

North Middlesex University Hospital NHS Trust

North Middlesex University Hospital

Quality Report

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

Ratings

Urgent and emergency services

Inadequate



Medical care (including older people's care)

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook an unannounced inspection at the North Middlesex University Hospital because of concerns raised by patients, commissioners and other stake holders in the health and care sector. A number of serious incidents had occurred in the Emergency Department (ED) which had raised concerns about the standards of care patients were receiving. We also had concerns about the high numbers of safeguarding incidents at the hospital for patients being cared for on medical wards.

In December 2013, the ED at Chase Farm Hospital was closed and the service replaced with an Urgent Care Centre (UCC). This had a significant impact on the demand for services at North Middlesex Hospital. In particular, this has led to significant increases in patient numbers attending the ED.

In June 2014, we completed a comprehensive inspection of the trust which was rated as Requires Improvement overall. Both the core services of Medical Care and ED were rated as Requires Improvement.

We inspected on 14 April 2016 and then returned to the ED on 4 and 5 May 2016.

We visited the ED and two of the hospital's medical wards. The inspection was responsive and unannounced based on concerns we had about the care patients were receiving at the hospital.

Whilst we found many examples of caring and competent staff, systems are not in place or were not working to ensure the proper care of patients. We found that the trust leadership was seen by many staff as overbearing and not supportive to delivering safe treatment.

Our key findings were as follows:

- Patients who came to the ED are not being seen quickly enough by clinical staff and are waiting too long to be seen by a doctor. At night, there are too few competent doctors who are able to assess and treat patients.
- The Rapid Assessment and Treatment (RAT) of all patients arriving by ambulance is led and undertaken by Band 5 and 6 nurses without an input from a doctor.
- ED staff are not monitoring the 15 minutes performance standard for initial clinical review.
- There are excessive delays in seeing a doctor and moving patients to specialist wards.
- Multi-disciplinary team working was poor. Doctors from other parts of the trust were slow to come and review patients and were not supportive of staff in ED.
- Patient flow is poorly managed and the trust's performance, with regard to waiting times, is poor. Performance has deteriorated in recent months. In February 2016, only 67.2% of patients were seen and treated within the national four hour target, compared to an England average of 88%.
- There is insufficient middle grade medical leadership to direct patient care and treatment.
- The department has lacked an established Clinical Director to provide leadership for more than six months. The leadership is shared among three consultants. The trust's senior clinical team has not been visible in providing leadership and support to the department, however the trust has recently appointed a new medical director whom staff hoped would give support and direction to the department.
- Trust management is seen as oppressive and overbearing and not supportive to staff in the ED. The culture meant that staff did not feel comfortable in raising concerns.
- The trust had not learnt from previous 'never events' and serious incidents. The trust is not seen to be open and transparent. Relevant information is not shared with staff.

Summary of findings

- The medical wards had good consultant support and availability and the number and skill mix of medical doctors is satisfactory. There is a daily multidisciplinary team meeting and good team working in patient care and on ward rounds. However, there is, on occasion, insufficient number of nurses per shift.
- There is a lack of respect and dignity in the way patients are treated and their needs are not always met appropriately. Patients' safety is being compromised through omissions in risk assessments, and through inconsistencies and inaccuracy in completing care records and observation charts.
- Patients' nutritional and hydration needs are not being met appropriately due to incorrect recording in the food and fluid charts. Trained staff are not following the medication policy in the safe storage, recording and administration of medicines.
- The trust has an impressive dementia strategy but most of it has not been implemented. Staff are not completing mandatory training, including safeguarding. Basic dementia awareness training is not being completed by 40.6% of staff working in the wards for older people. There are no dementia champions/link nurses in the wards to support staff. Patients are therefore exposed to the risk of not receiving appropriate care and treatment. Similar findings were reported in the CQC report in 2014.

During our inspection, we observed no areas of outstanding practice.

There are a number of areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure all patients attending the ED are seen more quickly by a clinician.
- Ensure that the more seriously ill patients are properly identified and seen more quickly by a doctor.
- Ensure middle grade doctors take greater leadership in clinical decision making and supporting junior colleagues.
- Provide the ED with greater leadership and support from other specialties to ensure effective pathways and improve patient flow.
- Seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders to evaluate the service and drive improvement.
- Take action to improve staff training – both mandatory and non-mandatory.
- Ensure there is an adequate supply of equipment, especially vital and life sustaining equipment which is fit for purpose.
- Ensure key data, such as waiting time performance and clinical outcomes, are recorded and used to drive improvement.

In addition, the trust should:

- Ensure that ED staff undertake risk assessments for those patients at risk of falls or pressure sores.
- Review arrangements for the consistent capture of learning from incidents and audits and ensure that learning and audit data is always conveyed to staff.
- Ensure consistent ownership and knowledge of the risk register across all nursing and medical staff.
- Improve multi-disciplinary team working with medical teams from other parts of the trust.
- Undertake auditing of patient outcomes.
- Endeavour to recruit full time staff in an effort to reduce reliance on agency staff.

Summary of findings

- Complete annual appraisals for all eligible nursing staff.
- Consider including Mental Capacity Act 2005 as part of mandatory training.
- Establish multi-disciplinary panels to review serious incidents and performance breaches.
- Review how patient dignity can be improved in the UCC during the reception process.

Following our inspection, the Commission wrote to the trust on 18 April 2016 raising issues of concern about care in the ED and asking for additional information and a response from the trust. After receiving and reviewing the additional information and the trust response, the Commission served a statutory Warning Notice on the trust requiring them to improve the care of patients in the ED by 26 August 2016.

The Commission will be undertaking a full comprehensive inspection of the trust in September 2016.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Inadequate



Why have we given this rating?

Patients who came to the ED were not being seen quickly enough by clinical staff and were waiting too long to be seen by a doctor. At night, there are too few competent doctors who are able to assess and treat patients.

Multi-disciplinary team working with medical teams was poor. Doctors from other parts of the trust were slow to come and review patients and were not supportive of their ED colleagues.

Patient flow was poorly managed and the trust's performance with regard to waiting times was poor. Performance has deteriorated in recent months.

The department lacked an established clinical director to provide leadership. The trust's senior clinical team has not been visible in providing leadership and support to the department, however the trust has recently appointed a new medical director whom staff hoped would give support and direction to the department.

Medical care (including older people's care)

Requires improvement



The trust had not learnt from previous 'never events' or incidents. The trust was not seen to be open and transparent. Relevant information was not shared with staff.

The wards had good consultant support and availability and the number and skill mix of medical doctors was satisfactory. There was a daily multidisciplinary team meeting and good team working in patient care and on ward rounds. However, there was, on occasion, insufficient numbers of nurses per shift.

