EOLC patients seen by the SPCT. Some patients recognised by the trust as end of life were also placed on the iPELC document. This document was a tool used by the clinician to provide care for the patient. It was used to managed and monitor pain, patient care plans including mouth care and feeding, through to holistic care, advanced care planning and care after death. Monitoring of EOLC patients was via tools within the document, such as Waterlow score and MUST score.

For patients with mental health issues, the SPCT were all level 2 trained in counselling. For patients that required additional or more complex help, referral to the mental health liaison team was available as and when required. Patients that were suffering with cancer were able to access counselling as part of the cancer pathway provisions within the trust, which was separate to palliative and EOLC.

We attended the mortuary as part of our inspection. We observed deceased patients stored correctly within the trust’s body storage facility. We checked and established that the deceased were wrapped and labelled correctly, as well as being labelled and registered within the mortuary.
signing in/out books. We also saw that there was a jewellery and possessions storage cabinet, and a booklet that was used and filled out as appropriate to log items in and out.

All staff within the trust that had a swipe card had access to the mortuary. This was a cause for concern within the trust. Out of hours, there was no one based within the mortuary, therefore this could be accessed by anyone with a swipe card. The issue had been reported to a senior member of mortuary staff. We did not see this recorded on the risk register.

A system was in place for deceased patients that had the same name, to ensure the correct patient was released to the correct family/undertaker. We saw they had appropriate checks in place to prevent any errors.

**Nurse staffing**
The SPCT had funding for five CNS’s. At the time of our inspection, there were 2 CNS’s, and one in training. Another was joining the team in July 2018 and an advert was out at the time of the inspection to fill the outstanding roll.

One of the CNS’s was the training lead for the team. He also developed training alongside the lead consultant to roll out to the trust. He was also available to facilitate trust training days or courses run by the trust educational department.

Each ward had an EOLC champion. This was a qualified nurse that could advise and support colleagues within their ward, with managing EOLC patients. Link nurses were given extra training which was provided by the SPCT and they were signed off as competent by the lead SPCT.

The trust has not provided their nurse staffing numbers for the period of February 2017 to January 2018, for end of life care, in a reportable format that could be used within the report.

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

The full complement of staff that the trust had agreed for the SPCT was eight. This was to account for five CNS’s and three consultants. There had been a period of eight months prior to our inspection, where the staffing within the SPCT had dropped to one CNS and one consultant (except for Wednesday mornings when there were three consultants available). This had caused problems with providing end of life care training for the rest of the trust, as there was no one available to provide this.

The SPCT consultant numbers were at full capacity at the time of our inspection. From February 2017 to January 2018, the trust reported a vacancy rate of -6.9% for nursing staff in end of life care; this indicates the trust have more staff in than had initially been planned for. The trust target vacancy rate is 7.5%.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

Since our last inspection, and more recently, a further CNS had joined the team as the lead CNS. A further CNS was due to join the team in July 2018, and another CNS was taking part in the training process to upskill from a Band 6 nurse to a Band 7 CNS palliative care nurse, internally within the trust. The vacancy rates reported in the trusts RPIR are inconsistent with what we found during the inspection.

During our last inspection during 2016, there were three CNS’s, however one retired just after our inspection and returned to assist the team until a replacement was found; a new team member was not found before the CNS completely retired. At the time of our inspection, there were two vacant SPCT CNS posts.
From February 2017 to January 2018, the trust reported a turnover rate of 0% in end of life care; this is better than the trust target turnover rate of 15%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Turnover within the SPCT over the past 12 months had been minimal. The SPCT had been a team of five, however a business case had been accepted to expand the team to eight. The team had a CNS retire and another leave the department just after our last inspection in 2016.

The members of staff recruited since had remained within the team, therefore the turnover rate for the previous year was 0%.

The SPCT were finding it difficult to recruit into the Band 7 CNS role. We were informed by the team that recruitment in London is difficult due to the higher cost of living. The SPCT had recruited from other areas within the trust to try to fill their vacancies. A Band 6 nurse was recruited and had started training to become a Band 7 SPCT CNS. This nurse’s training started in April 2018 and was due to last nine months until they were to be classed as competent to work autonomously.

From February 2017 to January 2018, the trust reported a sickness rate of 2.4% for nursing staff in end of life care; better than the trust target rate of 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust provided sickness rate for the palliative care community service from their own dashboard. As of March 2018, the trust reported an annual rolling sickness rate of 1.0% in palliative care community service compared to 4.3% trust wide. We were not made aware of any SPCT team members that were off sick or on long term sickness leave.

The trust did not use bank or agency staff within the SPCT. This is a specialist team and the trust did not fill sickness or temporary vacancies. The SPCT had made in-roads to train staff and doctors of different grades in palliative and EOLC, therefore there was provision with the other specialities, as well as on each ward, to support these patients without the need to employ bank or agency staff.

Each ward had an EOLC Link nurse, as well as access to the site manager (who was clinically trained), for any issues or support required outside of normal working hours.

Medical staffing
Medical staffing within the SPCT was provided by three consultants that create a 1.6 WTE (whole time equivalent) consultant staffing provision. The three consultants share the post; this figure includes the lead palliative care consultant. This was at the acute hospital location only. The trust showed that the consultant staffing cover in total is 2.9 WTE including hospice cover.

Consultant cover is available Monday to Friday 9am until 5pm. There is no out of hours cover provided by the SPCT. There are no current vacancies for consultants within the SPCT, they were at full capacity. The turnover rates for consultants within the SPCT was 0%. The same consultants were working within the SPCT during our inspection during 2016.

At the time of our inspection, we were not aware of any medical sickness. No further details were provided by the trust. The SPCT did not use bank or agency consultants or doctors for cover or to fill temporary vacancies. The team were specialists within EOLC and palliative care, therefore it would be difficult to find cover for this speciality and skill level.

It was also noted that as the SPCT had provided training to link nurses, staff of various skill levels from HCAs (health care assistants) through to consultants, were able to deal with various EOLC
and palliative care situations. The SPCT staff, especially consultants, were required for more complex cases.

**Records**

We reviewed six EOLC and palliative care medical records. All medical records were stored appropriately alongside the patient’s care plan, on the patient’s trolley bed. They were labelled correctly with the patient’s name and hospital identification number. Most entries were legible, signed and dated by the staff member attending to the patient. Five out of the six medical records demonstrated a discussion about the patient’s care had taken place with the family.

All six of the medical records showed evidence of advanced care planning discussion and/or plan in place. All the records also showed that the patient’s nutritional and hydration needs had been assessed appropriately and a plan had been put in place, if this was required.

Each patient record showed evidence that their individual needs had been assessed. This included spiritual, cultural and religious needs.

Risk assessments had been carried out for all EOLC and palliative care patients in line with guidance. This included malnutrition universal screening tool (MUST) scores, pressure ulcers, Waterlow score and pain score. Within care records, we also saw evidence of SSKIN (Surface, Skin inspection, keep your patients moving, Incontinence/moisture, Nutrition and hydration) bundles, body mapping and risk assessments being completed; we also observed that a purple flower sticker had been placed on the file of a dementia patient; this was one way that the trust notified staff assisting the patient that they suffered with dementia.

Four out of the six patient records assessed contained a document produced by the trust to assist in the care of palliative or EOLC patients. This was called an Individualised Priorities for End of Life Care (iPELC). This document was used by a large proportion of the trust for EOLC and palliative care patients. It had been developed after the use of the Liverpool Care Pathway discontinued.

The iPELC document was created to ensure all patients that were in palliative stages, or end of life care stages, received appropriate monitoring, care, pain relief and symptom control. It was also used to assist patients, their families and staff in appropriate care pathways, ceilings of care and advanced care planning decisions.

Part of this document related to do not attempt resuscitation orders (DNACPR), religious and spiritual needs, organ donation and psychological wellbeing. The iPELC document had been rolled out trust wide since the last inspection.

We reviewed eight medication records within palliative and EOLC. There is a difference between both records; for palliative care, this is generally for symptom control. With EOLC, as well as symptom control, anticipatory medication may be prescribed. This would be with other medications to make the patient more relaxed, comfortable and less anxious in their last days and hours of life. Where appropriate, we found anticipatory medications had been written either within the patient notes or on the patient’s iPELC document, (if it was appropriate for them to be on this). We observed a blue flower sticker on a patient’s care notes to indicate the patient was living with dementia.

We looked at six EOLC patient records and these patients were being cared for with the assistance of the iPELC document. All but one record showed discussions had taken place with the patient and their families about their care, and all six records showed evidence of advanced care planning.
All patients had their nutrition and hydration assessed and monitored using the MUST tool, and all records showed there had been an assessment of both physical needs/symptoms as well as spiritual needs and care. The patient records also showed patients had been assessed for pressure ulcers using the Waterlow score, as well as having their pain assessed and monitored.

The trust used an electronic medical records system to record patients care plans, DNACPR status and medications. This was available to community teams, GP's, pharmacists and the ambulance service. Part of the aim of this system was to ensure continuity of care for the patient regardless of the care setting, but also to prevent unnecessary hospital admissions.

**Medicines**

During our inspection, we saw syringe drivers were in place appropriate for patients’ needs.

We evidenced syringe drivers being used in line with national guidance (NICE NG31, NICE CG140 and NICE QS13). We also saw evidence that syringe driver checklists were in use and had been completed and we saw evidence that syringe drivers were checked four hourly in line with national guidance.

We visited the medical devices store to view the syringe drivers. The trust had 30 available and they were all on the devices register. Each syringe driver was stored in the controlled drug (CD) cupboard on the ward, however the medical stores library maintained and cleaned them.

During our visit to the medical equipment storage library, we observed three syringe drivers that had been prepared by the team and ready to return to the appropriate wards. The team kept a spreadsheet of syringe drivers and their maintenance records. We observed that there was a syringe driver policy that was due for review during July 2018.

We saw evidence that all controlled drugs (CD’s) and anticipatory medications for palliative and EOLC were kept on the wards and checked daily and the medical devices team regularly visited wards to check for devices that required maintenance. We found all medicines within palliative and EOLC to be stored, prescribed and dispensed within national and local guidelines.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From March 2017 to February 2018, the trust reported no incidents classified as never events within end of life care.

*(Source: Strategic Executive Information System (STEIS))*

During the inspection, we interviewed the SPCT and the clinical leads. We discussed Never events with the team and we were assured that there had not been any never events within the past 12 months. At our last inspection during 2016, there had been an issue regarding the reporting of incidents within EOLC and palliative care. It was found by the SPCT that some incidents were ‘slipping through the net’ due to coding and lack of options on the electronic reporting system. Changes were made to this system and this now includes a dropdown menu box that contains palliative and EOLC codes, to enable these to be recorded appropriately.

Each incident reported was reviewed and actioned on the electronic reporting system.

If appropriate, an action plan was created around the issues raised. Feedback was then given to those involved or those that had raised the concern/incident. Any trends identified were reviewed at the End of Life Care Steering Group.
In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from March 2017 to February 2018.

(Source: Strategic Executive Information System (STEIS))

During the previous 12 months, the trust stated that they had reported one serious incident, however once this had been investigated, the incident was downgraded and was no longer classed as a serious incident.

The trust had made progress where incidents and complaints were concerned. They had put a process in place to investigate each incident and complaint to ensure learning was taken from each. An action plan was created and followed to enhance the learning for all involved, as well as cascaded down to other healthcare professionals within the trust.

The reporting process for an incident or complaint was initially via the EOLC steering group (quarterly) and the Oncology Palliative Care Governance group (bi-monthly). The EOLC steering group processed this through the Guideline Review Process and reported the outcomes of the complaint or incident to both the Trust Patient Experience Group (quarterly) and the Divisional Risk Governance Meeting (DRGM) (monthly). The DRGM then reported directly to the Patient Safety Outcome Committee group (monthly) who then reported directly to the Trust Board.

The SPCT have worked alongside the complaints team to ensure that any trigger words relating to EOLC or palliative care were flagged, to ensure all complaints were recorded and responded to as appropriate. The deputy divisional nurse reviewed all complaints ahead of the EOLC steering group so that the information was ready for discussion. This was a regular agenda item at the meeting. We also found incidents that were reported on the electronic system now had a drop-down box that included palliative and EOLC. This was an improvement since the last inspection, as there were issues with coding and allocation of incidents and complaints for this service. In 2016, incidents were not recognised as palliative or EOLC as there was no way to separate these complaints and register them under the appropriate service.

We spoke to staff within, and outside of the SPCT. All staff could tell us about an incident that occurred and the learning that came from this. This incident had been cascaded from the SPCT through to Link nurses and ward sisters, who had then passed on the learning to their teams.

The mortuary informed us that they had reported incidents where the deceased arrived inappropriately prepared, for example without a sheet or a shroud. These incidents were raised through the electronic reporting system and we saw evidence of this. Feedback was given to the wards where this occurred, as well as notification from the mortuary to the ward via telephone.

The SLT team could describe the process for reporting incidents and how to escalate any issues or problems that occurred. They were able to report that they had no incidents occur since the last inspection during 2016. The SLT team were knowledgeable and confident on the use of the online incident reporting system and how to report a serious incident.

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 to provide reasonable support to that person.

There were no incidents that occurred within palliative or EOLC that utilised the duty of candour within the past 12 months. All the staff that we spoke with were fully aware of the duty of candour and how this was to be used, if appropriate.
Is the service effective?

Evidence-based care and treatment
There were 1094 deaths reported by the trust between April 2017 and March 2018; 565 patients were referred to the SPCT and 244 (43%) were seen by the SPCT.

During 2013, a review of the Liverpool Care Pathway took place and this system was removed. In response to this process, the trust produced the iPELC document to ensure EOLC patients were cared for appropriately in all aspects, from medical care and pain relief, through to chaplaincy, pastoral care, advanced care planning and after death. This document also took relatives and friends care and wishes into account.

The SPCT accepted referrals for all palliative and EOLC patients. Of the 565, 400 patients were cancer referrals and 165 were non-cancer referrals. Once the patient had been referred to the SPCT, 78% were seen within 24 hours. According to the figures presented at the annual general meeting, during the financial year 2016/17, the SPCT received a lower referral rate (673) than the previous year (696). Most referrals were cancer (74%); it was acknowledged that the percentage of non-cancer referrals was targeted at 30-40%. Advanced care planning (ACP) was showing an uptake rate of 68%, however the trust had set a target of at least 70%.

The service aspirations for the year 2017/18 was to be fully compliant with NICE guidance and CQC regulations, by offering a seven-day SPCT service with out of hours telephone advice service, ACP, and discharge coordination. Furthermore, they hoped to increase the SPCT activity by 10%, increase referrals seen from the emergency department (ED) and to increase teaching of palliative and EOLC. They also hoped to introduce a fast track discharge coordinator to reduce the discharge time for patients, increase ACP.

The trust was working towards achieving the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People through action plans shared at the palliative and EOLC annual general meeting (AGM). They updated the EOLC steering group and the board yearly at the annual general meeting (AGM) as to their progress. The last AGM was just prior to our inspection in May 2018.

The SPCT also hoped to further links and communication with the community teams, increase EOLC training and establish the use of the iPELC across the trust, to carry out audits into rapid discharge home and other audits, and permanent bereaved carers questionnaires.

An ACP policy, with an included ‘trigger list’ and clinic were due to be launched within the trust during September 2018.

Nutrition and hydration
The Speech and Language Therapies (SLT) team worked closely with the SPCT. They were available to assess and respond to patients and to assist in their nutritional and hydrational needs. Some patients that have certain medical conditions, or those that are palliative or end of life have trouble eating and swallowing food. We spoke to the SLT team and found they were very included and involved with assisting care teams in patient care.