There was a lack of respect and dignity in the way patients were treated and their needs were not always met appropriately. Patients' safety had been compromised through omissions in risk assessments, and through inconsistencies and inaccuracy in completing care records and observation charts. Trained staff had not been following the medication policy in the safe storage, recording and administration of medicines.

The trust had an impressive dementia strategy but most of it had not been implemented. Staff were not completing mandatory training, including

Summary of findings

safeguarding. Basic dementia awareness training had not been completed by 40.6% of staff working in the wards for older people. There was no dementia champions/link nurses in the wards to support staff.

North Middlesex University Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care)

Detailed findings

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Background to North Middlesex University Hospital

The North Middlesex University Hospital is the main site of the North Middlesex University Hospital NHS Trust which is medium-sized acute trust with around 450 beds. The hospital serves more than 350,000 people living in Enfield and Haringey and the surrounding areas, including Barnet and Waltham Forest.

The trust has a turnover of around £250 million and employs more than 3,000 staff. It provides a full range of adult, older people's and children's services across medical and surgical disciplines.

Our inspection team

Our inspection team was led by Inspection Manager David Harris.

The team included CQC inspectors covering emergency care and medical care. The team was supported by Specialist Professional Advisors including; two consultant physicians and two senior nurses with experience in ED and general medicine.

The team was also supported by four Experts by Experience, who undertook a large number of face to face interviews with patients and their families/carers.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital. We carried out an unannounced visit on 14 April 2016 and further visits to the ED on 4 and 5 May 2016. The inspection was conducted using the Care Quality Commission's new inspection methodology.

We spoke with 87 members of staff, including doctors, nurses, allied health care professional, health care assistants, managers and non-clinical staff. We reviewed 39 sets of medical notes. We spoke with 63 patients and 13 family members/carers. We also reviewed the casework for seven serious incidents.

Detailed findings



We sent an e mail to all staff working at the trust asking them to contact us and give us their opinion of the services provided by the hospital.

Facts and data about North Middlesex University Hospital

The trust serves the boroughs of Enfield, Haringey, Barnet, Waltham Forest and surrounding areas with a local population of more than 350,000. The trust has a multi-disciplinary Accident and Emergency (ED) and Urgent Care Centre (UCC).

The trust provides a full range of adult, elderly and children's services across medical and surgical disciplines. The trust's specialist services include stroke, HIV/AIDS, cardiology (including heart failure care), haematology, diabetes, sleep studies, fertility and orthopaedics.

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at the North Middlesex University Hospital is one of the busiest in London, seeing about 180,000 patients each year. Services include an Urgent Care Centre (UCC), which operates within the ED. This provides treatment of minor illnesses, injuries and non-life-threatening conditions which require urgent or immediate attention. The unit is led by GPs and is open every day 9am-10pm.

We inspected resuscitation (Resus), area 1 (Minors and Majors overflow), area 2 (Majors, more seriously ill patients), and the Urgent Care Centre (UCC). During our inspection, we spoke with 39 members of staff and 54 patients. We examined 18 sets of medical notes for patients who had been treated in the department.

Summary of findings

We rated the Emergency Department as Inadequate overall because;

The system of rapid assessment and treatment (RAT) for the immediate review of patients arriving by ambulance was led by Band 5 and 6 nurses without input from doctors.

The Emergency Department (ED) staff were not monitoring the 15 minutes performance standard for initial review of all patients arriving at ED.

There were excessive delays in seeing a doctor and moving patients to specialised wards.

At night, there were too few competent doctors who were able to assess and treat patients. There was insufficient middle grade leadership to timely direct patients' care and treatment.

Multi-disciplinary team working with medical teams outside of the ED was poor. Doctors from other parts of the trust were slow to come and review patients and were not supportive of their ED colleagues.

There was no auditing of patient outcomes taking place.

Patient flow was poorly managed and the trust's performance with regard to waiting times was poor. Performance has deteriorated in recent months. In February 2016, only 67% of patients were seen and treated within the four hour target compared to an England average of 88%.

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The department was without an established Clinical Director to provide leadership for more than six months. There was insufficient senior grade medical leadership of the department. The trust's senior clinical team was not visible in providing leadership and support to the department. However The trust had recently appointed a new medical director whom staff hoped would give support and direction to the department

Trust management was seen as oppressive and overbearing and not supportive to staff in the ED. The culture meant that staff did not feel comfortable in raising concerns.

However;

Staff told us they applied national guidance in their practice. Most staff were competent and endeavoured to provide good care and outcomes for patients.

Are urgent and emergency services safe?

Inadequate



We rated safety in the Emergency Department as Inadequate because;

- Many patients who arrived in the ED were not being seen by a clinician within 15 minutes and this meant they were at risk of deteriorating and experiencing poor outcomes.
- Many patients were waiting too long to see a doctor and this meant they were at risk of deteriorating or not receiving prompt diagnosis and treatment and therefore experiencing poor outcomes.
- Night time medical cover in ED was provided by middle grade doctors, many of whom were unable or unwilling to make decisions about patients' diagnosis and treatment. This meant they were at risk of deteriorating and experiencing poor outcomes.
- There was not always enough equipment available and there were significant delays to repairs of essential equipment.
- Infrequent checks of the portable resuscitation trolley meant that there was no guarantee that vital equipment was always to hand.
- Incidents were not always recorded on the electronic incident reporting system.
- Medical records were not always easy to locate.
- Safeguarding and other mandatory training completion rates were significantly below the target completion level.
- Patients at risk of developing pressure ulcers were not always transferred to a bed from a trolley within the trusts four hour target.

Incidents

- There were 22 serious incidents (SI) and no 'never events' reported between March 2015 and February 2016 and recorded on the Strategic Executive Information System (STEIS). Of these, eight related to delays in treatment (four instances), ambulance (two)

Urgent and emergency services

and diagnosis (two), five relate to sub-optimal care of the deteriorating patient, two incidents related to alleged abuse of adult patient by staff, and two related to commissioning.

- During the period of January 2016 to March 2016, the trust declared six serious incidents which related to care the patient received in ED. Of these, the trust requested de-escalation of one incident and is awaiting confirmation of this from the CCG. The remaining five are scheduled to have all investigations completed between May 2016 and June 2016.
- We spoke with the lead for resus and trauma governance about lessons learned from one SI, an unexpected death. Whilst the report was soon to be presented to the board and therefore was not available to CQC at the time of our inspection, we were told about some of the findings. Amongst the major findings, it was identified that the department was “two to three nurses and one middle grade doctor short on the day in question.” There were also issues identified around patient flow and poor communication between staff which included doctors to nurses and junior doctors to consultants.
- Some staff we spoke with told us that SI investigations and subsequent action plans were not always shared with staff in a timely manner. This meant that in certain circumstances, reports were received when actions should already have been taken in order to mitigate against a future occurrence. It also meant that there was little opportunity to consider lessons learnt from this SI.
- We were told that recommendations from a Serious Incident report would reinforce the need for hourly observations to be done in line with current trust policy, and for the review of monitoring facilities within the department. A request is to be made for new equipment to enable consultants to receive patient observations to a computer tablet for speedy additional treatment.
- An electronic system was used for reporting untoward incidents. Staff whom we spoke with knew how to access and use this system; however, two nursing staff told us they did not always report incidents such as staffing shortages as it happened so regularly.