The SLT team are qualified to risk assess, physically assess and make recommendations and prescriptions of care, to patients care teams and consultants, on the best way for the patient to receive their food and drink. SLT teams assess how a patient could swallow their food and drink and ensure this is done in a safe manner. They were able, for instance, to state that a patient required their food to be liquidised, or mashed; similarly, they were able to prescribe thickener to be added to a patient’s fluids, in order that it made it safer for them to swallow this without the risk, or a minimised risk, of choking.
During our last inspection, we found that the SLT team were not always included by doctors and consultants with patient care and they were, at times, reluctant to take their advice. This was due to a concern they would insist that the patient was nil by mouth due to swallowing risks. This is no longer the case; the teams work well together. The SLT team were more involved within the trust since the 2016 inspection and received approximately 1,000 referrals, however it is unknown as to how many of these were for palliative or EOLC patients.

Patients that we spoke with stated that food was readily available if they required this, even when this was outside of normal working hours. Families were welcome to bring in food for their relatives, however they were not allowed in the kitchen area to heat any food. They had a fridge on the ward that could store patients’ own food. We spoke with ward managers and staff about foods available. Dietary requirements such as faith requirements were catered for, for all patients.

Within patient records, and specifically within the iPELC document for palliative and EOLC patients, nutrition and hydration was recorded and monitored. This ensured all patients were receiving appropriate care. Patients that were not yet on the iPELC document system were looked after as per other patients. Within their patient medical records this was also recorded and monitored. All patient records that we reviewed contained a MUST tool that had been used to monitor a patient’s nutritional status and hydration.

We were also told by trust staff that they feel patients get appropriate nutritional support and hydration, if they wished to eat and drink at end of life. They stated it was generally the patient’s relatives that were more concerned with this process than the patient. Staff said the iPELC document covers this area well and in general, found this was well documented by all staff.

Pain relief
Pain relief was initially provided by the patient’s medical team on the wards; however, if the patient required more complex or advanced assistance or advice and they were EOLC patients, they were, in many cases, placed on the iPELC document. This contained a flow chart for doctors and nurses to be able to manage a patient’s pain and symptoms, as well as making sure they had considered other aspects of care for the patient (such as advanced care planning and spiritual care). The flow chart gave standard directions very clearly to the team to enable them to assist the patient appropriately. It also had instructions to contact the SPCT under certain conditions.

The SPCT hoped to train as many staff as possible (consultants, doctors and nurses alike), so that more patients could be managed on the wards by their own medical care teams.

Outside of the working hours of the SPCT, the oncology and medical consultants were called upon to assist with pain relief and symptom control. From the records we assessed, we found all pain relief, be it thorough oral/subcutaneous routes or via a syringe driver, was appropriate and in line with NICE guidance.

All patients we spoke with stated they were very happy with their pain relief and were given medication as and when required, or as prescribed.

Patient outcomes
The trust was part of a scheme which enabled their patients to have their medical records accessed by those treating them, as and when required. Patients seen at the trust would have their care, treatment escalation plans, preferred place of death (PPD), preferred place of care (PPC), and so on recorded on an electronic database. This enabled ambulance staff, community staff, GP’s and the hospital to access the patient’s medical/care records and receive appropriate care.
Using this system ensured that once a patient had been discharged, there was a continuity of care if the patient sought medical assistance. For example, if an ambulance was called to a patient that was dying, they were notified of the appropriate advanced care decisions, rather than relying on the patient’s relatives/carers for information. With this scheme, appropriate care could be given as required, without confusion or delay.

During the financial year 2016/17, 60 new records were created on the electronic database, and four records were updated. We were sent information to show that once the SPCT is at full capacity, this tool will be utilised more fully than has been used to date.

The lead consultant for the SPCT reviewed all complaints two weeks prior to the EOLC steering group monthly meeting, where all complaints were discussed. The complaints raised were also taken to the oncology meeting group and reviewed.

An incident occurred regarding a nasogastric tube (NG) insertion. This was fully investigated and the learning outcomes were disseminated throughout the SPCT and then through the trust. We were told of this incident by many staff members throughout the trust due to the learning that had been taken from this.

As part of the learning that had taken place from this incident, the EOLC steering group had updated the policy to state that for NG tube insertion, there would be a three-attempt maximum try at NG tube insertion and placement.

For patients in the last days or hours of life (end of life care patients), for the trust to ensure the patient received appropriate care in all areas (medical, pain, spiritual etc), they introduced the iPELC document. The SPCT rolled out the iPELC document across the trust so that EOLC patients that were not under the care or advice of the SPCT were still entitled to the same care and opportunities.

The trust conducted audits into palliative and EOLC. The uses and outcomes of the iPELC were audited by the trust on 10 records. This showed that 30% of EOLC patients had been placed on the iPELC between three and four days prior to their death, and 60% within the last 24 hours of life. 90% of patients on the document were recognized as being within the dying phase or deteriorating towards this and their treatment plan reflected this information.

The audit showed that 20% of patients were communicated with regarding the dying phase and this was recorded within the iPELC document; 40% were communicated with regarding this, however this was recorded in the patient notes and not within the iPELC document. Discussions with the patients’ relatives were documented 80% of the time on the iPELC, whilst 50% showed a documented discussion within the care team.

The audit also found that 70% of records showed that a discussion with the consultant and nurse were recorded on the iPELC document. The audit found that no patients had their wishes regarding their care documented on the iPELC, however 50% did have this recorded in their patient notes. In 1% of patient notes audited, it was found that the families wishes were documented on the iPELC, however in 80% of cases the families wishes were recorded in the patients notes. In 40% of the records audited, it was found that there was no discussion or record of preferred place of death (PPD).

In 100% of records audited, it was found that the patients were given an individualized care plan and that the patient’s symptom control chart was completed hourly and correctly. In 100% of records, symptom control medication was prescribed and in 80% of cases, this medication was given.
The audit found in 100% of cases, the death of a patient was certified and recorded, 80% of the time the next of kin were informed and in 40% of records, last offices were carried out and documented; 60% of the time this was not documented. It was also found that in 40% of records, religious beliefs were addressed; however, in 50% of cases, this did not occur. We have not seen any action plans that have come from this audit.

A further audit was carried out against the number of deaths the trust experienced versus the number of patients being placed on the iPELC document. Out of 1090 deaths, 412 patients received care via the iPELC document and 678 did not.

We asked the trust if there was a target percentage they wished to reach for EOLC patients being placed on the iPELC document. They stated that they did not have a target for this as they felt that it was inappropriate. They felt that EOLC patients should be placed on the document as required and not dictated due to targets.

Bereaved carers surveys were given out with death certificates to the relatives or carers of the deceased patient. The national response rate utilised by the trust for this survey was 10%, however, the trust had achieved 12-13%. Once the results had been received, the lead CNS for the SPCT collated the results and these were compared with the results from the previous six months. The trust provided data for years November 2016- March 2017 and April 2017 – March 2018. There were 35 responses received for the year ending 2017 and 95 responses for the year ending 2018. The results showed a small decrease in positive comments and increase in negative comments. Some of the positive comments included “The ward organised a side room for my relative which helped us greatly at this difficult time” and “Staff were caring and compassionate”. There were negative comments received; some of these comments were regarding lack of communication and the patient not being moved to a side room.

Satisfaction with overall care received from doctors and allied health care professionals (AHP’s) had dropped, whilst nursing care had increased by 1%. Satisfaction with spiritual care had increased across excellent and good ratings by 3% and 6% respectively. Emotional care percentages had dropped across excellent, good and fair ratings and increased by 3% for poor a rating. The trust noted there was a drop in the ratings of excellent, to good by a margin of 8 - 13% respectively. An action plan was in place to increase the ratings by a series of improvements they were hoping to put in place. This was based on further training and communications being passed on to staff.

The trust was advertising for a rapid discharge coordinator to join the SPCT. At the time of the inspection, the whole SPCT supported rapid discharge ‘home’ to die, however they feel that this would make the process more efficient and cost effective. It was also hoped that the CNS appointed to fulfil this role would also support the SPCT and patient with advanced care planning. The team stated that they still had work to do and areas of improvement with regards to advanced care planning and were working on this provision.

Last year (2017), the trust joined a national programme set out by National Health Service Improvements (NHSI) called ELCHIP (end of life care hospital improvement programme). This programme was put in place to specifically focus on patients admitted to the ED that were EOLC patients. The trust conducted an audit to see how many patients that came into the ED were palliative or EOLC patients with a DNACPR in place and accessible. The result was 0% out of the 20 patients audited. Therefore, they decided to join this scheme.

They were working to ensure palliative and EOLC patients had their records, including DNACPRs readily available for any visits that they made to the hospital. They were doing this through the electronic patient record system that had been set up and started to be used by the trust. This was
a way of the hospital, ambulance service, community teams, GP’s and so on being able to have access to patients’ records, wishes and care plans, regardless of where the patient requested or required medical help or attention.

We requested the initial audit results from the trust, however these were not provided.

The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed worse than the England aggregate for all three metrics.

- Metric 1: Proportion of patients for whom there was documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days. (Trust: 87.3%, National aggregate: 93.4%)

- Metric 2: Proportion of patients for whom there was documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient? (Trust: 93.8%, National aggregate: 94.6%)

- Metric 3: Proportion of patients for whom there was documented evidence in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care? (Trust: 42.9%, National aggregate: 73.0%)

(Source: Royal College of Physicians)

This data had not changed since our last inspection during 2016. The National Care of the Dying Audit is a national audit that hospitals use to monitor their care and benchmark themselves against each other.

The audit makes recommendations as to best practice for patients coming towards the end of their life. The types of recommendations made from the data analysis from the audit include seven-day a week working, pastoral care, pain relief and so on.

The hospital was collecting data in preparation for the next audit.

Since our last inspection, the trust had decided to send out bereaved relatives surveys. These had been prepared but not used at our last inspection. No information was available to show the result of this audit. The trust was not working towards any national accreditation scheme within palliative or EOLC.

Competent staff
The SPCT nursing staffing was two CNS’s and one new CNS in training. There was a new CNS that had started her training within the SPCT and she was being mentored by the training lead for the team. They had a good rapport and were positive and efficient.

The trust could provide evidence to show that the CNS’s in post were up to date on all mandatory training. They were also able to show the training that the new CNS was undertaking to become fully competent with palliative and EOLC. The trainee CNS had already attended a specialist training event in palliative and EOLC care and was continuing training during our inspection. Palliative and EOLC had also been part of the nursing yearly mandatory training by the trust. The SPCT was very pleased with this outcome, as they believe EOLC is ‘everyone’s business’. The SPCT had a training facilitator permanently within their team. He was the lead CNS, and was responsible for palliative and EOLC training. All SPCT staff were trained in advanced care planning. This training was rolled out to members of staff that attended various training days with the SPCT, however, not all staff were trained. The SPCT was working towards their target of 80% of nursing staff on each ward completing training in EOLC.
The trust had secured funding to place an advanced care planning coordinator within an elderly people care home to try to increase uptake and reduce unnecessary hospital admissions.

Every Wednesday morning, the SPCT met to discuss past and present patients and review care plans. This included advanced care planning for patients on the iPELC document.

The SPCT nursing staff were instrumental in assisting the trust with their EOLC training. They had facilitated many training days and events for the trust. Training figures for palliative and EOLC training on each of the wards had a target set at 80% per ward. Eight of 15 wards had achieved this target of fully qualified staff being trained in palliative and EOLC care.

Seven wards had not reached the target of 80% of adult registered nurses receiving training in palliative and EOLC. This equated to 49 qualified adult nurses having been trained in palliative and EOLC. Within the intensive care unit and high dependency unit, 49 nurses had been trained in palliative and EOLC. The target within these units was to train 50% or more of nurses. The trust had achieved this.

The SPCT was available to offer guidance, training and support for the trust for more complex patients that required more in-depth and specialist care. All oncology and medical doctors were provided with a palliative and EOLC pocket guide, which assisted these doctors in decision making for this patient group. They were the trusts’ first unofficial point of contact for palliative and EOLC patients outside of normal working hours, weekends and bank holidays, when the SPCT was unavailable. All other doctors and other healthcare professions that attended palliative and EOLC training were also provided with a palliative and EOLC pocket guide.

Each ward had an EOLC Link nurse. A Link nurse is a nurse that has undergone some extra training with the SPCT on palliative and EOLC. They are there to cascade new information and changes down to the rest of their ward teams, as well as be there to support their colleagues with palliative and EOLC patients. The lead SPCT CNS and trainer for palliative and EOLC, created a workbook and competencies to be completed and signed off, prior to a link nurse being signed off. The lead SPCT CNS assessed the Link nurse’s competence.

Each ward was also supported by an EOLC and palliative care poster board. On this board, it gives information as to caring for palliative and EOLC patients, contact telephone numbers and pager numbers for the SPCT plus any additional information the SPCT or ward feel is relevant to this group of patients.

We were informed the trust had taken ownership of syringe driver training via their education department, however the SPCT stated they facilitate this training if asked to do so by the trust.

The trust had a competency check list for the use of their syringe drivers and we saw evidence of this. The EOLC Steering Group were positive about this change, as it meant that there was a specific and official record kept of this training. All SPCT team members were competent and trained on the use of syringe drivers.

Porters were trained by the mortuary staff how to handle the deceased and the protocols they should follow. Porters were trained to collect the deceased patient from the ward, how to transfer the body from the ward to the mortuary and how to ensure the patient details were correct.

They were also taught how to sign the body into the mortuary and store the deceased in the mortuary fridge or freezer.

They also ensured deceased patients were wrapped in a dignified way with the correct identification, death notice and wrist/ankle bands in place. There were specific porters that had been trained to deal with sudden deaths within the emergency department only.
The porters were trained in infection prevention and control and had aprons, gloves and other personal protective equipment (PPE) available to them at all times. We were told that this training took place, however we did not see any evidence of this. We requested the porters training records but these were not supplied. Training for porters was carried out by mortuary staff on the procedures and protocols within the mortuary area, including how to handle deceased bodies with dignity and care. We spoke with the porters about the arrangements for transporting patients to the mortuary. Training was delivered over six weeks, which included meetings with the mortuary staff to ensure that the necessary procedures in the mortuary were maintained at weekends and overnight. The porters we spoke with could tell us about the protocol they followed.

The mortuary staff told us that they had completed their mandatory training. We were not provided with this information. They also informed us that they had attended a bereavement workshop, however, no further training had been received. No evidence was provided.

From February 2017 to January 2018, both nursing staff reported to work in end of life care had received appraisals which is better than the trust target of 90%. Mortuary staff received training and had a team meeting once per month however, no evidence was seen. We requested training information for porters but did not receive this.

The SPCT nurses received clinical supervision on a monthly basis. The lead consultant received their clinical supervision at the hospice that they had links with. The lead consultant was in the process of setting up clinical supervision within the trust for new SPCT members that were to join their team.

The trust also held Schwartz rounds that were open and available to all staff. This was a safe space for staff of all grades and service areas to attend a meeting to discuss difficult cases that they may have been involved with, as well as attending to hear colleagues’ experiences, from which they were able to learn. These were well attended from all grades such as porters, all the way through to consultants, and that all staff who attended benefitted from the experience; this was via feedback from those that attended.

Physiotherapists told us that they had not received any specific palliative or EOLC training, and none of their mandatory training included palliative or EOLC. The referrals were more for palliative care rather than EOLC patients.

Every Thursday, the palliative care team met with trainee doctors on the oncology ward only, to discuss and review/teach EOLC. Each care of the elderly registrar spent a week training and shadowing the SPCT and consultants to improve their knowledge of this area. The SPCT told us they have been inundated with requests from many service areas across the hospital to be able to shadow the SPCT. Two pharmacists have shadowed the team; in the future this will include visits to hospices and community palliative care services.