- We were told by a senior nurse that there had been a number of incidents in recent months. They identified incidents such as low levels of staffing, particularly in nursing, and breaches of the 15 minutes to triage target. We asked whether each of these incidents was entered on the electronic incident reporting system and were told that due to the high volume of breaches, they were not reported in every case. Instead, they were raised at management meetings.
- One nurse told us how they ensured they added incidents onto the electronic incident reporting system as soon as possible. They gave an example of an issue from their last shift where there had been just one commode available for the whole department. We subsequently saw this had been entered and the action taken was to order three more commodes. We looked at the electronic incident reporting system information for the 24 hours prior to our inspection. We noted that there was one incident recorded which resulted in a Safeguarding alert being raised. We were told this was as a result of delayed initiation of essential treatment. We discussed this further with a senior member of staff, who told us this was very poor care and should never have happened. They said that a 48 hour investigation and report would follow.

Cleanliness, infection control and hygiene

- All areas of the ED appeared clean and tidy. We spoke with patients about the level of cleanliness in the reception area and were told, “It’s not the greatest, but I have seen worse.”
- We saw that the waiting area was clean, with no high or low level dust or build-up of rubbish.
- We observed all staff used protective clothing appropriately, regularly washing their hands and using hand gel both between patients and when moving from one clinical area to another. They complied with the ‘bare below the elbow’ guidance. All the hand gel dispensers were well stocked.
- Weekly hand hygiene audit data submitted by the trust between October 2015 and March 2016 showed that the department was usually compliant with the trust’s 95% target. The department scored below 95% one week in December (90%), two weeks in January (90%) and one week in February (below 80%).

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- We observed staff routinely following the sepsis pathway. We noted how staff received a patient with sepsis and followed the full protocol within one hour of arrival, in line with NICE sepsis guidelines.

Environment and equipment

- Minutes from an ED staff meeting held on 1 April 2016 noted 'Staff were concerned over the apparent lack of equipment within the department.' Specific reference was made to the lack of monitors and the action to be taken was that a list of current equipment and requirements would be compiled.
- Staff told us there was not enough equipment available. For example, most cardiac machines in the resuscitation area lacked a set of leads which allowed an ECG to be printed off at the bedside, thus enabling staff to get an instant reading. Instead, these readings had to be printed off in a nearby area. We were told that this had been frequently raised as a safeguarding alert but the situation had not improved.
- A nurse told us about the lack of seemingly minor pieces of equipment, but which nevertheless had a potential impact on patient safety. There are two wristband machines in the whole department, with none in Triage or Resuscitation. They explained that the impact of this was potentially serious if a patient collapsed in Triage, and they were not wearing a wristband to assist with identification. They also said they spend an unnecessary amount of time locating these machines.
- We saw in Governance meeting minutes that the chute which took specimens to pathology from ED was recorded as not working since January 2016. This equipment ensured the delivery of specimens and blood to the pathology laboratory for urgent analysis. Minutes of a meeting in March 2016 noted that it remained out of operation, and specimens were being delivered to pathology by hospital porters. The chute was back in service on the day of our inspection but had been out of operation for at least six weeks. Staff told us this caused major delays to the speed in which results were returned to the department, thus slowing down the time in which some patients could be treated.
- We saw that the portable resuscitation trolley had a notice on the front stating that it needed to be sealed in order to protect the contents (which included needles and drugs such as adrenaline). However, it was not sealed on the day of our inspection and nurses to whom we spoke told us it was normally left open and they had no knowledge of where these seals were kept. We looked at the checklist signature book and saw that routine checks of the resuscitation trolley contents were not being carried out. For example, there were 10 days in January 2016, four days in February 2016, seven days in March 2016 and six days in April 2016 when no checks were made according to the signature book. This is unsafe practice as in the event of a cardiac arrest, there is no guarantee that all vital equipment will be on the trolley.
- We saw evidence that daily checks were made of oxygen, suction and defibrillator. Requests for additional supplies were written, and noted when they were added to a stock order sheet. However, these checks did not include ECG machines and so it was unclear whose responsibility it was to order leads to enable readings to be taken at patient's bedside.
- We observed that there were insufficient vital observation machines to cater for the number of patients. A senior member of staff told us how equipment from ED frequently ended up in other departments around the hospital.
- We were told that on the previous day, there was just one commode available in the whole of the ED, to serve over 100 patients. We saw this was raised as an incident on the electronic incident reporting system, with an update which indicated that three commodes were put on order. We spoke with a senior member of staff who told us they expected these additional commodes to be delivered within three days of being ordered.
- The children's ED cared for both children attending the urgent care centre (UCC) and more seriously ill children. There was a dedicated paediatric resuscitation bay. We were told that the paediatric team had full responsibility for this.
- The psychiatric assessment room had been refurbished since our last inspection. Potential ligature

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points around the ceiling vent and door handle had been eliminated. The room had two points of entrance/exit and both doors had observation windows inset.

Medicines

- Medicines were stored safely. The drug cupboard was kept locked and when opened, we saw that the drugs inside were kept in an orderly fashion. The keys to the controlled drugs cupboard were held by the senior nurse on duty and we saw recorded evidence that daily checks were made. There were four clinical fridges in the department. Temperatures were checked daily and remained within the accepted safe range.

Records

- Medical notes were not always easily accessible, particularly for patients nursed in the corridor. For example, we observed a patient with a deteriorating condition in the corridor. A nurse was unable to find this patient's notes at this time and confirmed that the patient's blood test had been returned but not yet reviewed. When our own specialist professional medical advisor reviewed these tests with the nurse they gave sufficient cause for concern and the patient was admitted to a resuscitation bay for immediate treatment. The patient notes had not been located by the time we left the department.
- No discharge documentation could be found for a patient whose presenting symptoms had indicated a possible stroke. The patient flow coordinator on the day of our inspection told us they were unaware that the patient had already been reviewed and discharged. They could not find any related documentation to support the rationale for discharge and the patient had already left the department by this time.
- We reviewed minutes of Trust Board meetings and saw that in March 2015 it was recorded that a new risk had been added to the risk register. This was entitled 'Failure to manage and store patient notes in accordance with Trust policy, due to increase in volume and restrictions in space, adversely impacting on patient experience and quality of care'. The Chair of

the Risk and Quality Committee raised concerns in each subsequent Trust Board meeting, up to March 2016, about the lack of resolution to the problem with accessing patient notes.

- We examined 18 sets of patient notes during our inspection and found that initial clinical observations, such as pulse and blood pressure were always recorded. Doctors' names and grade were signed and timed at each entry.
- Nursing notes we looked at were clearly documented, with evidence of nutrition and hydration recorded.

Safeguarding

- Not all staff were trained in safeguarding for adults. For example, nursing staff were 86% compliant with Safeguarding Adults level two training and 85% compliant with Safeguarding Adults level three training. For medical staff, the figures were lower; 49% compliant with Safeguarding Adults level two training and 73.3% compliant with Safeguarding Adults level three training. Both of these statistics were listed as red on the training matrix, indicating they were below the accepted level of 90% compliance.
- Staff we spoke with had a good understanding of safeguarding concerns for adults and children. Access to information on how to report a concern was available and displayed on boards in the department.

Mandatory training

- Data submitted to us by the trust showed that figures for completion of mandatory training for both medical and nursing staff were significantly below the target completion rate of 90%. Completion varied between 49% and 54% for medical staff and between 66% and 74% for nursing staff.
- Nursing staff we spoke with told us that mandatory training was good and that the matron monitored their attendance.
- There was no formal induction programme for agency nursing staff. We were told that agency staff receive a department orientation as a local induction at the start of their shift prior to dealing with patients. We were also told that all ED agency staff had to have prior experience of working in an ED.

Assessing and responding to patient risk

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- Data submitted to CQC by the trust showed that the 90% target for hourly rounding was achieved for the whole of January 2016. However, this was not achieved in any other week, up to the end of March 2016, with the figures varying between 61% and 75%. A matron showed us a sample of daily audits carried out on hourly rounding by nurses, this included general observation of a patient's condition and to see if the patient was 'comfortable' and did not necessarily always include taking their vital signs. We were told if nurses did not carry out hourly rounding, then this would be addressed with the individual nurse.
- We were told that one recent SI investigation concluded that a failure to take hourly rounds meant that a patient had lain dead for up to four and a half hours before being found.
- Walk-in patients were seen by a receptionist, who decided if they were suitable for the Urgent Care Centre (UCC) or with a more serious condition, needed to go to the main ED. If the receptionist decided on the UCC, they entered the patient's personal details onto the computer with a few words describing their condition. A triage nurse then used this information to decide if the patient should see the triage nurse, a GP or an Emergency Nurse Practitioner (ENP).
- A walk-in patient's first point of contact was with receptionists, who are not trained to spot concerning conditions. Increasing delays in time to triage can mean that it is then up to two hours before a patient is seen by a nurse (when the national standard is 15 minutes), during which time their undetected condition could deteriorate. We were given several recent examples of where this had happened. We were told that since the time to triage has been steadily increasing, then it would be safer for patients if a nurse were available to do an initial quick assessment of patients to ensure they were safe to wait to be seen. Another point of concern about the current practice in UCC is that there is no GP cover after 10pm or ENP cover after midnight. Staff identified this lack of round the clock cover as a contributing factor to the long delays for patients to be seen during the night.
- The national clinical indicator for a patient to be handed over from ambulance staff to hospital staff is 15 minutes. The trust has a target of zero for ambulance handover delays of greater than one hour. The Emergency Department dashboard showed a total of 174 handovers greater than one hour between January 2016 and March 2016.
- During our inspection, we observed delays of between 38 and 41 minutes for patients to be handed over. During this time, patients were accompanied by ambulance staff in the Emergency Department who would alert medical staff to any deterioration in the patient's condition prior to handover of the patient to the Emergency Department
- Trusts in England have a target of triaging 95% of patients within 15 minutes of their arrival in the ED. This means that they should have an initial assessment with a nurse or doctor. We found that patients have prolonged waits in the UCC which could increase the probability of their having poorer outcomes for their treatment. Data submitted by the trust confirmed that this target had not been achieved between November 2015 and February 2016. Minutes of the bi-weekly governance meeting in February 2016 referred to patients encountering delays in being triaged. Subsequent minutes of March 2016 confirmed that this had been added to the risk register.
- Staff we spoke with told us there was no escalation policy in place for them to follow when the waiting time for patients increased. They said they usually told the nurse in charge who then tried to get help from other parts of ED. We observed a nurse discussing the need for an additional nurse in UCC with a senior nurse. After a lengthy conversation, it was agreed that a nurse from Resuscitation would go to UCC for a short while.
- The department had a system of rapid assessment and treatment (RAT) for the immediate review of patients arriving by ambulance. This system is meant to ensure that patients receive a clinical handover from the ambulance service, an early clinical diagnosis and early treatment. When this was initially established, senior doctors oversaw the process. However, at the time of our inspection, RATing was led by Band 5 and 6 nurses including initial triage of ambulance attendances. The triage involved observations and modified early warning score (NEWS) measurements and did not have any input from medical staff.

Urgent and emergency services

- Data submitted by the trust demonstrated that nursing staff managed to attain the 90% target level for assessing patients using a national early warning system (NEWS) on 5 out of 15 weeks since January 2016.
- Monitoring of response rates for those patients who present with chest pains began in February 2016. The target threshold to see patients within 15 minutes of presenting to ED was set at 80%. Data submitted by the trust demonstrated that this target was achieved only once in the 10 weeks recorded. The figures for the weeks in which the target was not met ranged between 23% and 78%.
- We found the chest pain pathway was unclear. We looked at the notes of one patient who had been admitted to ED with chest pains. We noted that this person waited more than three hours to see a doctor. We were assured by a member of the nursing staff that this person's ECG had been reviewed since they arrived into the ED department and had given no cause for concern.
- We looked at 12 patient records and found that there was good documentation. All relevant observations were done, including triage score, pain score, NEWS, vital signs and nursing and medical notes.
- All patients were nursed on trolleys in the ED department. Staff told us they aimed to transfer those assessed as being most at risk of developing pressure ulcers from a trolley to a bed within four hours. However, during our inspection, we did not find that this was the case; for example, we saw three people deemed to be at risk of developing a pressure ulcer (according to their NEWS) who had been in the ED department for between 6 and 13 hours, still on hospital trolleys. They were subsequently transferred onto beds shortly after this was drawn to the attention of senior staff.
- We were told by staff that the ED department "relied heavily on agency nurses." There was no specific induction programme for agency staff. A senior member of staff told us the agency staff used were regular and therefore familiar with the department.
- Levels of absence amongst nursing staff due to sickness in January and February 2016 were between 8% and 9%, when the England average was between 3% and 3.9%. No data was available for March 2016.
- The trust increased the nursing establishment in ED in April 2015 by one for both day and night shifts. Despite this however, staff told us there was a shortage of established nurses. We asked how staffing levels were planned and reviewed so that people receive safe care and treatment at all times. A senior member of staff told us they had presented a completed acuity tool to the trust board on at least two occasions in the past year. They said this had highlighted shortages, "but there has been no official response or remedy to this to date."
- Staff told us that the nursing to patient ratio in cubicles area should be 1:4. We were told that this was rarely achieved since they frequently had patients in corridors which significantly reduced this ratio. We were told how more recently the ratio was 1:10 because they had 20 patients in the corridor. We saw an entry on the electronic incident reporting system for the day before our inspection. It recorded how there were two nurses assigned to those patients in the corridor and the comment entered stated, 'we had over 20 patients to look after. The recorded action taken was, 'informed nurse in charge; was advised to try our best.'
- Nursing handovers occurred three times a day and included a detailed plan which considered information on a patient's presenting condition, treatment given, tests undertaken or awaited, recent hospital admissions and relevant social circumstances. Staffing for the shift was discussed, as well as any high-risk patients or potential issues.