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<th>Number completed</th>
<th>Percentage Completed</th>
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<th>Target Met?</th>
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<td>100%</td>
<td>90%</td>
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The trust has only provided appraisal data for two nurses and no other staffing groups in end of life care.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
**Multidisciplinary working**

Patients that were entering EOLC or that had been recognised as entering the dying phase were placed on the iPELC document if seen by the SPCT. Not all patients within the trust that were EOL were on the iPELC. It was found that not all wards and consultants used this document as a standard, however awareness and use of the iPELC was increasing with further training and input from the SPCT and Link nurses. The iPELC document encouraged a multi-disciplinary team (MDT) approach by involving and providing space for a range of services within the trust. This ranged from medical care and pain management through to spiritual care and preferred place of care/death (PPC/PPD).

The SPCT attended one MDT per week. This was on a Wednesday morning and was the oncology MDT. The SPCT did not attend any other MDT, as there are many within the hospital. Each department conducted their own MDT, however due to the small number of SPCT CNS’s, it was not possible for the team to attend them all.

The SPCT also met for a monthly team meeting after their normal MDT on a Wednesday, quarterly clinical governance meetings, and a general meeting which was held yearly. The SPCT operational policy was the same as at the last inspection. This MDT did not include AHP (allied healthcare professional, social workers or other chaplains) therefore this was not a complete MDT.

Referrals were made to the SLT team via telephone. The team stated they had a mix of referrals, some were for palliative and EOLC patients, however many of these referrals came from the care of the elderly wards. The SLT team advised daily on unsafe swallowing and this was built into the holistic picture; there was no flagging system for patients that had already been seen by the SLT team. This team did not regularly attend ward MDT’s; however, they would attend when requested so that they were involved where needed, in decision making.

We spoke with six SLT (Speech and Language Therapists) team members. They were a content team and worked well together. They were a fully staffed service. They had a provision to provide cover until between 6pm and 7pm and this was apparently a very valuable service. This team worked across most services within the trust but specifically the acute adult team, acute stroke team, outpatient clinics and small paediatric team. We observed they were a passionate and committed team and were very knowledgeable around the topic of palliative and EOLC. They were particularly knowledgeable around pragmatic feeding, swallow assessments, mouth care, and communication with patients and families at end of life. They could advise and prescribe mouth care and food for taste/flavour.

Physiotherapists we spoke with stated that they had frequent exposure to EOLC and palliative care patients and this is via referral through individualised needs.

The palliative and EOLC lead consultant, two palliative care consultants, Band 6 CNS, Band 8 CNS lead and the chaplaincy lead all attended the weekly palliative and EOLC MDT. They started with a very short teaching session lasting no more than 10 minutes. They then went on to discuss new referrals; diagnoses, social situation, capacity through the Mental Capacity Act (MCA) assessments, relatives, risk assessments carried out, preferred place of care/preferred place of death (PPC/PPD). Also discussed were family meeting arrangement if appropriate, spirituality, if known to other services, discussions regarding the withdrawal of IV (intravenous) medications before transfer to hospice, discharge planning and fast track and non-fast track discharges.

We heard good cross discipline discussions regarding patient assessments and symptom management tools, as well as MCA assessments. There were also discussions for safeguarding as deemed appropriate. For some patients, it was appropriate to discuss their treatment escalation.
plan (TEP) and this took place. A positive discussion also took place regarding the appropriate person to assess certain patients and whether this should be a CNS or consultant.

The chaplaincy discussed spiritual care and mindfulness exercises to help relax patients and reduce their stress and anxiety. A leaflet was available.

Electronic records used to store patients’ records and decisions that gave access to the community team was also a topic for discussion as well as updating these. Patients within the community were discussed separately from inpatients within the trust. The team looked at PPD and those patients that had died since the last MDT, to establish if the patient’s wishes were met.

**Seven-day services**
The SPCT worked Monday to Friday, 9am until 5pm. There was no out of hours working by the team. There was also no provision for out of hours or holiday cover for either consultants or CNS’s. During our inspection in 2016, we discussed seven-day services in-depth with the SPCT. NICE (National Institute for Health and Care Excellence) guidance suggests that within palliative and EOLC, there should be a seven-day face to face service with out of hours cover.

In 2017, the SPCT had put forward a business case to gain extra staff, to provide the recommended service as described above. We saw evidence that the business case was successful after our inspection, and funding was put in place for the team to recruit. The SPCT are currently providing a five-day service with no out of hours cover, as they have been unable to fully recruit to all positions. The team have their full complement of consultants, however there are still CNS vacancies outstanding. As this is a CNS led service, the seven-day working will be provided by the CNS’s; therefore, the recruitment of specialist nurses is vital to the running of the planned service.

The trust has successfully recruited a CNS to their team and they are due to commence their post in July 2018. Another Band 6 nurse has been recruited from within the trust, and is currently in training to become a palliative care CNS in a Band 7 role. This nurse has completed the EOLC two-day training and continues to work towards completion of the appropriate training for this role. There is a further CNS role still vacant. The vacancy is currently being advertised; we have seen evidence of this.

There was no weekend cover for the SLT team, however this was out at consultation. Cover for bank holidays was provided on a voluntary basis. At the time of the inspection, the SLT team was a Monday to Friday service, although it did cover bank holidays. There was a plan in the process of being written to be put forward to provide a seven-day service, however this idea was in its infancy.

Outside of normal working hours (5pm until 8am), the porters were responsible for facilitating viewings of deceased patients.

Some religions required the deceased to be available for burial within 24 hours of death. The trust was aware of this and accommodated the families’ requests where possible. The site manager and porters were responsible for collections of deceased patients outside of normal working hours.

**Health promotion**

Patients could speak with the chaplaincy and the SPCT to gain counselling and spiritual and pastoral care. This was part of the holistic assessment and part of the iPELC document.

Patients could access leaflets with regards to organ donation and how this is believed to be perceived by some religions.
Anticipatory medication was prescribed mainly as and when appropriate. It was noted that this was generally completed prior to the weekend, if it had not already taken place, therefore leaving the patient in a positive position should they deteriorate out of hours or over the weekend, when there was no SPCT cover.

There were also smoking cessation leaflets available in the multi faith area. This was to assist patients, relatives and staff as well as others that use the space to understand the options and benefits available and how to assist in quitting smoking.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

At the time of production of this report, the trust had supplied no data around Mental Capacity Act or Deprivation of Liberty training for any of their staff within end of life care.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

During our inspection in 2016, we found that mental capacity assessments were not being completed prior to a DNACPR order being put in place. The trust audited their DNACPR orders in August 2017 over two days and found on 17 wards 35 DNACPR orders had been written; 97% of DNACPR orders had been completed correctly, 77% had been discussed with the patient or their next of kin, and 48% of patients were deemed not to have capacity; however, none of these patients had a mental capacity act (MCA) form completed.

It was found that 97% of nursing staff were aware of the DNACPRs and 14% were recorded in the nursing notes. At handover, 97% of DNACPRs were discussed, but none of the patients had a TEP as per trust policy. From these findings, the trust concluded that completion and awareness of DNACPRs was good, however, they identified areas of improvement to be the lack of MCA form completion and TEP completion. The SPCT formulated an action plan to be reviewed in February 2018. We were not provided with any evidence to show that a further audit was completed, or any progress the trust had made.

During our last inspection, we found that MCA of patients were not routinely taking place prior to a DNACPR being put in place. Out of the 12 DNACPR records we reviewed, we found five patients had their mental capacity assessed and documented prior to their DNACPR being put in place. One patient had their mental capacity assessed six days after their DNACPR was put in place. One patient had not had their mental capacity assessed prior to their DNACPR being put in place and there was no documented discussion with their relatives or carer prior to their DNACPR being put in place.

We found four patients where assessment of their mental capacity was not applicable; documented discussions with the family or next of kin were clearly stated. One of the patients where the trust decided the MCA assessment did not apply, had not spoken to the patient about the DNACPR decision however, the DNACPR order stated the patient had capacity; the notes recorded discussions had taken place with the patient’s family.

We found eight out of 12 DNACPR orders we reviewed were countersigned by another healthcare professional. In all 12 cases, we saw evidence that a rationale for issuing a DNACPR order had been recorded.

During our inspection, mental health colleagues reviewed DNACPRs and their compliance with completing MCA assessments. The records reviewed by our mental health team were for patients that were not under the care of the SPCT. They found the clinicians within the trust were not carrying out a mental capacity act assessment and best interests meeting before completing a ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) form, which documented the patient lacked capacity. Our mental health inspectors looked at five DNACPR forms.
These forms did not state what help had been given to the patient to help them understand the decision that was being made. In one example, the care records indicated the patient spoke a different language and did not understand English. There was no evidence that a translator had been engaged for this purpose; staff told us that a translator had not been called. This meant clinicians were not following the principles of the Mental Capacity Act, which states, a person is not to be treated as unable to make a decision, unless all practicable steps to help him to do so have been taken without success.

The trust carried out two audits on compliance with the trust’s consent policy during the previous 12 months. The audits looked at whether clinicians carried out mental capacity act assessments before filling in a DNACPR form, which indicated the patients lacked capacity. Both audits, one in August 2017 and one in February 2018, showed that no MCA assessments had been done before the DNACPR forms had been issued. This meant the trust was not ensuring these clinical audits were effectively acted upon. Compliance within palliative and EOLC team was stronger than within the rest of the trust.

The SPCT had decided that due to the results of their audit, which showed a lack of MCA and TEP completion, that they would pilot an idea. They stapled the three forms together, reminding the clinician that all three forms needed to be completed in appropriate circumstances.

We were informed by the SPCT that this had a positive effect on the completion of appropriate forms and care of the patient. These forms were still available, singularly also, where situations did not warrant all three to be completed. This change was agreed by the EOLC steering group but led by the resuscitation group. These forms were at the printers ready for roll out across the trust. We were not provided with any audit results to show how effective this pilot scheme had proved.

The SPCT held a training day for consultants on this new idea; 40 consultants attended.

Staff had access to mental health/deprivation of liberty safeguards guidelines on the trust intranet.

Is the service caring?

Compassionate care
During our inspection, we spoke with four patients that were either palliative or EOLC patients.

All patients that we spoke with were very positive about their care. They all stated the staff were helpful, kind and listened to their needs.

There were occasions when some patients said their call bell could have been answered quicker than it was, however if the patients were in pain or required medication, they all stated that this was given immediately.

Most patients said they always had access to food and drink, as required. The only improvements suggested was nursing cover on one of the wards overnight and the poor reception received via the television at the bedside.

We observed a kind caring attitude to palliative and EOLC patients via the SPCT. They remained calm and professional at all times when we observed them at work, and showed a supportive and positive attitude towards each other. The team worked efficiently and within their scope of practice and national guidelines to provide appropriate and up to date care.
Emotional support
The SPCT provided emotional support for patients referred to their team. All the SPCT nurses were level 2 trained counsellors. The team was able to deal with everything from speaking to patients to give them some support, or to talk through what they were feeling or about to experience, all the way through to dealing with patients that were in mental health crisis.

If a patient was known to have mental health needs, they were likely to have support from the mental health team already. If the patient was to be discharged, for example if they were under palliative care, if required they would be referred to their GP or appropriate mental health teams for ongoing support.

The SPCT were on hand to offer their patients support by speaking with them, looking at ways to manage and control their pain and symptoms, as well as provide support for their families.

Much of the emotional and spiritual support came from the chaplaincy. They were trained and used to providing support for all patients that required emotional or spiritual support. This was part of the service that the chaplaincy offered.

Families could access the bereavement team for support and follow up. The service also referred patients and their families to the chaplaincy team upon request. The Chaplaincy was very visible and visited all wards within the hospital. Referrals were made to the chaplaincy via wards, MDTs, family, friends and self-referral. If the chaplaincy was required outside of normal working hours, a list of on call chaplains was kept by the hospital switchboard. This was a list of many different faith chaplains. There were occasions where the full-time chaplain was asked to contact another faith chaplaincy if required. If outside of normal working hours, or an alternative faith to those available was required, there was generally a call out time of an hour to an hour and a half. Different faiths were catered for within the hospital chaplaincy.

Understanding and involvement of patients and those close to them
We observed that the SPCT not only supported and provided information to patients, but also their family, relatives and friends. They were there to provide advice and guidance and explained processes. The SPCT CNS’s advised patients’ care teams on the best course of treatment for symptom and pain control, advanced care planning, rapid discharge planning and TEP’s. They were also there to offer counselling to patients and their families.

CNS’s also spoke to the patients’ family, and explained the events their relative will experience; they were able to explain how the patient may not want to eat or drink as they became more unwell, and that their breathing may change. It was a way for relatives and carers to be able to know what to expect, to reduce the stress and anxiety they may face, and to offer emotional support. After a patient had died, the SPCT were able to assist the family with information as to what they needed to do, and whom they needed to contact. For example, speaking with the bereavement officer to arrange collection of the death certificate. The team were also happy to answer any queries or questions the relatives may have had.

On each ward, there was a palliative and EOLC folder that contained information for the ward staff treating the patient, as well as a booklet that could be given to the relatives or friends to explain what the patient may be going through and what to expect as the patient declines and dies.

Patients that were palliative or end of life were able to have their family with them outside of visiting hours. They were also able to stay at the hospital with their relative. If possible, the patient was moved to a side ward so that they were not disturbed by the noises of the ward and given more privacy. Having a side room also made it easier for relatives to stay with the patient without disturbing the other patients.
The trust produced a booklet titled ‘Carer’s Information Booklet’. This is a small leaflet that explains how the hospital can support carers of any of their patients; this is not just for palliative or EOLC patients. The leaflet gives a brief overview of admission into hospital, discharge from hospital and some advice as to what to do if the carer had ongoing concerns. It describes where further help can be found, for example charity telephone numbers and websites. There is also a section that tells carers of the benefits that are available whilst they are at the hospital, for example 20% off food at the hospital restaurant. There was a further booklet titled ‘Last Days of Life’. This was also provided to patients, their relatives and friends via the SLT team as well as the SPCT and wards; they also signposted patients relatives and carers to other services as appropriate.

The trust had several fold-up beds on various wards available for family members to utilise overnight, when staying with a palliative or end of life patient.

If the fold up beds were not available, comfortable recliner chairs were provided. We saw evidence of these in use. The SPCT and wards stated that this was easier to facilitate if the patient was housed in a side room. There was more space and less disturbance for the other patients.

Relatives of palliative and end of life care patients were given a carer’s passport to use within the trust. This gave the carers parking at the hospital for £1 per day rather than the standard rates.

Also included in the carers passport were food vouchers that could be spent at the hospital during their stay. Visiting hours for EOLC and palliative care patients was open 24 hours a day, there were no restrictions.

On a ward, we saw ‘thank you’ cards that had been received from families of patients that had died. They thanked the wards for ‘excellent care and support’.

We also asked the mortuary what they had in place to assist relatives and carers that attend the mortuary to see a deceased loved one, in case they became upset. The mortuary was able to describe a scenario where this had occurred recently and they were able to describe clearly, how they dealt with the situation.

Relatives and friends were able to visit the mortuary to view the deceased patient. The normal viewing hours were Monday to Friday 12pm until 3.30pm. Outside of these hours, the porters arranged viewings for relatives and friends. There was a dedicated viewing room for relatives/friends to view the deceased, a waiting area and toilet facilities. Families were supported during a viewing, and relatives were advised what to expect. Appointments could be organised through the bereavement office or mortuary from Monday to Friday.