Nursing staffing

- The ED data dashboard submitted to us indicated that the accepted ED nursing staff vacancy rate was less than 5%. However, the data for January 2016, February 2016 and March 2016 shows a 12% to 14% vacancy rate.

Medical staffing

- The ED data dashboard submitted to us indicated that the accepted ED medical vacancy rate was less than 5%. However, the vacancy rate between January and March 2016 was between 9% and 13%.

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- Trust data for 12 months to March 2016 show that there was a budget for 12 consultant posts, however the number in post was 9.70, three of whom are long term locum appointments. In addition the budget for SHO trust doctors was nine posts with 11 in post in March. Similarly the Trust had 5.5 specialist trainees in post against an established budget of five posts. This indicated that the trust, whilst not using the full budgeted amount for consultant posts, exceeded their budget for the less experienced medical grades'.
 - The Royal College of Emergency Medicine standard is that middle grade doctors and above working in ED would have two out of the following - Advanced Life Support (ALS), Advanced Paediatric Life Support (APLS) and Advanced Trauma Life Support (ATLS)
 - We looked at three records of minutes from bi-weekly governance meetings for February 2016 and March 2016. It was noted in the February meeting that there was a lack of Advanced Trauma Life Support (ATLS) training amongst middle grade doctors. The decision was taken to add this to the risk register. This risk was raised again in late February where it was noted for the Managing Director to discuss the risk assessment and approve the risk reduction action plan with the executives. The minutes of a meeting in March noted that, 'ED Middle Grade Clinician do not meet Royal College of Emergency Medicine and NHS England standards. This has now been approved and on the Risk Register.'
 - A letter from the trust to CQC following our inspection confirmed there were 15 middle grade doctors (of whom 9 were full time and 6 were locums). Of these, 14 had Advance Life Support training (one locum did not); five had Advance Trauma Life Support and two had Advanced Paediatric Life Support.
 - Staff expressed concern about the impact on patient safety in relation to the competency of middle grade medical staff, especially during the night, when they were the most senior doctors in the ED. We were told how at times, middle grade doctors were unable or unwilling to take decisions, especially to admit, discharge or stream appropriately. This meant that in many instances, patients who came in during the night were waiting to be progressed when the morning staff came on duty. We were also told that many middle grade doctors had no previous ED training and that they were being formally trained whilst in post. Nursing staff told us there was a lack of leadership from most middle grade doctors, as a result nurses spent a substantial amount of time supporting and advising more junior doctors.
 - During the inspection, we were told that there is frequently only one middle grade doctor in the ED, although two are rostered. We were also told how there is a lack of certainty about what the staff cover will be on any given night as the available roster does not always accurately reflect changes which may have been made. We spoke with the divisional manager who told us that there were always two middle grades on duty. However, we were able to confirm later that whilst two middle grades were rostered on one of the nights during our inspection, one of them had been asked to cover elsewhere in the department. We were told this was not an unusual occurrence. For example, there is usually a GP in Paediatrics, but in their absence, the middle-grade is allocated to that department, as occurred on the night in question, which left one middle-grade to cover ED for the remainder of the night.
 - There is no consultant presence in the department after 11pm. Some staff told us this resulted in a lack of leadership for the middle grade doctors who were the most senior on duty during the night. For example, we were told that there was a culture of 'holding' situations until the day staff came on to make discharge or admission decisions. This impacts on the staff who come on duty the following morning as they have to manage these patients who should have been progressed through the department overnight, as well as respond to the continuous flow of new arrivals. Over the course of our inspection, there were between 7 and 11 patients waiting for day staff to make a decision to be discharged or admitted.
 - Members of staff told us there was a culture of not calling consultants out at night. They said that middle grade doctors seemed to assume that it was acceptable to leave patients in ED overnight, thus treating it as if it were a hospital ward.
- ### Major incident awareness and training
- On the day of our inspection, several staff were practising for a major incident (a heat wave).

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- Security staff were based in the unit at all times. They were able to provide additional support for nursing staff when patients required one-to-one observation because of actual or potential violence or aggression. They were readily available when needed and we saw them respond to at least four situations during the course of our inspection.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



We rated effectiveness in the Emergency Department as Requires Improvement because;

Multi-disciplinary team working was poor. Doctors from other parts of the trust were slow to come and review patients and were not supportive of their ED colleagues.

There was no auditing of patient outcomes taking place.

Patients were not being reviewed by doctors or nurses regularly enough to monitor any changes in their condition.

However;

We were told that national guidance was applied to clinical practice.

There had been improvements to the management of food and nutrition since our last inspection in 2014.

Evidence-based care and treatment

- We were told that the ED followed up to date National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. However, there was no data to corroborate this. Local policies were written in line with these guidelines.
- There were specific pathways for certain conditions; for example, fracture of neck of femur, asthma, infectious diseases, cardiac arrest and dementia.

- Patients with mental health issues and who may need assessment under the Mental Health Act were referred to mental health liaison nurses who were available 24 hours per day

Pain relief

- Patients we spoke with who had been in pain during their attendance told us they had been given pain relief soon after arriving at the hospital. One told us, “I was asked whether I was in pain and offered painkillers by the nurse”. Staff we spoke with were aware of the appropriate guidance on providing pain relief to patients. We looked at 12 records and saw that each patient had a recorded pain score and was prescribed analgesia as required, which was administered in a timely manner.

Nutrition and hydration

- We noted that patient access to fluids and food had improved since our last inspection in 2014. A housekeeper was responsible for ensuring that patients were offered hot or cold drinks and sandwiches during the day, Monday to Friday. This role was carried out by a Health Care Assistant at all other times. We saw patients being offered fluids at regular intervals and fluid intake was recorded on patient notes. There was a kitchenette in the ED area, accessible to staff. The housekeeper made hot and cold drinks here for patients. We were told that the main kitchen delivered a quantity of sandwiches each day. If these ran out, the housekeeper could request more.

Patient outcomes

- Unplanned re-attendance rate to ED within 7 days was above the England average of 7.9%. The average rate of re-attendance to ED for the period up to December 2015 was 9.2%.
- The trust informed us that they routinely monitor the time to triage and this is available across the trust in near real time as well as formally reported as part of the ED performance report. However, when we asked some senior members of staff, they were unable to tell us how this information is captured.
- We were told that there was a tendency to ‘over investigate’ patients, as a means to expedite any future decision making by a clinician. This included

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doing blood tests and ECG on almost all patients following triage, irrespective of their presentation. A member of staff explained that as a result of long waiting times to see a doctor, nurses prefer to do a variety of tests just in case they will be required by the doctor when the patient is eventually seen. They termed this 'defensive medicine' since there was no medical leader to direct and make decisions at triage and streaming stages.

- Medical staff we spoke with told us that because they were so busy very little auditing of patients outcomes was undertaken. None of the staff we spoke with were able to describe the learning from recent audits.

Competent staff

- Doctors and nurses we spoke with told us they followed guidance from the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) in their practice.
- Several nursing staff undertook advanced training in emergency care. All Band 5 nurses had completed an Accident and Emergency course and eight Band 7 nurses were currently on a leadership course.
- We saw from submitted data that there was a 100% completion rate of annual appraisals for medical staff.
- Appraisals for nursing staff were completed for between 37% and 50% during the first three months of this year, despite having a target rate of 90%.

Multidisciplinary working

- Nursing staff we spoke with told us that effective co-working and communication with clinicians was varied and was dependent upon the individuals concerned.
- We were told it has been difficult to develop a back pain/spinal cord compression pathway in conjunction with Orthopaedics, as a result there is not one in ED for staff to follow. Staff we spoke with told us that colleagues outside of ED were not always supportive.
- The on-site presence of a Mental Health Liaison team ensured those patients presenting with mental health issues were appropriately managed and in a timely manner.

- Some staff told us the relationship with other departments could be improved in order to make the patient experience better. For example, there are frequent delays in the medical registrar coming to see patients in ED. The current practice is that ED is unable to identify medical patients for early admission, because they have to be seen and then clerked by Medicine staff first. This results in long waits for the patients to be seen by the acute consultant physician. We saw several patients waiting between three and five hours to be seen by a medical registrar.

Seven-day services

- There is a GP Project based in the Urgent Care Centre. This includes two GPs whose role it is to see and direct walking patients between 10am and 10pm, 7 days a week. Each GP sees between five and six patients each hour with the intention of treating and sending patients back home or to their own GP. Separate to this, there is another GP who works in the Urgent Care Centre from 9am to midnight, funded by the Trust.

Access to information

- Staff were able to access patient information using the electronic system and using paper records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 was not included in mandatory training for medical or nursing staff. However, staff we spoke with demonstrated an understanding of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (the deprivation of liberty safeguards (DoLS) provide legal protection for those vulnerable people aged 18 and over who are, or may become, deprived of their liberty in a hospital or care home). We spoke with the mental health service manager who told us he ran MCA and DoLS courses every two to three months for ED medical and nursing staff.
- We saw that it was routine practice for staff to ask patients for their verbal consent before conducting any assessment or treatment procedures. Where a patient was assessed as lacking capacity to consent to treatment, we saw how a doctor had discussed treatment options with the family as part of a Best Interest meeting.

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Are urgent and emergency services caring?

Requires improvement 

We rated caring in the Emergency Department as Requires Improvement because;

The ED scores poorly in the Friend and Family test with scores for February 2016 and March 2016 being 46% and 49% respectively.

The privacy and dignity of patients attending the UCC was not respected during the reception process.

However;

We saw that care was given in a friendly and considerate way.

Most of the patients and relatives we spoke with were positive about the care they had received. However, many complained about the length of time they were waiting to see a doctor.

Compassionate care

- We spoke with 54 patients, the majority of whom told us they were satisfied with their care. One said, “staff are really caring here and have offered me lots of drink and something to eat.” Another said, “Staff are good, they are professional and have treated me with kindness.”
- We observed a member of staff checking with patients on a regular basis, offering them drinks and a sandwich. This person told us they “got around people every hour, just to make sure they are not hungry or getting upset, I think it helps them to feel a little better.”
- Several people we spoke with complained about the length of time they waited to see a doctor once they had been seen by a triage nurse. One person told us, “I have already been waiting six hours to see a doctor. It would be helpful if there was an indicator board to say what the waiting time actually is.” Another told us, “it is now three hours since we saw the nurse. There does not seem to be any way to update us on the expected wait to see a doctor.”

- During our inspection, we observed good care being given to patients in a friendly and considerate manner. There was a mix of male and female staff available to treat those patients who expressed a preference for either a male or female. However, during our visit we noted that people’s dignity was compromised when they were receiving treatment on trolleys in the corridor. We saw how some patients were not fully covered up and it was difficult for staff to discuss confidential information with them since the trolleys were in a major thoroughfare. One family member said, “it is not ideal that my mum has to be on a trolley in the hallway. She has blood on the side of her face and she has not been cleaned up yet. It is embarrassing for her.”
- In our last inspection in 2014, we commented that the privacy and dignity of patients attending the UCC was not respected during the reception process. During this inspection, we found that the reception desk had not been changed. The structure of the reception desk was designed in such a way that it compromised patient confidentiality. Patients had to talk with receptionists via a microphone, and exchanges were clearly audible to those sitting in the waiting area. One patient said, “Confidentiality is not managed well because when you speak to reception staff through glass, everyone can hear what is being said.” Another patient told us, “I have a serious illness and do not feel comfortable telling reception because the current set-up they have does not allow for privacy.”
- The Friends and Family Test (FFT) is a feedback tool which gives people who use NHS services the opportunity to provide feedback on their experience. Results of feedback for ED indicate that patients had a poor experience from September 2015 to March 2016. With a benchmark set at 90%, results for January and February 2016 were 52% and 46% respectively for ED and 84% and 55% for UCC. The response rate for ED in January was 14% and in February was 25%. UCC response rates were 6% and 0.6%. The benchmark for both these was 20% and above.