### Is the service responsive?

**Service delivery to meet the needs of the local people**

The trust provided a chaplaincy service for patients, their relatives and their friends. They were on hand to visit the patient to offer spiritual and pastoral support. If a chaplain of another faith was required, this was readily available via an on-call system. The chaplaincy also had many volunteers of different faiths that had been trained to assist and attend patients. The volunteers had been trained by the Chaplains and had attended external courses to enable them to carry out this work. Once their training had been completed, they were mentored via the chaplains before being signed off as competent, and able to work alone.

On each ward, there was a palliative and EOLC ‘Help’ folder for doctors and nursing staff to utilise. This folder contained a booklet titled ‘Care in the Last Days of Life’, details on the SPCT and the
consultants’ availability within the team, a copy of the iPELC document and how to use this, links with the community palliative care team, details for the chaplaincy, contact details for various assistance from community teams, and charities that are available to give advice and support. It also described the fast track pathway for discharge for palliative care patients—this included advice and guidance on symptom control.

There was also separate guidance for EOLC patients that required rapid discharge home for patients that were in the last days or hours of life. This folder also gave further information for discharging dying patients to various locations, for example a hospice. There was also information regarding bereavement support for the relatives and carers of the patient. There were also charity telephone numbers and email addresses to be provided to relatives and carers if required.

The mortuary had access to ‘pop up fridges’. These were used during high pressure times, such as during the winter. This enabled the mortuary extra fridge body storage space when they were at capacity. During our inspection, we were informed that the pop up fridges had been returned two weeks prior to our inspection. They were not on site during our inspection. At our 2016 inspection, we were told that this was just a temporary situation, however they have been used since.

The trust also had an agreement with local undertakers, that they would be able to remove and store deceased patients if the hospital fridges were at capacity, or in the case where any of the fridges broke down. This arrangement was also available, should there be a major incident and the trust required further body storage facilities. The trust body storage fridges could accommodate four bariatric patients and two concealment trolleys to transport deceased patients, including bariatric patients, to the mortuary.

Meeting people’s individual needs
The SPCT was accessible and available Monday to Friday 9am until 5pm. They received referrals through a multitude of routes; this could be from within the hospital e.g. a ward requests assistance, advice or guidance, via community such as a one-off case review, or even a lay person (a person that is not medically qualified or has little or no knowledge within that specialist area). Referrals were only able to be taken during normal working hours as there was no cover outside of these times. Urgent referrals had a target time of two hours to be seen by the SPCT and non-urgent referrals had a target time of one working day.

Every Wednesday morning, there was an SPCT MDT where the current case load was discussed. The team discussed any patients that had died since the last MDT, and any new cases that had been referred. On a Wednesday morning, all team members were present.

As per the last inspection, the question was raised as to whether the consultant cover could be organized differently in order to provide a seven-day face to face service. The lead for the SPCT stated that it was important for all the team to be available at the same time to encourage good team working and ensure all members of the team were aware of the case load.

This was also a predominantly CNS lead service, and the CNS’s will provide the full seven-day face to face cover, once they are fully staffed.

Patients could be referred to the SPCT for symptom control, psychological issues arising from their illness, for rapid discharge home to allow the patient to die in their preferred place of death (PPD), and to discuss advanced care planning. We spoke with ward matrons and sisters and were told that the SPCT was readily available for palliative and EOLC patients as required, during normal working hours.
Fridges were available on wards to allow relatives and friends to bring patients food that they enjoy or request, to the hospital. However, there were no facilities for patients or their relatives to heat up food. This was due to health and safety protocols.

The SPCT looked at the main languages spoken, and there were 162. Instead of translating the EOLC leaflet into just a few languages, they were innovative, and decided to have the leaflet made into an easy read format, so that everyone, regardless of language or reading ability was catered for. This also catered for those with learning disabilities. The trust had two Turkish translators as well as Polish translators, and these were easily accessible by all teams as and when required. If they were not available, or a different language was required, other translators were able to be requested in person, or a telephone service was able to be used. Translation and interpretation services were available 24 hours a day, seven days a week. This was either on a face to face basis or via a telephone service line. These services were easily accessible and readily available.

Some patients preferred to be able to spend their last moments at home, amongst their familiar surroundings. The SPCT had a process where they could discharge patients home, with all the medication and equipment required, within four hours. This process was called a rapid discharge. This process was normally used for those patients within their last days or hours of life, to expedite them home or their preferred place of death as quickly as possible. We requested any outcome audits associated with rapid discharge, however, these were not provided.

The trust operated ‘The Forget-Me-Not Scheme’ for patients living with dementia. There was a leaflet to explain how the scheme worked. With the consent of the patient and their relatives/friends, a blue flower sticker was placed on the patients’ care notes and the symbol was placed above their beds. This indicated to hospital staff that the patient was living with dementia and therefore these patients could have their care planned accordingly. This scheme also asks staff to obtain information from the patient and their relatives about the things they like or dislike, what food they like to eat and the things that upset them. This was so that the patient could be cared for in the way they would wish, even if they are unable to specify this at certain times.

The leaflet provided to relatives and carers that described the scheme gave websites to age related and memory loss charities that could provide further information on the patients’ conditions.

We asked the Chaplaincy if bedbound patients were able to attend services and events. This information was not available however, the chaplaincy did have a Bluetooth speaker that they were able to use to play hymns and songs to patients at their bedside. We were also told that another trust broadcast their radio station at this hospital, and patients could access this.

There were provisions to broadcast any services or events at the patient’s bedside. The Chaplaincy provided 1-2-1 services at the bedside if this was required by a patient or their relatives.

Every Monday, the chaplaincy held a mindfulness group that was open to all faiths and beliefs, including those with no faith. This encompassed a midday meditation; a Hindu colleague attended to facilitate this. Unfortunately, only those patients that were mobile, or those that had support from either physiotherapists or nursing staff could attend these groups. There was no provision for bedbound patients to attend.

The Muslim Imam conducted prayers on a Friday for patients, their relatives and staff. This took place in the Muslim prayer room that was attached to the multi-faith room. The multi faith room was also used as a trust meeting room, therefore it was not always available to those that may require the space for their spiritual and pastoral needs. This was the same situation that we found during our last inspection in 2016. The multi faith room was not available during certain times on
Fridays during Muslim prayers, as there was a large congregation that attended. The women used the multi faith room attached to the Muslim prayer room for their prayers. Within the multi faith area, there were two wash room facilities so that both the female and male Muslim congregation could carry out ritual washing prior to praying.

There were plenty of prayer mats and Qurans available for those attending the Muslim prayer room and multi faith centre. There were also Muslim posters and fact sheets regarding the religious thoughts on organ donation. We also found a small poster that was available for the Muslim community regarding the current Ramadan. It was informative as to medical treatment and keeping and breaking the fast. There were a few of these available on the table in the multi faith area, as well as one of the posters was placed on the wall.

We saw that there were a few ladies head scarves available for Muslim ladies that wished to pray. The ladies’ area was substantially smaller than the male prayer area. This was the same as we found in our last inspection. During our last inspection there were plans to expand this area, however we did not see evidence of this. Due to the demographic of the trust, there was a large Muslim community attached to the hospital.

The Chaplaincy also conducted a yearly baby memorial service for parents and relatives that had lost their child. There were plans to celebrate and support different faith religious days and celebrations. They had events for Easter, Christmas, Jewish New Year, Ramadan, Eid and so on.

There was access to the hospital Chapel, Multi-faith room and Muslim prayer room 24 hours a day, seven days a week; however outside of normal working hours, this was via swipe card access only. This meant that a patient or their relatives would be required to find a member of staff or security to give them access.

The multi-faith room provided some alternative religious scriptures. There were very small provisions for Christian and Hindu faiths, however other religious scriptures remained unrepresented. This area (which was also used for trust meetings) was very basic. It contained some tables and chairs, a couple of posters and some religious scriptures as described above. This area felt more like an office and was unwelcoming rather than a peaceful space for all faiths to enjoy.

The Chapel was almost opposite the multi-faith/Muslim prayer area. It was neat, clean and tidy, and contained real candles that the congregation could light within a designated area.

This area was watched over via CCTV (closed circuit television). It was a quiet area, and contained many Christian, Catholic and other Christ faith icons and pictures. There was also a large cross behind the altar. There were no other faith symbols or items, except for a small table that housed some other faith religious scripts. Again, very few faiths were provided for within this area and within religious text. We brought this to the attention of the Chaplaincy during our inspection in 2016 and they agreed that there were areas for change. We did not see any change within these areas.

We also noted during the previous inspection, that the cabinets containing other religious scripts and items were locked. The Chaplaincy agreed during the last inspection that this may not have been the most appropriate situation as outside of normal hours there was no access to the keys for the items. This had not changed. The Chaplaincy had recently secured funding to refurbish the multi faith area, however there was no information on the changes that were to be made at this time.
The information leaflets that we saw available regarding EOLC and palliative care were only available in English. The SPCT had also decided that EOLC leaflets were to be printed in easy read format, so that even patients, relatives or friends would be able to understand the information provided.

**Access and flow**

There were two designated beds on Podium ward for palliative or end of life care patients. There were no other designated beds on the other wards throughout the hospital for palliative or end of life care patients. Palliative and EOLC patients were cared for on all wards. Each ward was able to cater for these patients either within their own protocols or with the assistance of the SPCT.

The trust had a third party to provide portering services. Part of their role was to collect deceased patients from the wards and deliver them to the mortuary. The majority of porters were trained to do this (65 out of 70 porters). The porters were contacted within 30 minutes of the patient’s death to arrange transport of the body to the mortuary.

We saw evidence that EOLC patients going through the rapid discharge process could be discharged to their preferred place of care/death within four hours. In 68% of cases, the patient achieved their preferred place of death within the reporting period.

A business case was put forward by the SPCT following our previous inspection in 2016 to increase the CNS’s cover by 2 WTE posts as well as increasing consultant cover. The reasoning put forward by the team for this increase was partly financial, as well as for patient care. The business case could demonstrate the cost savings that could have been made, if there were appropriate procedures in place to prevent inappropriate and unnecessary admissions to the trust. The addition of staff as per the business case, would allow a seven-day SPCT CNS lead service, face to face, with out of hours telephone consultant cover, as deemed appropriate by NICE guidelines and Royal College of Physicians guidelines.

The trust was under the required number of consultants within the SPCT; the trust had 515 beds. Guidance states that for every 250 beds, there should be 1 WTE consultant. The business case stated the impact that having the required number of staff within the SPCT would enable better EOLC and palliative care, cost savings and a more efficient service, delivering care in line with national guidance and standards and achieving the best outcomes possible for the patients and their relatives.

**Learning from complaints and concerns**

During our last inspection in 2016, the SPCT stated that they had not received any complaints due to computer error. They were having an issue coding the complaints to ensure they reached the team. During this inspection, the team have stated that they have worked alongside the complaints team developing trigger and key words, that cause the complaint to be flagged as a palliative or EOLC complaint.

We have been assured this system is working well and confirmed this by checking that the SPCT team were able to speak about complaints that they have received and action plans and learning they have taken from these. The SPCT and other ward staff throughout the trust were able to tell us of incidents and learning that had taken place within EOLC.

Complaints were looked into and investigated. From the outcomes of investigations, action plans were put in place and the learning was cascaded to the rest of the team if appropriate; this learning was also shared with other colleagues within the trust for learning purposes.

The SLT team stated that they had not received any complaints within the last 12 months.
We spoke to the PALS and complaints officers within the trust. They told us that it was rare to receive a complaint regarding palliative or EOLC. Over the past six months, the team were aware of two palliative and EOLC complaints. One was that the patient’s family felt that palliative care should have been introduced at an earlier stage for their relative. There were no complaints regarding the mortuary however, a comment was passed regarding the tone of the answerphone message to contact the morticians in feedback from a relative.

From January 2017 to December 2017 there were 12 complaints about end of life care. The trust took an average of 33 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be resolved within 30 days.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We were only told about one complaint by the trust, although the SPCT stated they receive approximately six complaints per month.

Is the service well-led?

Leadership

The SPCT was led by a lead consultant and a lead CNS. The SPCT was a team of three consultants (1.6 WTE) and three CNS’s (clinical nurse specialists) that worked Monday to Friday, 9am until 5pm.

The reporting structure for this team was under surgical service. For consultant cover the clinical lead reported to the clinical director of oncology and palliative care; they then reported to the divisional director of clinical services. For nursing, the matron of haematology, oncology, sickle cell, stroke, radiotherapy and palliative care reported to the divisional head of nursing.

Within the mortuary, the lead consultant for histopathology reported to the medical director, who then reported to the chief executive.

During our previous inspection, there was no non-executive director (NED) of palliative and EOLC. Shortly after our inspection in 2016, a NED was appointed. We discussed this with the SPCT at our inspection and was told that there was now a new NED in place. We were told that the NED was visible and spoke to staff when they carried out a visit to the trust. The NEDs were on a rota system and attended generally for planned visits. These usually took place monthly and to attend the trust board meetings.

The leadership of the service has changed since the last inspection. The lead for the SPCT was very well informed and knew exactly how the service had changed and where it was headed. They had been part of the team to write the palliative and EOLC strategy. The lead consultant was also present during our previous inspection, therefore was able to explain the changes and differences since 2016.

They were all aware of the new vision and strategy, and were working towards achieving their action plan. They updated the EOLC steering group and the board yearly at the annual general meeting (AGM) as to their progress. They could clearly state where they had been successful, as well as areas still to improve. The team were fully aware of national guidance within palliative and end of life care and had incorporated this smoothly into their strategy, and were attempting to bring this into day to day activities. There had been a large amount of work that had taken place since the last inspection regarding the running of the team and business cases. These had been
approved, and once in place, the team hoped the palliative and EOLC service they provided would be in line with national guidance.

There was passion and excitement from the team around the positive changes; they were also very realistic as to their current position and the challenges they faced ahead. Recruitment of CNS’s to the team had proved difficult, however the team were innovative and were attempting to try alternative, non-conventional recruitment techniques, with success.

Vision and Strategy

The trust had a vision and a strategy for EoLC in place. This had not been in place during the previous inspection. The trust EOLC strategy was based on the 5 Priorities of Care, NICE guidance and the ambitions of the service. The trust strategy was adopted from The Royal Free Hospital 2016 version and in conjunction with Palli8. This strategy was launched in October 2017 and this included a five-year plan.

There are six ‘ambitions’ that underpin their strategy, these were: each person is seen as an individual, each person gets fair access to care, maximising comfort and wellbeing, care is coordinated, all staff are prepared to care, each community is prepared to help. The strategy made it clear that EOLC is defined as the last 12 months of life. This was an area of confusion identified at the previous inspection as there were varying definitions depending on the staff member that was asked.

The trust has set their vision goal as to deliver excellent EOLC. The way they hope to achieve this is to include patients, their relatives and staff, through organisational and working processes; through commissioned and locally provided care; through the communities, and through the trust board and its members. The strategy defined the roles and responsibilities of those involved. It also specified the reporting structure and governance, and line of responsibility. This involves the EOLC steering group and the patient experience group as well as the trust board and others.

The trust used this as a means to benchmark themselves against other trusts that provide palliative and EOLC. It used KPI’s (key performance indicators), bereaved relatives surveys, NCDA (National Care of the Dying Audit), complaints, incidents reported, equality and diversity and staff and patient experience performance reports.

The strategy sets out how it hopes to achieve this for example, through holistic support for the patient and their families, access to the SPCT, all the way through to care after death and bereavement support for the families. The aim of the strategy is to be fully compliant with NICE guidance in EOLC by 2020. The trust was working towards this through action plans and processes in conjunction with other palliative and EOLC organisations, as well as other trusts.

The strategy was launched and staff were informed of this through different routes. The SPCT had a stall in the atrium of the hospital with information on palliative and EOLC.

The business case put forward by the SPCT for two additional CNS’s and additional consultant cover had been agreed and signed off at the beginning of March 2017. At the time of our inspection, the team were still yet to recruit to capacity to be able to provide the palliative and EOLC service as set out in guidance.