Understanding and involvement of patients and those close to them

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care. One person said, “Staff told me how they

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were going to treat me and how long I would have to wait for the results.” Another said, “The staff have been great, we have not felt ignored by them because they are giving us frequent updates.”

Emotional support

- The ED staff had a protocol on how to deal with relatives who experienced bereavement and the hospital had a chaplain available, who could be contacted on a patient's request. Representatives from other faiths could also be contacted by staff on behalf of the bereaved.
- We were shown a booklet, ‘Practical help following the death of a relative or friend’, which is given to all bereaved people. It contained information on how to access the Chaplaincy, an explanation in the event of a post mortem and how to register the death. A matron we spoke with told us how they tried to lend as much dignity as possible to the whole process, including giving a full explanation of the circumstances of the death.
- During our observations, we saw that staff spoke to patients with empathy and in an open, understanding manner. One patient told us, “The staff are fantastic, I find this environment very uncomfortable and they keep me calm by talking with me.”

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

Inadequate



We rated responsiveness in the Emergency Department as Inadequate because;

Patient flow was poorly managed and the trust's performance with regard to waiting times was poor. In February 2016 only 67% of patients were seen and treated within the four hour target compared to an England average of 88%.

Patients with a Decision to Admit who should have been moved to other parts of the hospital were remaining in the ED for too long.

However;

The ED has access to and used a language line in order to communicate effectively with patients for whom English is not their first language.

Service planning and delivery to meet the needs of local people

- Some of the service planning we observed was based on short term reactions to issues as they arose. However, the trust had initiated the NHS England Faster, Safer, Better programme, designed to develop good practice in delivering urgent and emergency care. In addition, a 'see and redirect' service has been set up, run by local GPs. They will either redirect the patient to their own GP, or, in the event of the patient not registered with a GP, assist with the process of registration.
- We found no examples of consultation with local people and patients' groups in service design.

Meeting people's individual needs

- The department catered for a culturally diverse population, speaking many different languages. Nursing, clinical and administrative staff told us they accessed ‘Language Line’, which provides a range of interpreters. A nurse told us they also asked family members to translate and an administrator told us they were frequently asked to translate for patients who shared the same language as them. This is recognised as not good practice and was identified as an issue in our last inspection in 2014.
- We saw how staff responded to an unaccompanied patient with a learning difficulty with respect and sensitivity. Their use of language was appropriate and this helped to reassure the patient whilst they waited to be discharged.
- On-site psychiatric liaison nurses were able to provide a rapid response visit to the unit if needed. One ED nurse we spoke with described this service as, “A really positive experience for patients and staff alike.”
- There was a family room where the bereaved could sit, as well as a viewing room where they could spend time with their deceased relative.

Access and flow

- Trusts in England are given a target by the government of admitting, transferring or discharging 95% of

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patients within 4 hours of their arrival in the ED. The trust has managed to meet this target only once (in July 2015) since October 2014. Performance in August 2015 was 92%. It has consistently deteriorated since then with performance at 87% in September 2015, 84% in October 2015, 77% in November 2015, 72% in December 2015, 66% in January 2016 and 67% in February 2016.

- Staff cited a number of reasons why patients breached the 4-hour target. These included lack of a bed on a ward; a delay in ED review; a delayed specialty review, such as to a medical team; a delay in transport; or a clinical issue requiring the patient to remain in the department longer.
- The initial streaming process followed a 'triage and treat' model that enabled staff to assign patients to the most appropriate stream for treatment.
- We found the flow of patients from the department into other parts of the hospital was ineffective. For example, on the day of our unannounced inspection, there were 15 patients for whom a decision to admit (DTA) had been made several hours prior and who were still waiting to be moved to the appropriate part of the hospital. In the meantime, these patients remained in ED, occupying bays and requiring on-going monitoring until they left the department.
- We were told that the 12 hour target for time from DTA to admission was rarely breached and the data submitted to us by the trust showed just one 12 hour breach between the beginning of January and the week preceding our inspection. However, there were three patients in breach of this on the first day of our inspection for whom a DTA was made between 13 and 15 hours earlier.
- We were told that Area 1 (Minors) of the ED department was used as a ward to hold those patients who had a DTA, until a bed could be found for them in the hospital. This had the effect of reducing the capacity of available bays by 13.
- Monitoring of the clinical situation in the department is carried out using an online patient management computer system. However, on the day of our inspection, there was no evidence of a senior doctor taking control of the clinical situation and directing clinicians to the most appropriate or high risk patients.

- Staff told us they no longer "worried much about the 4 hour wait target to see a doctor; we breach it so often that it loses its significance. Staff told us they no longer, "worried much about the 4 hour wait target to see a doctor; we breach it so often that it loses its significance." During our inspection, we recorded waits of between four and nine hours. A senior nurse told us these breaches were common knowledge within the trust. We observed a bed meeting in which the manager reported 50 breaches of the four hour wait to see a doctor since midnight.
- Staff told us there was a number of reasons why patients breached the 4-hour target amongst which they felt was the lack of decision making by doctors during the night. This led to a backlog of patients who had come to ED during the night and for whom no decision had been taken about whether they should be admitted or discharged. The staff who came on duty in the morning had to assess these patients and make appropriate decisions, in addition to dealing with the regular daytime flow of patients..

Learning from complaints and concerns

- Leaflets on how to make a complaint and about PALS were available in the ED. One of the patients we spoke with said they were aware of how to make a complaint.
- Staff told us they tried to resolve complaints and concerns at the time where ever possible. They told us they received feedback about complaints and the learning from them.
- We did not find evidence that complaints were discussed at staff meetings.

Are urgent and emergency services well-led?

Inadequate



We rated leadership of the Emergency Department as Inadequate because;

The department had been without an established clinical director to provide leadership for more than six months. The leadership was shared among three consultants.

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Leadership by the senior clinical staff was not seen to be effective in supporting staff.

Trust management was seen as oppressive and overbearing and not supportive to staff in the ED. The culture meant that staff did not feel comfortable in raising concerns.

Most of the ED middle grades are not providing leadership to their more junior colleagues.

Serious incident reporting and investigation processes were not seen as transparent, with some staff feeling not all incidents were being properly investigated.

Some data which the trust relied upon, and which was submitted to CQC was found not to reflect the true situation when reviewed by the inspection team.

However;

Many nurses and doctors were doing their best to deliver good care in difficult circumstances despite not feeling supported by the senior leadership.

Vision and strategy for this service

- Most staff we spoke with told us that there was a lack of strategic planning and the ED just focused on day to day activity.
- Some staff said they chose not to wear their official lanyards which had the Trusts 5 core values on it because they felt these values were neither honest nor respected by executive board.