Culture

The SPCT was a small but strong team; they were very supportive of each other and kind and caring to one another. The team were passionate about their role and helping one another; they showed care and support to the new nurse that had come from another service area within the trust, and they provided support and training to them.
Despite the team being understaffed, they tried to offer a full service to palliative and EOLC patients during normal working hours. We saw the caseload the SPCT held during our inspection. More patients were added to their list as the week progressed.

The CNS’s and consultants within the SPCT worked very closely and respected each other. They worked to provide a good level of service to their patients, as well as trying to make inroads to increase the profile of palliative and EOLC within the trust. We did not see any evidence of negativity or bullying within the SPCT. We were told by staff members of the trust that the SPCT was visible, very responsive and always happy to help and offer advice when required. Another member of staff told us that the SPCT are ‘readily accessible when needed; they are very responsive when needed’.

They had managed to raise their profile throughout the trust since the last inspection during 2016. We spoke with a ward sister on one of the wards and they informed us that when there is a death on the ward, the staff member that has taken care of the patient is offered 1-2-1 support.

The SLT team were confident to raise any complaints or concerns with ward managers and the Head of Therapy. They were valued by the trust especially since our last inspection, where they had felt undervalued. The majority of consultants and medical teams they work alongside valued their input and contribution to the patients’ care, especially on the stroke ward where risk of aspiration was particularly high.

They were a dedicated and compassionate team that attended many best interest discussion meetings, regarding the withdrawal of nutrition and feeding at end of life. The team were able to describe the process in detail skilfully and compassionately. This was also evident within patient notes. The team had a good working relationship with the SPCT and could name the team members and how to contact them. They were also aware as to the definition of palliative care and EOLC, which was part of the trust EOLC strategy. During our last inspection, there was much confusion as to these definitions.

**Governance**

At the time of our inspection, the trust did not carry out audits within the mortuary or post mortem areas. The IPC lead was very clear that the trust was behind with their review of policies. The IPC lead had joined the trust in this role approximately six months prior to the inspection and had not visited the mortuary until attending with us during our inspection.

During our last inspection, we were concerned with the air changes that were taking place within the mortuary and post-mortem suite. The IPC lead was aware that there were issues with the air changes in various areas of the hospital, however, during our visit to the mortuary and post-mortem area, we did not find any concerns with this. The DoH (Department of Health) has guidance on mortuary IPC. The IPC lead was not aware of this guidance. The morticians told us that in the absence of SOP’s, they utilised NICE guidance and called other mortuaries for advice. The IPC lead stated that the mortuary and post-mortem suite had not been ‘on the radar’ and they stated they had little understanding within this area. We were also informed that there was no guidance on how specimens should be stored within the mortuary.

Whilst we were on-site, the health and safety officer attended the mortuary separately with the IPC lead and the interim mortuary lead, and stated that they were happy with the current storage of specimen facility. This was not assessed against the DoH mortuary standards for storage of specimens. We were not shown any risk assessment or mitigation for this.

We requested SOP’s for the mortuary and post-mortem suite, showing the day to day running of these areas. We were shown documents that related to the hospital laboratory and manufacturers
guidelines; the mortuary lead stated that these were the only written items available. We were also shown a document titled ‘Procedure for Cleaning the Mortuary’. This was dated 22 August 2012. The document stated that it was for yearly review, however, there was no evidence this had taken place. Due to some of the information contained within the document regarding cleaning fluids, it was clear this document had not been reviewed and was out of date. This was brought to the attention of the IPC and mortuary leads; they stated that this would be reviewed as a priority. The HSE document titled ‘Safe Working and the Prevention of Infection in the Mortuary and Post Mortem Room, paragraph 147 states that the SOP’s for the mortuary should be used to measure outcomes and make any changes or improvements. The mortuary did not have any SOPs at the time of our inspection. This document stated that all mortuary employees should be provided with a copy of the SOP’s when they start working within the mortuary.

Legionella testing took place every day, except during weekends. We saw evidence that this testing had taken place.

Fridge temperatures were recorded every day except during weekends and bank holidays. We noted that some of the fridge and freezer temperatures recorded were not within the stated range. Their procedure was to recheck the fridge temperature. There was no record or evidence to show that this took place. We were told engineers came out to the hospital fairly promptly and rectified any situation. We saw no evidence of this.

There were three rooms attached to the inside of the post-mortem suite. Both rooms were ‘semi-clean’. We spoke with the IPC lead and mortuary lead regarding this situation. Both utility rooms were kept locked when not in use. During the 2016 inspection, we noted that the taps in the ‘dirty utility’ of the post-mortem suite were not compliant with HBN (Health Building Note) regulations. The mitigation explained by the IPC lead was that a tissue could be used to turn off the tap once used. This washing basin and the taps were not on the risk register.

The HTA (Human Tissue Authority) had recently carried out an inspection of the mortuary and post-mortem suite. We were provided with a copy of the report. Some of the concerns raised by CQC were reflected within this report. At the time of our inspection, this report had only just been issued, therefore no action plans were available.

Incidents and complaints were reviewed at both the EOLC steering group monthly meetings, and again at the oncology monthly meetings. They were further reviewed at the divisional risk governance meeting that occurred every month; this was a regular agenda item. Serious incidents and never events and their outcomes were then fed into the patient safety and outcome committee meeting.

We received the summary of the EOLC Steering Group Meeting held on 16 May 2017, where the action points for the new financial year were declared and set, and which form the basis of the 2018 palliative and EOLC annual report. The summary was an action plan of six main areas, split down further into subcategories. Most of the categories and subcategories were ‘in progress’, however it was noted that areas marked as ‘complete’ were for example, ‘Monitor proportion of iPELC documents used per number of deaths across the Trust (to document individual plans for EoLC)’. To ensure the team or service did not become complacent, and to continue to check areas of improvement and areas that may require further attention.

Audits are normally repeated annually or biannually to benchmark and monitor the service. There was no mention in the action plan of the audits or monitoring of completed tasks to ensure ongoing compliance.
The end of life committee meeting took place on 14 March 2018 and discussed EOLC training across the trust. This meeting discussed the percentage of trained adult nurses within the trust, the target and how this has been met so far. This was a summary given to CQC of the meeting.

Bereavement surveys were given out with a stamped addressed envelope to 80-90% of bereaved relatives. Those cases referred to the coroner were not sent a survey. These surveys were provided with the death certificate. This was a change since our last inspection.

In 2016, we found that the trust had a bereavement survey available to give out to bereaved relatives, however none had been given out. We were assured that, within two weeks of our inspection during 2016, the surveys would start to be sent out to relatives. An audit took place of the results received from the survey, therefore this is evidence that this took place.

We requested outcomes of this survey, however, we did not receive any details from the trust.

At the time of our inspection there was no advanced decisions policy available.

The EOLC steering group met biannually; we were only provided with a summary of the meeting.

The SPCT operational policy was reviewed annually and signed off at the annual general meeting (AGM). The 2018 meeting had occurred just prior to our inspection.

**Management of risk, issues and performance**

We asked to see the EOLC risk register; the only item for palliative and EOLC showing was no seven-day working as set out in NICE guidelines; we were informed by the SPCT that there had been other concerns registered on the risk register, however, these had now been mitigated, corrected and removed. This was unable to be confirmed.

At the time of our inspection, the mortuary was not on the risk register. This was unable to be confirmed. We did not find a risk assessment attached to the storage of produce of conception.

These were stored in formalin within plastic tubs and many were in each metal container; there was no ventilation. We questioned this from a health and safety point of view and were told by the lead health and safety officer that this was within regulation. The IPC lead informed us that the trust had placed the cleaning contract for the trust on the corporate risk register. This could not be confirmed.

The mortuary had no SOPs or IPC audits carried out. There was a lack of evidence of PAT testing within this area, and we were not shown any risk assessments with regards to the washing and reuse of sharps (suture equipment) or reusable surgical equipment. We were informed that after our last inspection, all equipment within the mortuary was single use disposable items. This was not the case on inspection. We found three trays containing cleaned reused surgical equipment. We also found a box of out of date gloves that was disposed of immediately by the mortuary technicians.

DoH mortuary standards state that formalin is a toxin if inhaled, as well as an irritant.

We did not see any risk assessment associated with the use and storage of this substance.

Formalin is a flammable substance. We did not see any fire extinguishers close to the room that stored the items sealed in formalin. We brought this to the attention of the trust.

We were made aware of the trust using a cleaning fluid within the mortuary for washing reusable instruments, as well as the fridge trays and other areas within the mortuary.

Under EU/528/2012 (European Union Directive), this substance was removed from use in 2012. We brought this to the notice of the IPC lead and mortuary lead.
They told us that they were informed by the manufacturer that this was a different formulation to the banned substance, however they removed this from the mortuary immediately. The substance was classed as a phenolic and this is hazardous to health. The trust stated that they would be replacing this with a chlorinated agent instead across the whole trust. There was no risk assessment associated with this cleaning agent. The mortuary multi-use equipment was not autoclaved or sterilised in any way.

We were assured that the IPC and mortuary leads were going to carry out an audit and risk assessment of the mortuary and the post mortem areas as soon as possible, to identify risks and mitigate these. The IPC lead was also not aware of the mortuary staff cleaning suturing needles by hand, however they stated that this was not appropriate and would cease immediately.

The mortuary staff told us that in the event they were unsure as to what to do, or a situation arose that they didn’t know how to deal with, they would call other trust mortuary departments for advice and guidance. The mortuary lead was not aware of this situation; however, he had only been in post approximately one month as an interim lead.

The HSE (Health and Safety Executive) sets out mortuary standards under the document ‘Safe working and the prevention of infection in the mortuary and post-mortem room’, this includes how to carry out a risk assessment, and how these should be recorded. It states….’ 25 The main findings of the risk assessment must be written down in all but the simplest of cases. Employers often incorporate these in the standard operating procedures. These procedures are then used as working documents for managers, employees and safety representatives.’ There were no risk assessments carried out for the mortuary; furthermore, there were no SOP’s for this area. Paragraph 36 of the same document describes the transition areas between clean and dirty utility. The trust mortuary did not have a clean and dirty utility at the time of our inspection.

Paragraphs 45 and 59 of the same document describe the level of ventilation required for the storage of specimens. We brought to the attention of the IPC lead and the mortuary interim lead, that there was a lack of ventilation in the area that stored specimens within the mortuary. The trust told us that they were happy with the storage of the specimens and they did not feel the need for them to be stored in a ventilated area. This is contrary to the named paragraph of this document. This is also a requirement of COSHH (Control of Substances Hazardous to Health) regulations.

**Information Management**

The trust kept paper and electronic records for patients. Paper records were kept with the patient at their bedside. The trust used an electronic system to record palliative and EOLC patients’ care and medical treatment; this included DNACPRs, letters to the GP, advanced care planning and treatment plans. This could be accessed by the hospital, the ambulance service, pharmacists and GPs, so there was continuity of care and correct treatment options offered to the patient.

The iPELC document produced by the trust was used to ensure patients’ needs were met. This provided a framework of best practice and guidance for clinicians to work with. It provided vital information and flow charts that could be followed to provide relevant care and support to patients and their relatives alike.

This document was used to record medical care such as medications and treatments that the patient was undergoing, and medications prescribed. It also captured and recorded details of nutrition and hydration, mouth care and food for taste. The patients care plan was recorded within this document so that any clinician providing care to the patient could see all details in one place. There was space for further details to be recorded.
The iPELC document prompted clinicians in advanced care planning processes as well as issuing DNACPRs. It recorded discussions with patients and/or their relatives and reasons behind decisions. It also recorded MCA assessments and outcomes which are part of the trust policy for issuing DNACPRs. Within the iPELC, discussions with chaplaincy were documented and those for care after death. This was to state the patient’s wishes as well as religious rituals and observations.

Engagement

We spoke with the SLT team and found that since the 2016 inspection, there had been positive changes. The doctors and consultants were more inclusive of the SLT team with the care of their patients, especially with care of the elderly ward consultant However, they did feel undervalued by the trust. The SLT team was not included in the development of the iPELC document used for palliative and EOLC patients. The SLT team did regular training with junior doctors on risk feeding. This was called Rolling dysphagia training; however, the team found it a challenge to get funding to attend external training courses.

The trust had an EOLC steering group meeting every three months. Complaints and new policies were discussed and polices or changes in policy were ratified. The results of the bereaved carers’ survey were presented to this group; this also included any comments relatives had made on their survey regarding their relative’s care. Any trends in complaints were also discussed at this meeting. We requested details of any news letters or communications sent out to staff and patients from the SPCT regarding EOLC. None were received.

We saw evidence the SPCT provided training days for staff within the trust. Each of these training days explored different conditions and problems a palliative or EOLC patient may face; this included medical complications as well as the need for spiritual and pastoral care, and how these can be addressed. The trust also conducted the bereaved carers survey and created an action plan based on the results. The results showed an increase in negative comments and results, however, the trust was working on improving identified concerns to improve their service.

Staff engagement took place through training days, special events through the SPCT and trust such as educational and feedback lunches, newsletters and staff surveys.

Oncology and medical consultants and FY1 (foundation year 1 doctors) and FY2 (foundation year 2 doctors) that attended Core Medical Training (CMT) were provided with a palliative and EOLC pocket guide. This was also provided to other members of staff that attended the SPCT training. There was also guidance on the intranet for all staff to access.

The palliative and EOLC network known as Palli8 and the trust (both hospital and community) subscribed to the same guidelines for symptom control in palliative and EOLC patients.

A mobile phone application (app) was produced for these guidelines. One of the hospices that is part of the Palli8 network gave funding so the trust staff could access and utilise this app free of charge.

The bereavement officers and mortuary staff had input towards the EOLC policy with regards to dignity of the deceased patient, and when it is appropriate to place a patient on to the iPELC document.

The trust held a series of lunches over three different days and invited those involved with the MDT, porters, administration staff, healthcare professionals and others to discuss EOLC and that ‘dying matters’. The idea to have these lunches was developed as a result of the bereaved carers survey results. The commentary provided by one of the patients stated the doctor ignored her after her mother had died. The SPCT took this comment seriously. The purpose of these lunches was
to help staff to communicate and speak with those that were going through a loss or bereavement and what to say, as some staff said, at times, they didn’t know what to say. At the end of the lunches, all who attended were asked to write a sentence on something they thought might be an appropriate statement to say to the relatives of the deceased. This was to help staff feel more comfortable with talking to relatives that they were caring for. Each attendant at the event was able to take their sentence, and any others they felt comfortable using, away with them to use.

**Innovation and continuous improvement**

Feedback from an EOLC patient’s relative. There was noise disturbing their dying relative, and they both found this difficult. A staff member trialled an idea to place a flickering candle and explanation notice on the ward, if they had an EOLC patient present. This was a gentle reminder to those on the ward, without being too specific and identifying the patient, that there is a patient on the ward that is nearing the end of their life, and they need calm and peaceful surroundings.

This idea has been rolled out across the hospital and each ward had been provided with a candle and explanation poster. The flickering candle and explanation is normally displayed on the reception desk to the ward. This innovation had been very well received by patients, relatives and staff alike.

The trust, as part of their strategy and action plan, performed a gap analysis of their service. They looked at all aspects of the care of the dying to create the gap analysis and action plan to remedy their findings. An independent reviewer analysed 17 areas relating to palliative and end of life care. They identified gaps in service from coding of patients through to holistic care and seven-day face to face SPCT provision. The action plan created specified dates for completion for each recommendation. We saw this document was kept up to date and reviewed on a regular basis. We also noted that part of the action plan were the areas CQC identified for improvement during the 2016 inspection. We have not been provided with evidence on all areas to show that all changes have taken place. For example, during our last inspection, it was noted that there was psychological support in the form of counselling for oncology patients, however other palliative and end of life care patients were referred to the chaplaincy for psychological support. This has not changed.

The business case put forward by the SPCT was also looking to extend the palliative care provision from a 9am until 5pm service, to an 8am until 8pm provision. This business case was agreed and signed off on 1 March 2017. We were informed by the SPCT lead that this appointment had been filled and the facilitator was in post. It was a fixed term three-year post; if improvements are seen, it was likely that this position would continue. The trust had also agreed a business case for a rapid discharge coordinator to be part of the SPCT, however, this post had not yet been recruited.

This was to make the system run smoothly and have a single point of contact to coordinate the rapid discharge of the patient, as time is of the essence with EOLC patients wishing to be transported to their PPC/PPD.

The SPCT realised that there are several languages spoken within the boroughs they serve. They looked at ways to get their leaflets translated in as many different languages as possible; however, with the number of languages used within the area, they came up with a simple and effective way to communicate via a leaflet to all language groups and reading abilities, how a patient may behave or appear during the last stages of life. This leaflet was provided to relatives and carers to help them to understand what was happening at each stage. They concluded that
this leaflet would be provided in ‘easy read’ format, which would enable all reading abilities, understanding and language barriers to be overcome, as well as being cost effective.

The trust had signed up to be part of the NHSI programme ELCHIP to try to improve the care and speed of care for EOLC patients that were admitted to the ED. This was voluntary.
Outpatients

Facts and data about this service

The outpatients services at the North Middlesex University Hospital come under the surgery division. The gynaecology OPD is under the women’s and children division and is operated out of the women’s centre.

All outpatient services were open Monday to Friday 9.00am to 5.00pm with ophthalmology offering appointments on occasional Saturday’s to manage the waiting lists. The phlebotomy clinic (blood tests) was available from 7.30 am each morning to 5.45pm on Mondays, 6.45pm on Tuesdays and Thursdays, and 4.45pm on Wednesdays and Fridays.

The outpatient services included clinics in gynaecology, ophthalmology medicine and care of the elderly, trauma and orthopaedics, urology, general surgery, cardiology, rheumatology, thoracic medicine, cardiothoracic surgery, general medicine, dermatology, oral surgery, neurology and gastroenterology.

We visited a range of clinics in OPD 1,2,3,4,5,6,7, and the gynaecology OPD. We met with people who use services and carers, who shared their views and experiences of the OPD service. We spoke with 33 patients and two relatives who used the services and looked at 16 patient records. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We spoke with 45 members of staff including doctors, nurses, administrative and ancillary staff. We also spoke with the OPD management team.

In addition, we reviewed national data and performance information about the trust and read a range of policies, procedures and other documents relating to the operation of the OPD and related services.

Total number of appointments compared to England

The trust had 423,676 first and follow up outpatient appointments from January 2017 to December 2017. The graph below represents how this compares to other trusts.
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from January 2017 to December 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Middlesex Hospital</td>
<td>583,469</td>
</tr>
<tr>
<td>Trust total</td>
<td>605,443</td>
</tr>
<tr>
<td>England total</td>
<td>103,454,525</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Number of appointments by specialty

The table below shows the number of outpatient attendances for the trust by speciality from December 2016 to November 2017.

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Number of Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical specialties</td>
<td>173,031</td>
</tr>
<tr>
<td>Surgical specialties</td>
<td>130,441</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>58,296</td>
</tr>
<tr>
<td>Oncology</td>
<td>52,607</td>
</tr>
<tr>
<td>Dermatology</td>
<td>12,606</td>
</tr>
<tr>
<td>Other(s)</td>
<td>184,030</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)
Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from January 2017 to December 2017. The percentage of these appointments by type can be found in the chart below:

Number of appointments at North Middlesex University Hospital NHS Trust from January 2017 to December 2017 by site and type of appointment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Staff told us the quality of training was good and mandatory training included both e-learning and face to face meetings.

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to February 2018 for nursing staff includes staff working in outpatients, fracture clinic, pre-operative assessment, ophthalmology and gynaecology is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Eligible staff - YTD</th>
<th>Number of staff trained - YTD</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>35</td>
<td>33</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>35</td>
<td>31</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>35</td>
<td>30</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Training Course</td>
<td>Eligible staff - YTD</td>
<td>Number of staff trained - YTD</td>
<td>Percentage Completed</td>
<td>Trust Target</td>
<td>Target Met?</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------</td>
<td>------------------------------</td>
<td>----------------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>34</td>
<td>27</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>35</td>
<td>27</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>35</td>
<td>27</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 84% which does not meet the trust target of 90%. Only manual handling met the trust target of 90% and six training modules were below the trust target of 90%.

Workforce dashboard information provided by the trust showed the overall completion rates for mandatory training in outpatients, fracture clinic, and ophthalmology were meeting the trust target of 90%. However, the completion rate for phlebotomy staff was 50% which does not meet the trust target of 90%. Only adult basic life support met the trust target of 90% and six training modules were below the trust target of 90%.

The trust has not supplied any mandatory training data for medical staff in outpatients. The trust reported there were no dedicated medical staff for each clinic and mandatory training would be reflected within the speciality.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

The trust had an up to date safeguarding adults at risk policy. Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to.

The trust reported no safeguarding referrals have been made by the OPD. Staff we spoke with did not always demonstrate an understanding of the safeguarding process. Staff in areas where children under age 18 attended were not aware who held safeguarding level 3 training for children.

The OPD provided appointments to children under the age of 17 years. The trust did not have a standard operating procedure for seeing paediatric patients in the OPD.

The trust reported the safeguarding adults and children training included female genital mutilation (FGM) as a topic as part of their training. Patients were able access the Iris clinic which provides care and support for women who are experiencing problems as a result of FGM. Staff told we spoke with told us of the escalation process they would follow.

Staff we spoke with said they use the learning disabilities passport for clinic visits. This passport was designed to give hospital staff helpful information to make patients feel more comfortable about the hospital visit.

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to February 2018 for nursing staff includes outpatients, fracture clinic, pre-operative assessment, ophthalmology and gynaecology is shown below:
The overall completion rate for nursing staff was 82% which does not meet the trust target of 90%. Safeguarding Adults and safeguarding children were below the trust target of 90%. Workforce dashboard information provided by the trust showed the completion rates for safeguarding adults level 2 training in outpatients and ophthalmology were meeting the trust target of 90%. However, the completion rate for fracture clinic (86%) and phlebotomy staff (40%) was below the trust target of 90%. Safeguarding children level 2 level training in outpatients, fracture clinic and ophthalmology were meeting the trust target of 90%. The completion for phlebotomy staff (81%) was below the trust target.

Information provided by the trust demonstrates none of the nursing staff working in the outpatients and ophthalmology were required to undertake safeguarding children level 3 training as part of their role.

Information provided by the trust demonstrates two medical doctors have received safeguarding children level 3 training in ophthalmology.

**Cleanliness, infection control and hygiene**

Staff could not always tell us who was responsible for cleaning certain areas. We found one of the treatment rooms required cleaning, some equipment had been moved and the floor was very dirty and dusty. This was escalated at the time of the inspection. There was no clear responsibility of who oversaw cleaning in the children’s play areas or documentation to support this. Daily clinical and environmental cleaning schedules were not available in all the clinics, which meant the trust could not be assured daily cleaning was being undertaken by staff in outpatients. This was similar to the last inspection.

During inspection, we found most areas in outpatients appeared clean and tidy. Clinics displayed their cleaning audit score for the month. The daily cleaning of the departments had been outsourced to another provider, monthly monitoring audits were undertaken to monitor cleanliness. Monthly cleaning audits were undertaken across all the clinics showed the OPD consistently scored higher than 95% compliance.

Patients told us they thought the waiting areas and toilets were clean. Several patients told us “The hospital is always clean”.

Across the department we saw variable use of ‘I am clean’ stickers which were placed on items to indicate they had been cleaned after use.

We observed staff using infection control practices. There was adequate personal protective equipment (PPE) throughout the department. While some PPE dispensers were not filled and one hand sanitiser bottle was not filled, we observed staff having these supplies at their work stations.

We noted all staff adhered to the hand hygiene, “bare below the elbows” and hospitals uniform protocol in clinical areas. This reduced the risk of infections to staff and patients and was in line with good practice.
Quality metric information boards were on display in each of the clinics. Hand hygiene audit results for clinics 1, 4, 6 and the fracture clinic showed between April 2017 and March 2018 staff had achieved 95% compliance. There was only one month when compliance was below 90% in July 2017 when it was 88%.

The trust was managing and decontaminating reusable medical devices in line with national guidance such as the DH Health technical memorandum on decontamination. The decontamination unit demonstrated the dirty to clean pathway and had a named individual as the authorised person or competent person for endoscopes. This is an individual trained and qualified to ensure all endoscope machines are commissioned to HTM01-01: Decontamination of reusable medical devices (health test memorandum – HTM).

Sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.

Infection prevention was part of the mandatory training programme; 86% of staff had completed the training which was below the trusts target of 90%.

Environment and equipment

In the OPD none of the resuscitation trolleys had paediatric resuscitation medications or paediatric resuscitation equipment. This meant appropriate equipment was not available to children under the age of 17 years were children were being treated.

Resuscitation trolleys were located in different areas of the OPD readily available and within easy access for staff and sealed. The seal was changed weekly when medicines and stock were checked. The resuscitation trolley medicines log showed all medications were in date. The resuscitation trolleys looked visibly clean and ‘I am clean stickers were used. Oxygen cylinders were full and in date. Defibrillators were tested on a daily basis.

Re-useable devises such as the cleaning of ear, nose and throat ENT OPD scopes was undertaken by the endoscopy department. Staff were aware of the processes for decontamination and high-level disinfection of flexible scopes and documentation for OPD scopes management. However, we found some single use items of equipment dates had expired.

Electrical Medical Equipment (EME) had a registration label affixed. Portable Appliance Testing (PAT) labels were attached to electrical systems showing they had been inspected and were safe to use. We found an item of equipment used for testing urine had expired in November 2017.

Assessing and responding to patient risk

The OPD did not have clear pathways and processes for the assessment of people within the outpatient clinics or who were clinically unwell and required hospital admission. The trust advised they did not have a policy for deteriorating patients in the OPD. Staff advised sometimes patients will need to be admitted from clinic. If the patient is stable, a system is in place to request an inpatient bed and if the patient is unstable, processes are in place to send patient to the accident and emergency department.

We looked at 16 records and found one of the records had a completed national early warning score (NEWS). The NEWS is a trigger which enables staff to recognise “at risk” patients for early intervention by medical staff to help prevent deterioration. Patients’ clinical observations such as pulse, oxygen levels, blood pressure and temperature are monitored in line with the national institute for health and care excellence (NICE) guidance CG50 ‘Acutely Ill-Patients in Hospital.’

Staff could access the resuscitation trolleys which were located at outpatient clinics 3 and 6.
Staff reported the outpatient clinics had access to a mental health liaison and staff showed us where they would find their number to contact them.

**Nurse staffing**

There was no baseline acuity tool for nursing staff in outpatient clinic as staffing levels were based on the number of clinic that are run. Senior staff advised the staffing levels within the OPD clinics had not been reviewed while the number of clinics operating had increased. A business plan was in development for two additional qualified nurses and health care assistances (HCA’s). Staff we spoke with said there were not enough staff; the number of clinics had increased and additional patients were added to lists or the clinics were extended. In phlebotomy staff felt under pressure due to the numbers of patients attending. The ophthalmology and the breast clinic had recently introduced a safe care acuity tool for staffing levels. However, in the breast clinic staff advised the breast clinical nurse specialist (CNS) would support the consultant’s clinics due to lack of nursing staff.

The OPD did not have qualified children’s nurses working in the ophthalmology or fracture clinic where children were treated. There were no plans to address this.

The orthopaedic clinic had an identified link dementia nurse. Link nurses are part of a system that shares information and provides formal, two-way communication between specialist teams and nurses in the clinical area.

Bank and agency staff were used in the outpatients department, but many of these staff had a worked in the department for regularly and had a long-standing relationship with the hospital.

Not all of the clinics operated with qualified nursing staff. Band 2 HCA’s were used to support clinics. The trust offered apprenticeship scheme for HCA’s.

The trust has not provided the planned vs actual staff levels for nursing staff outpatients, fracture clinic, and breast care.

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

<table>
<thead>
<tr>
<th>April 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>13.5</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018, the trust reported a vacancy rate of -1% for nursing staff in outpatients; this indicates the trust have more staff in than had initially been planned for. The trust target vacancy rate is 7.5%.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

In ophthalmology from April 2017 to March 2018, the trust reported a vacancy rate of between 1.0 WTE and Nil. The indicate the trust have no vacant posts.

From February 2017 to January 2018, the trust reported a turnover rate of 9.9% for nursing staff in outpatients; this is better than the trust target of 15%.
The trust had provided monthly turnover rates for nursing staff working in fracture clinic, ophthalmology and breast care from June 2017 to May 2018. Monthly turnover rates range from 0.0% to 16.7% in fracture clinic, from 0.0% to 11.1% in ophthalmology and from 0.0% to 33.3% in breast care.

The trust has provided monthly turnover rates for staff working in phlebotomy from June 2017 to May 2018. Monthly turnover rates range from 7.0% to 32.3%.

From February 2017 to January 2018, the trust reported a sickness rate of 5.8% for nursing staff in outpatients; this is worse than the trust target of 3.5%.

The trust provided monthly sickness rates for nursing staff working in fracture clinic, ophthalmology and breast care from June 2017 to May 2018. Monthly sickness rates range from 0.0% to 2.5% in fracture clinic, from 0.0% to 15.9% in ophthalmology and from 0.0% to 18.7% in breast care.

The trust has provided monthly sickness rates for staff working in phlebotomy from June 2017 to May 2018. Monthly sickness rates range from 2.5% to 8.6%.

The trust provided monthly agency and bank usage for nursing staff working in ophthalmology from May 2017 to March 2018 which ranged from 0.2 whole time equivalents (WTE) to 1.0 WTE.

**Medical staffing**

The trust reported there were no dedicated medical staff for each clinic and cover of the OPD was included within the speciality job plan. Medical staff appraisals were also undertaken within their speciality so the trust was unable to provide data relating to this for outpatients.

<table>
<thead>
<tr>
<th></th>
<th>April 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>10.6</td>
<td>12.3</td>
</tr>
</tbody>
</table>

From April 2017 to March 2017, the trust reported a vacancy rate of 16% for medical staff in Ophthalmology.

The trust has provided monthly turnover rates for medical staff working in orthopaedic and ophthalmic departments from June 2017 to May 2018. Monthly turnover rates range from 5.2% to 15.9% in orthopaedics and from 12.5% to 41.5% in ophthalmology.

The trust has provided monthly sickness rates for medical staff working in orthopaedic and ophthalmic departments from June 2017 to May 2018. Monthly sickness rates range from 0.0% to 5.3% in orthopaedics and from 0.0% to 21.0% in ophthalmology.

The trust has not provided total shifts including those covered by permanent staff.
Records

We were told by staff across the outpatients clinics there were still issues with missing notes. This could cause an appointment to be delayed or cancelled and rescheduled. Senior staff advised tracking records throughout the trust was an issue. The records department have recently started tracking records electronically by using barcodes which meant they were able to track records in and out of the department. The trust was developing an in-house training programme for filing and tracking and they were seeking to recruit more staff looking to increase the staffing levels to 34 whole time equivalent staff (WTE) from 28 WTE staff.

We requested information on the number of temporary records created in the last 12 months; however, the trust advised this information was not collected.

Receptionists told us information about patient’s special needs, such as dementia, should have a flag on their chart, but we saw no evidence of this. Staff were not able to tell us whether there were flags for patient's special needs in the electronic medical record.

The OPD used paper records. We looked at 16 patients’ records. Some paper medical records we looked at were untidy, unclear and difficult to navigate. Most of the records we looked at did not have a stamp which recorded the doctors or nurses professional pin number. All records we looked at had GP referral letters available.

Clinics were using a mix of paper and electronic records systems. Medical staff were able to access results from investigations electronically. Reception staff would be checking in patients using a new data system which was used to recorded patients demographics. The electronic records system used in ophthalmology was specific to that speciality.

Paper records were held securely with in lockable note trolleys which had a keypad. Records used by reception staff were kept out of sight to ensure patient confidentiality was maintained. We observed nurses checking records in clinical rooms out of sight of patients. However, in one consulting room we observed the computer was left on with the staff member still logged on. We also observed a trolley full of records for the ophthalmology which was not lockable had been left in a corridor unattended.

When clinics were finished, patient notes were transferred to the administrative staff so further appointments could be booked and relevant letters or investigation results filed. Notes were transferred back to medical records library when complete.

Information governance was not part of the mandatory training programme.

Medicines

Medicines were stored in locked cupboards and treatment rooms. However, in one locked treatment room, we found a cupboard with no lock storing medications. Staff were not aware of who had electronic badge access to this room. We found that checks for stock and expiry dates were not being consistently recorded.

We noted the temperature of clinic refrigerators storing medications had daily temperature recordings. Temperatures were recorded daily when the department was open to ensure medicines were stored at the correct temperature. Record logs confirmed fridge temperatures were within range. The temperature of rooms storing medications was not recorded.

The trust audited the safe and secure handling of medicine in March 2018. The audit assessed adherence to trust guidelines for storage and security of medicines. The audit identified three
areas for improvement which included ensuring medication fridges were locked and ensuring daily fridge temperatures were recorded. An action plan had been put in place with a proposed re-audit scheduled.

Consultants issued outpatient prescriptions or referred patients to their GP’s for prescribed medicines. We found suitable arrangements were in place for the secure storage of prescription sheets as these were locked away at night and put into rooms at the start of clinics. The ophthalmology department issued FP10 prescriptions as patients waited too long for dispensing from the OPD pharmacy. FP10 pads were logged and issued to specific clinic rooms and were stored securely at night.

The OPD pharmacy was available from 9.00am to 5.30pm Monday to Friday for prescriptions which needed to be dispensed immediately. The OPD pharmacy did not provide a weekend service.

The trust advised an average 80% of patients are receiving their medication within 30 minutes from the outpatient pharmacy.

The outpatient pharmacy satisfaction survey showed 97% of patients mentioned they were happy with the pharmacy service received.

**Incidents**

From March 2017 to February 2018, the trust reported no incidents classified as never events for outpatients. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

*(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from March 2017 to February 2018.

*(Source: Strategic Executive Information System (STEIS))*

The OPD used an incident reporting system widely used in the NHS to report incidents. From May 2017 to April 2018 a total of 737 incidents were reports at various outpatient locations. Of the incidents reported 74 were reported by ophthalmology, and 66 related to the OPD. The largest number of incidents (106) reported related to records which were missing, lost or unavailable missing records.

Staff knew how to report incidents. Some staff we spoke with told us they had not reported any incidents. Staff advised most of the incidents reporting were for waiting times for patients and missing notes. Another staff member advised their manager told them to stop incident reporting missing notes because they were already aware of the issue.

We received mixed feedback from staff regarding their comfort level reporting incidents. Some staff members told us there have been incidents of verbal and physical abuse against them and did not feel like they had as many rights as patients. Therefore, they did not report these incidents at times because they did not think their concerns would be heard. Five of the 737 incidents reported by staff related to verbal abuse in the period regarding May 2017 to April 2018.

Staff reported some feedback from incidents but this did not appear to be consistent across the OPD. Staff said they were informed about serious incidents from the intranet.
Staff advised us of one measure had been put in place because of incident reporting. To reduce waiting times and clinic running over time, a cap on the number of patients added onto a clinic schedule had been introduced.

Surgery, cancer and associated services division (SCAS) meetings were held and minutes showed serious incidents and incidents were discussed. However, a review of OPD nursing, administrative and phlebotomy staff meetings minutes showed incidents were not discussed. This meant senior managers could not be assured staff groups working across the outpatients department were learning from incidents across the trust.

From November 2014, NHS providers were required to comply with the duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty 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.

Most staff were aware of their responsibilities under the duty of candour, which ensured patients and/or their relatives were informed of incidents which affected their care and treatment and they were given an apology and offered support.

**Safety Thermometer**

The NHS patient safety thermometer is a national tool used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering ‘harm free’ care. This information is intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide.

The safety thermometer is an inpatient tool and does not relate apply to outpatient departments.

All patients due to be admitted had a venous thromboembolism (VTE) assessment prior to admission. Daily audits were in place to see this was done.

Signs were available in clinics for contact for the fire warden. Most staff were able to describe what their role was in case of a fire. However, most staff did not know how to evacuate patients who had mobility issues.

Staff were not able to tell us their role in case of a major incident or where to find their major incident plan. The trust had a business continuity plan which was available on the staff intranet this set out the trust expectations which stated:

‘Managers need to ensure that employees for whom they have responsibility for are aware of procedures and can be contacted / managed as appropriate. Staff are expected to follow instructions and to work flexibly as needed.

All staff are expected to make themselves aware of their appropriate Service Business Continuity Plan, and ensure they understand their role within the Trust’s response to a business continuity incident’.

**Is the service effective?**

**Evidence-based care and treatment**

The trust had a number of policies and procedures in place which were based on the national institute for health and care excellence (NICE) guidelines or other nationally or internationally recognised guidelines.
The Trust policies and guidance were easily accessible for staff on the trust intranet. Staff we spoke with were aware how they could access trust policies and guidance on the intranet.

The OPD was part of the surgery division which participated in the trust audit programme. In 2017 17 national and local audits had been undertaken with 10 completed, no report or action plan had been produced. A further 38 local and national audits were had been planned for 2018.

Ophthalmology had five audits planned to start in 2018, this included the cataract surgery risk stratification audit, the national ophthalmology audit, eye drop compliance in eye casualty - quality improvement project and audit of macular laser for diabetic macular edema. This demonstrates the hospital was engaged in auditing the effectiveness of the care they provided.

We saw evidence of staff recently participating in a dementia awareness week and an insulin safety week to educate both staff and patients on these topics.

**Nutrition and hydration**

Every outpatients department had cups available for patients to get water. However, sometimes the water was outside the clinic area and not necessarily easy to find.

Some clinics could provide patients with snacks if appointments were running late and the patient had a medical condition warranting sustenance. Clinics which did not have access to snacks had a nearby vending machine for snacks and drinks or patients could visit the hospital cafe.

**Pain relief**

Staff in the pain management clinic told us there were no standardised pain assessment tools available in clinics. One clinician said they would access pain assessment tools on their phones as there were no paper tools available.

We did not see any evidence of appropriate tools for patients who were non-verbal, with learning disabilities, or dementia. One staff member told us normally carers would be responsible for relaying the patient’s pain level to them. The trust advised patients who were non – verbal, had a learning disability or were living with dementia were reviewed and assessed in the outpatient pain clinic by the pain consultant or the pain nurse specialists.

In the eye clinic patients were routinely asked about pain and were provided with local anaesthetic eye drops or oral analgesia pain relief was routinely given to all the patients in eye casualty.

Staff were able to access appropriate pain relief for patients within outpatients clinics.

The trust advised they did not have a multidisciplinary team (MDT) pain service but was in the process of developing a business case. The plan was to employ a psychologist and physiotherapist with special interest in pain to set up the pain MDT.

**Patient outcomes**

The trust advised the OPD did not hold separate audit meetings for the OPD as these were included within the individual speciality audits. None of the audits planned in the surgery division were specific to the OPD.

An outpatient’s improvement programme had recently been implemented to look at clinic utilisation to improve the performance of the OPD. This included reduction in the number of did not attend (DNA) rates, increase in the number of clinic slots, reduction of clinics cancelled within 6 weeks, and improvement of the new follow up rate. An in-house training programme was being developed for staff as part of the improvement programme.
In 2016/2017 and 2017/2018 ophthalmology had also undertaken two ‘quality of consent in ophthalmology’ re-audits and was yet to report. The trust advised the audit results for 2016/2017 were to be submitted in May 2018.

The follow-up to new rate for North Middlesex Hospital was better than the England average from January to March 2017 then worse than the England average from April to December 2017.

(Source: Hospital Episode Statistics)

Competent staff

New nursing, bank and agency staff were given a local induction. An agency staff member advised they would receive a local induction into the different clinic's, but were not aware where medicines within the clinic were held or what the door code was for the dirty utility room. Staff reported they had a one-week induction which included their mandatory training when they first joined the trust.

Nursing staff we spoke with reported there were limited learning and development opportunities. Courses offered were mainly half or a one-day course but frequently they were unable to attend due to staff shortage and lack of coverage. Regular bank staff told us they were not provided opportunities for further development and felt they were missing out on professional development.

A student nurse who had just started their placement advised they received a local induction, been allocated a practice educator and been advised there would be training fortnightly.

In the ophthalmology clinic, new staff told us they were signed off as competent on different equipment before they could test patients.

Staff received an annual appraisal. Staff we spoke with told us they had an appraisal within the last 12 months.

From February 2017 to January 2018, 88% of staff within outpatients at the trust had received an appraisal compared to a trust target of 90%. Nursing staff includes staff working in outpatients, fracture clinic, pre-assessment, ophthalmology and gynaecology is shown below:
The trust report appraisal rates for nursing staff working in fracture clinic, ophthalmology and breast care as of May 2018; these were 100%, 90% and 100% respectively.

The Trust reported appraisal rates for medical staff working in ophthalmology as of 31st March was 1005.

**Multidisciplinary working**

There were regular multidisciplinary team meetings within outpatient specialisms. Staff were able to access the liaison mental health team.

The breast clinic operated as a one stop clinic for patients with different clinicians and clinical nurse specialists (CNS).

Patient information would be shared with GP’s when patients were discharged or following appointments to ensure continuity of care.

The outpatients administrative staff told us they worked well with the outpatients nursing and medical staff.

**Seven-day services**

The outpatient department was open Monday to Friday 9.00am to 5.00pm with ophthalmology offering some appointments on a Saturday to reduce the waiting lists and meet demand. The phlebotomy service (blood tests) was available from 7.30 am each morning to 5.45pm on Mondays, 6.45pm on Tuesdays and Thursdays, and 4.45pm on Wednesdays and Fridays.

Senior staff told us the trust had been working on the utilisation of clinic to ensure the OPD operated at capacity during the week. In the last 12 months the trust utilised 84.5% of appointments compared to the trust target of 92%.

The outpatient pharmacy was open Monday to Friday from 9.10am to 5.30pm.

**Health Promotion**

Across the OPD we saw little evidence of health promotion information available for patients. We saw leaflets on stopping smoke were behind one reception desk and not easily assessable. These were only available in English.

In the gynaecology OPD there was a pamphlet on the Iris clinic and domestic violence and a cancer support board.

The trust had an insulin safety week to raise the profile of diabetes and insulin.

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### Staff Group Summary

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of individuals required</th>
<th>Number completed</th>
<th>Percentage Completed</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing Staff</td>
<td>30</td>
<td>27</td>
<td>90%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>27</td>
<td>23</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>57</strong></td>
<td><strong>50</strong></td>
<td><strong>88%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a policy for consent to examination, treatment and autopsy in place. Consent is a patient’s agreement for a health professional to provide care including making physical contact with the patient for the purposes of care and treatment. Patients may indicate consent non-verbally, orally, or in writing.

The OPD used a standard consent form which was used to obtain consent from patients before carrying out most procedures or providing treatment, which we saw evidenced in patients’ notes. The bottom copy of the form was given to patients. Records reviewed showed evidence that consent was gained for care and treatment where appropriate.

Staff were aware of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). Staff knew how to contact mental health liaison service.

We requested information from the trust on OPD Mental Capacity Act and Deprivation of Liberty for nursing staff in outpatients, fracture clinic, pre-operative assessment, ophthalmology and gynaecology but this information was not provided.

Is the service caring?

Compassionate care

Staff provided treatment and care in a kind and compassionate way and treated people with respect. Staff were seen to be very considerate and empathetic patients. Patients we spoke with were positive about the staff who provided their care and treatment.

The OPD had a main reception desk which was staffed by reception staff. During the inspection we observed patients queuing to check in, the queue sometimes stretched into the main concourse. Reception staff would check people’s personal data on the electronic record system before directing them to their clinic. However, we observed people could be over heard and there was no signage asking people to wait a discrete distance from the reception desk. Reception staff at the main reception desk and in clinics were friendly and helpful.

The OPD gathered feedback from patients to monitor their experience of the department. To the question ‘Did we respect your privacy and dignity at all times when examining you?’ the department scored an average of 94% for period March 2017 to April 2018. There was one month when the department scored less than 90% in October 2017 when the department scored 84%.

Friends and family test (FFT) results were displayed in the waiting area of the OPD clinics. For the period of March 2017 to April 2017 the OPD scored an average of 84% for recommending someone to come to OPD. A total of 14,408 patients responded over the twelve-month period. This was lower than the England average (95.6%) and trust’s average (94%). Electronic friends and family feedback pads were available in some areas of the OPD so patients could provide feedback on their visit.

We spoke with 33 patients and 2 relatives and they were mostly positive with the care they received. Patients commented, “No objections’ to care here, staff are polite and kind,” “Positive experiences with staff so far”, “Very nice here,” “Nurses are nice and caring” and “I really find everyone friendly”. In one clinic we saw cards from patients thanking staff for their kindness, care, advice, and their caring, friendly and empathic attitude.” However, one patient told us “Have had to
make sure we see the same consultant as this was not automatically sorted for us. If we had not intervened we would have been seen by a different consultant each time."

The trust had a chaperoning policy. It was mandatory for healthcare professionals to have a formal chaperone present when performing intimate examinations and no child, young person or vulnerable adult at risk of abuse should be examined without a chaperone being present. The trust defined a chaperone as a health care worker who was involved with a patient who needed to be accompanied. Staff we spoke explained the procedure for using chaperones and obtaining their consent. In clinic rooms there were notices about chaperones. Medical and nursing staff advised they would ask people if they wanted a chaperone, but this was not recorded.

**Emotional support**

In one clinic patients told us “Staff go the extra mile, staff call me after 6pm. Staff are willing to stay behind and help people, very friendly”.

Staff in OPD told us they did not have a dedicated room which could be used when breaking bad news. Staff would try and find a room so the patient had time to come to terms with the news. Staff told us when it was really busy they were not able to offer a suitable area. The breast clinic had a quiet room available.

The hospital had a multi-faith centre. Chaplaincy and counselling services were able to patients who needed them, and nursing staff were available in some clinics to offer support.

Cancer patients were also able to access counselling and complimentary therapy services through the Helen Rollason cancer support centre and Macmillan Cancer support.

Patients attending the gynaecology OPD could also access the Iris clinic which provides care and support for women who are experiencing problems as a result of female genital cutting (FGC).

**Understanding and involvement of patients and those close to them**

Patients told us staff helped them to understand their care and treatment, and medical staff took time to ensure they answered their questions and felt confident in their treatment. Patients told us staff “Explain everything clearly to you so you understand. Show pictures of before and after”, “Staff fine, doctor takes time to explain”. Happy with it”, “Doctors have shown me x-rays and explained well”.

As part of the feedback from patients who used the OPD to monitor their experience of the department patient were asked ‘If you had important questions to ask the doctor, did you get answers that you could understand?’ The department scored an average of 83% for the period March 2017 to April 2018 and was under 80% in April (75%), July (71%), October and February 2018 (79%).

Patients we spoke with understood why they were attending the outpatient clinics and the types of investigations they were having.

The department had access to interpreters which could be booked when patients’ appointments were made.

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**Is the service responsive?**

**Service delivery to meet the needs of local people**

The outpatient services operated from seven clinics and the breast clinic in the main hospital with the gynaecology out patients operating from the women’s centre. Clinics 1, 4, and 6, were
provided by different specialities and included phlebotomy. Clinics 2 and 3 were ophthalmology and clinic 7 was the fracture clinic and orthopaedic.

Outpatient clinics were clearly numbered, however it was not always clear where patients should sit in the main waiting areas. One patient we spoke with was sitting in the OPD pharmacy waiting area but waiting for a blood test. They had used the self-check in and it hadn’t been clear where they should sit. We also observed patients were getting lost as some of the signage directing patients to the clinics was not clear. The gynaecology outpatients was not clearly signposted from the main entrance, however was very easy to find if coming through the women’s centre.

The outpatient departments had adequate seating however one of the waiting areas which had seating for the OPD pharmacy, phlebotomy and the ophthalmology was not clearly signposted and confusing to navigate.

The seating was fixed and quite close together. Some patients we spoke with told us the chairs were hard and uncomfortable. No bariatric seating was available. Staff told us bariatric equipment was not available in the clinics, but if a patient needed to be admitted, a bariatric bed would be available.

The department did not have a private area for patients if staff needed more privacy to talk to patients; staff had to utilise treatment rooms when they were not in use.

The OPD did not offer telemedicine, skype or telephone appointments as an alternative to face to face appointments.

Children attending the fracture clinic or ophthalmology did not have a separate waiting area. Small play areas were near these clinics. Staff we spoke with reported children were prioritised and usually seen quickly.

The OPD had access vending machine for snacks and drinks or patients could visit cafes which were available on the ground floor. The OPD also had access to toilet facilities.

All outpatient services were open Monday to Friday 9.00am to 5.00pm. The OPD operated adhoc ophthalmology clinics on a Saturday based on the demand for the service.

The OPD pharmacy was open hours Monday to Friday from 9.00am until 5.30pm. There was no Saturday opening when the OPD was open.

The hospital had a separate outpatient children’s clinic; however, children and young people were also seen in the adult OPD. In the last 12 months 6,116 children were also seen in by different specialities, the largest attendances were for fracture and orthopaedic clinics (4,828), ophthalmology (279) and clinical physiology (229). The trust did not have a standard operating procedure for children and young people in the OPD.

### Meeting people’s individual needs

The outpatients department offered a range of nurse led clinics for patients, these included COPD, respiratory, diabetes, stoma care, breast, pain management and pre-operative assessment clinics.

There were very few information leaflets for patients, relatives and carers available in languages other than English. This was similar to what we found at the last inspection. Patients requiring leaflets in another language, larger print, braille or easy read had to request these.

Each clinic had its own dedicated seating area, but we found none of the areas had bariatric seating. Patients we spoke with told us they found the seating uncomfortable.

Chaperones were available in some clinics. In the breast clinic everyone was offered a chaperone, however in the gynaecology clinic staff told us due to nursing staff levels nurses are spread across
two clinics which makes chaperone availability difficult. In phlebotomy clinic staff told us they did not have designated chaperones. They advised that parents would stay with their children and some patients would request to have a staff member of the same sex take their bloods which the department would do their best to accommodate.

Children’s play areas with toys were available in some areas; in the orthopaedic and fracture clinic the play area was small with limited play equipment. The gynaecology OPD did not have a children’s area in the clinic.

Interpreters offering both face to face and telephone interpreting could be pre-booked for patients where English was not their first language. The electronic records system had an option for interpreter required to be ticked. In the breast clinic staff told us they booked interpreters for giving bad news as telephone interpreting services weren’t appropriate for sensitive news. However, one patient whose was first language was not English told us they were not offered an interpreter. We also observed a member of staff came out of a bay and shouted to the waiting area ‘I need someone who speaks Turkish’. A person from waiting area offered and went in to bay. This did not reflect best practise. Interpreters were used for a total of 1,271 times for outpatient appointments during the period 1st January to 31st March 2018.

The self-service check in for blood tests translated into six languages. The check in had accessibility options so patients could indicate if they used a wheelchair, were hearing or sight impaired, had slow mobility, or had a learning difficulty.

The trust had a dementia link nurse who was available to support patients, families, carers and staff. In Clinic 7 (Orthopaedics and fracture clinic) there is a link dementia nurse who supports other members of the team when working with patients with dementia. Staff told us some of the initiatives to support patients included carer’s passport and a ticker book for carers/relatives (includes £1 off tickets for food in the hospital and the car park). Patients with dementia are flagged to staff in the trauma staff meetings in the mornings and fast tracked and given priority in the queue for appointments. The hospital used the purple forget me not flower scheme on the notes to identify patients who were living with dementia.

There was a learning disability flag on the electronic medical record system which identified patients with learning disabilities. Staff we spoke with told us patients who were living with dementia, had a learning disability, or suffered from mental ill health would be identified on their patient records and given priority in clinic to be seen quickly. Not all staff have received dementia training; staff reported dementia training was not part of their mandatory training programme.

We requested information from the trust on dementia training for nursing staff in outpatients, fracture clinic, pre-operative assessment, ophthalmology and gynaecology but this information was not provided.

The breast clinic provided a one stop clinic, which included a nursing team of cancer nurse specialists (CNS) who could be contacted directly by mobile phone or email.

Patient transport was available for patients with mobility issues. One patient told us transport to the hospital was arranged for him, the nurses were helpful in sorting that out and they have a porter available when needed, this is requested from the OPD reception.

Staff told us if patients arrived late they were still seen. If transport was delayed in collecting patients they would be taken to the discharge lounge where they would be able to access refreshments.
Access and flow

The trust had a policy for the Management of Outpatient, Diagnostic and Admissions Pathways which was in the process of being reviewed. The policy set out how the trust and commissioners manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment.

In the twelve-month period January 2017 to December 2017. The trust had 423,676 first and follow up outpatient appointments, which included 6,116 children and young people under the age of 17 years which was 1.4% of the total attendance.

The OPD department was in operation Monday to Friday from 9.00 am to 5.00pm and offered ad hoc ophthalmic appointment on a Saturday. Patients were usually referred by their GP, optician or attended follow up appointments following treatment at the hospital. Patients reported to the main reception desk near the main entrance of the hospital where they were registered and directed to the appropriate clinic. Patients attending for blood tests were requested to use the self-check in service when they arrived. Between May 2017 and April 2018 an average of 80% of GP referrals were booked within seven days.

The trust did not monitor waiting time for patients, however this was one of the main concerns raised by patients we spoke with during the inspection. Patients commented “Today’s appointment is running over; arrived half hour early to avoid being sent home.” “Been waiting for 1 hour, this hasn’t been communicated” (The white board said clinics were running 20 minutes late), “Clinic has been delayed today. Says 15 minutes wait, but I have been waiting for 40 minutes”. In clinics we saw white boards were used to notify patients if clinics were running late but these were not always updated. The OPD gathered feedback from patients to monitor their experience of the department. To the question ‘Were you informed of delays in the clinic waiting times?’ The department scored an average of 57% positive feedback for the period March 2017 to April 2018. There were five months when the department scored under 55% May (53%), July (52%), August, October and February 2018 (50%).

Information was requested on the number of clinic’s delayed or over ran in the last 12 months, however the trust advised the data quality was too poor to submit.

Information was requested on the number of cancelled clinic’s in the last 12 months, however this information was not provided.

The trust had weekly access meeting to monitor performance against the referral to treatment pathways. Minutes of the meeting demonstrated action points were in place to follow up where any issues were anticipated.

From March 2017 to February 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently better than the England overall performance.

The latest figures for February 2018 showed that 92.6% of patients were treated within 18 weeks versus the England average of 88.9%.
Ten specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>99.0%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>98.7%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>98.4%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>98.2%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>97.2%</td>
<td>88.0%</td>
</tr>
<tr>
<td>General surgery</td>
<td>97.1%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>96.9%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Other</td>
<td>94.8%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>93.5%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>93.4%</td>
<td>88.7%</td>
</tr>
</tbody>
</table>

Four specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>90.1%</td>
<td>92.4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>88.7%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>80.8%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>77.1%</td>
<td>85.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

From March 2017 to February 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently better than the England overall performance. However, trust performance declined during the reporting period. This follows the England average trend. The latest figures for February 2018 showed that 93% of patients were treated within 18 weeks versus the England average of 88%.

(Source: NHS England)
Twelve specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>99.4%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>97.4%</td>
<td>90.3%</td>
</tr>
<tr>
<td>General surgery</td>
<td>96.7%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>96.7%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>96.5%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>96.2%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Other</td>
<td>95.4%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>95.1%</td>
<td>83.6%</td>
</tr>
<tr>
<td>General medicine</td>
<td>95.0%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>95.0%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>94.5%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Neurology</td>
<td>92.2%</td>
<td>88.3%</td>
</tr>
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</table>

Two specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>90.0%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>90.4%</td>
<td>91.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.

Performance deteriorated in the latest two quarters. In the most recent quarter, the trust performed worse than the England average although it was still above the operational standard.

(Source: NHS England – Cancer Waits)

The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). There was deterioration in performance in 2017/18 Q2 to just below the England average before an improvement in the most recent quarter.
From 2016/17 Q4 to 2017/18 Q1 the trust performed better than the 85% operational standard and the England average for patients receiving their first treatment within 62 days of an urgent GP referral. From 2017/18 Q2 to 2017/18 Q3 the trust performed worse than the operational standard and the England average.

(Source: NHS England – Cancer Waits)

From January 2017 to December 2017, the ‘did not attend’ rate for North Middlesex Hospital was consistently higher than the England average. Performance improved across the reporting period, with the lowest rate in November 2017.

(Source: Hospital Episode Statistics)

The number of patients who did not attend (DNA) in the period May 2017 to April 2017 had reduced from 18.9% in June 2017 to 13.5% in April 2018. This was higher than the trust target of
8%. Patients were sent text reminders of their appointment which helped to reduce the ‘did not attend’ rate (DNA).

The trust’s policy for the Management of Outpatient, Diagnostic and Admissions Pathways set out process for managing patients who were DNA. Patients were referred back to their GP if they did not book within two weeks, if patients did not rebook or had two DNA’s the patient notes were reviewed by a consultant who made a clinical decision about whether to offer the patient a further appointment, within what time scale or whether to remove them from the list and refer them back to their GP.

**Learning from complaints and concerns**

From January 2017 to December 2017 there were 13 complaints about outpatients. The trust took an average of 32 days to investigate and close complaints; this is in not line with their complaints policy, which states complaints should be resolved within 30 days.

*(Source: Routine Provider Information Request (RPIR) P61 Complaints)*

The trust had complaints policies and procedures in place. Information on the trust’s complaints policy and procedures was available on the trust’s internet website.

All the complaints had been investigated and were completed seven of which had been upheld and one partially upheld. Most staff were aware of the trust’s complaints policy and of their responsibilities within the complaints process. Formal complaints were directed to the trust’s complaints department. Staff told us complaints mostly related to clinics over running and car parking costs.

**Is the service well-led?**

**Leadership**

The OPD was part of the general surgery, trauma and orthopaedics and outpatients which was led by a clinical director was a sub division of the surgery, cancer and associated services division (SCAS) which was led by the divisional director of clinical services. Outpatient service was split across three surgical directorates.

The leadership team for OPD was new with the clinical lead appointed in March 2018; the acting head of OPD had been in post since April 2018. The OPD matron and health records manager was also part of the leadership team. However, the matron for the OPD was not responsible for all the clinics which operated out of the department. This meant the matron for the OPD was not responsible for all the clinics that operated out of the department which mean there was lack of oversight across the whole department.

The ophthalmology clinic came under the ophthalmology, theatres and urology another sub division which was led by a clinical director. The leadership team for ophthalmology had a clinical lead, service manager and matron. The matron was also responsible for breast clinic.

Staff were positive about their immediate managers and felt supported. Local managers were described as having an open-door policy and supporting staff in their roles clinically as and when required.

**Vision and Strategy**

The OPD leadership team’s patient experience improvement programme detailed the journey the OPD needed to take to improve the services for patients. The areas identified included
communication, signage, processes, and waiting times. The patient experience improvement programme linked to the OPD improvement’s programme implementation plan. Both programmes were in the early stages of being rolled out. It was not clear how involved the leadership team for ophthalmology had been involved in the development of the improvement programme. A similar piece of work had been in progress at the last inspection.

All the staff we spoke with was aware of the trust values and could relate to these, particularly putting people first. Some staff we spoke with were aware of plans to improve the OPD.

**Culture**

Staff were enthusiastic about the care and treatment they provided for the people who used their services. However, staff felt there were limited opportunities for progression within the OPD as it was a small staff team. Staff also reported there were limited learning and development opportunities and felt they were missing out on professional development. This was similar to the last inspection.

Most staff described the trust as having a good culture. However, some staff reported they did not feel able to report incidents of verbal and physical abuse against them and did not feel they had as they had the same rights as patients. They did not report these incidents at times because they did not think their voice would be heard.

They felt they would be able to contact their line managers if they had any concerns.

Staff described good team and peer support; they felt they worked well as a team. We observed good interactions between nursing, administrative, medical staff, patients and relatives working together to achieve good outcomes for patients.

Most patients acknowledged a positive and caring ethos and were happy with the care they received.

**Governance, management of risk, issues and performance**

The OPD leadership team advised it did not have any risks on the divisional risk register and did not hold a local risk register. This meant the department had no sight of any risks within the department which did not reflect our findings on inspection. These included staffing levels, paediatric patients being treated in the OPD, and lost or missing records.

The trust did not monitor waiting time for patients; however, this was one of the main concerns raised by patients we spoke with during the inspection.

Waiting times for patients were not monitored which meant the trust did not know how long they kept patients waiting in the department. The trust was also unable to provide information on the number of clinic’s delayed or over ran in the last 12 months.

A review of OPD nursing, administrative and phlebotomy staff meetings showed incidents were not discussed. This meant senior managers could not be assured staff groups working across the outpatients department were learning from incidents across the trust.

The surgery divisional risk and governance meeting took place to review overall performance of the clinical areas. We reviewed meeting minute’s which showed risks, incidents, serious incidents and complaints were discussed. The action points were in place which identified leads for completion. However, there was evidence within the surgical division that open incidents on incident reporting system were not being closed.
Public and staff engagement

Quality metric information boards in each of the OPD’s were on display and were used to record the latest family and friends survey results, and the OPD’s performance in relation to hand hygiene audits, slot utilisation, attendances and patients who did not attend.

The trust participated in the trust 2017 NHS staff survey. The percentage of staff who would recommend the trust as a place to work was 57% which was worse than the England average of 61%. The percentage of staff that were happy with the standards of care was 54% which was worse than the England average of 71%. The trust had a staff experience action plan in place for the 2016 staff survey which was still ongoing to address the key issues identified in the staff to improve the experience of staff working within the trust.

The trust had procedures in place for staff to raise ‘whistleblowing’ concerns outside of their line management arrangements and staff had access to confidential counselling and support services.

Learning, continuous improvement and innovation

There was a commitment to continuous improvement to improve patient experience within the OPD. There was a focus on the utilisation of slots across the OPD to ensure they were used clinics were operational. The slot utilisation for the period May 2017 to April 2018 was an average of 84.5% which was lower than the trust target of 92%.