Governance, risk management and quality measurement

- According to the 2015 National NHS staff survey, 'Fairness and effectiveness of procedures for reporting errors, near misses and incidents' and 'Staff confidence and security in reporting unsafe clinical practice' were both below the national average for acute trusts.
- During our 2014 inspection, we commented that although managers had acknowledged that shortages of staff and delays in UCC triaging were risks, they were not recorded in the department's risk register. During this inspection, we found that the delays in triage were added to the risk register.

- Concerns were raised about the fact that there was no panel to validate whether incidents, which resulted in 48 hour reports, should be recorded as serious incidents. Currently, this is mainly done by one person. It was felt that a panel would lend greater transparency to such decision making.
- Some senior staff expressed concern about a similar lack of transparency and consistency in relation to the monitoring and validation of four hour breaches within the department.
- We were told that there was auditing of certain areas, for example, hourly rounding, patient experience, C Diff and hand hygiene. However, there has been no auditing of malnutrition universal screening tool (MUST, which is a means of preventing malnutrition by, for example, recording changes in weight and body mass index) since 2014. The Nutrition Steering Committee stopped in 2015. There are no pain audits currently being done.

Leadership of service

- The 2015 National NHS staff survey highlights key findings for which the trust compared less favourably with other acute trusts in England. These are as follows: 76% of staff believe that the organisation provides equal opportunities for career progression or promotion where the national average is 86%; 35% of staff experience harassment, bullying or abuse from staff, where the national average is 26%; 34% of staff experienced harassment, bullying or abuse from patients, relatives or the public where the national average is 28%; 17% of staff experienced discrimination at work where the national average is 10%.
- We found that the strength of leadership within ED nursing was good. Staff spoke highly of the new assistant director of nursing, who was described as supportive, hardworking and with a good overall vision of the direction in which the department should be going. The head of nursing was also seen to be supportive and encouraging. We were told that both the assistant director and head of nursing often gave practical nursing assistance when the department was very busy. More junior grades told us about the high

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levels of support which they received from more senior nurses and matrons. Our observations were that there was a strong sense of camaraderie and mutual support amongst the nursing group.

- However, most staff to whom we spoke told us they found the management style of executive board members to be oppressive and non-consultative, they were rarely to be seen in the department. We were told that nursing staff were frequently moved around the hospital without consultation or explanation. For example, a recent announcement was made concerning a change of skill mix across the wards and a reduction of nurse to patient ratio, which is to result in the displacement of approximately 23 full time equivalent staff. Those to whom we spoke with expressed grave concerns about the efficacy of this as it was likely that nurses, highly skilled in certain areas could be placed in another area where their skills were under-utilised.
- Matrons meetings are held infrequently. This resulted in poor communication and relevant updates on trust wide information from the senior clinical staff to the Matrons was not always shared in a timely manner. We were told that this level of poor communication was exacerbated by the lack of any written communication or record of discussions.
- We found that there was ineffective medical leadership. The ED does not have a clinical director. The role was being covered two days a week by a locum CD and from May 2016 after this person had left his post the role was being shared between three consultants in the ED. Senior managers told us that a new clinical director had been appointed and attempts were being made to expedite his start date. The trust has subsequently confirmed that the new Clinical Director is now in post.
- ED consultants were unable to agree a new pathway with their orthopaedic colleagues which would have helped patient flow. The ED consultants had not received any support from senior clinical staff during the negotiation process. The trust has since appointed a new medical director and the trust told us they hoped she would be able to provide the support to improve performance in the ED.

- Most of the middle grade doctors in the ED do not show effective leadership to the more junior doctors. During the day, we found that some consultants did provide effective clinical leadership; however at night, medical leadership was poor.

Culture within the service

- We spoke with a total of 40 members of staff during our inspection, including on site and in subsequent telephone calls, the majority of whom were nursing and medical staff. A large majority of these staff spoke of low morale within the trust and how they were fearful of the consequences if they challenged the leadership.
- According to the NHS Staff Survey 2015, the percentage of staff reporting good communication between senior management and staff was 26% as against a national average of 32%.
- A number of staff told us they felt management at trust level was oppressive and overbearing. They also told us they did not feel confident to raise any issues which the executive board as they were constantly urged to come with solutions rather than problems.
- Most staff told us that whilst they knew the name of the Chief Executive, they had never met her and could not tell us whether she visited the operational parts of the hospital as a matter of course. They were unable to name other members of the trust's executive board, who were described to us as being invisible. Although, we saw it was noted in the trust board minutes of March 2016 that executives were said to attend ward rounds on a rota basis to help them better understand the issues contributing to patient flow.
- Staff within the department spoke positively about the care they provided for patients. They told us how quality and patient experience were seen as priorities and everyone's responsibility, despite feeling overwhelmed by the volume of work at times. The national NHS staff survey showed that 69% of staff believed that care of patients was the trust's top priority, below the national average of 75%.
- We observed staff to be caring and considerate in their interactions with patients and in most cases, ensured they gave the patient adequate time to discuss any concerns they had.

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Public engagement

- The trust does not respond to feedback from the public. Both CQC surveys and the trust's Friends and Family survey have highlighted high levels of public dissatisfaction.
- The trust and the ED do not have any action plans about how they could improve patient experience.






Staff engagement

- Many staff told us that they felt distanced from the management board of the hospital. Staff said they did not feel they had a voice and were afraid to speak up for fear of retribution.

Innovation, improvement and sustainability

- We found no evidence of innovation, improvement and sustainability

Medical care (including older people's care)

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

Information about the service

The medical care services at North Middlesex University Hospital consisted of a short stay medical ward, acute medical unit (AMU), the ambulatory care unit (ACU), an acute assessment unit (AAU), an older persons' assessment unit (OPAU), an acute stroke unit, five general medical wards, one having older people's care as a second specialty, three wards for the care of older people, an outpatient department, an oncology ward, the Alexander Pringle Centre for patients with HIV infection and an outpatients department. They are spread between the Pymmes building and the Tower.

During our unannounced inspection dated 14 April 2016, we visited Charles Coward ward and T8 ward. Charles Coward ward is a general medical acute male ward for people aged 70 years and older. The ward has 29 beds and is divided into four bays each with five beds. There are four side rooms for seriously ill patients and patients who require barrier nursing for infection control. T8 ward is a renal ward with 22 beds, including 4 side rooms. T8 is a mixed sex ward with the genders in separate bays. We carried out an additional visit to the hospital on 4 and 5 May 2016.

We spoke with 18 patients and a relative and 30 members of staff, including doctors, nurses, ward managers, matrons, allied healthcare staff, health care support workers and domestic staff. We reviewed patients' care notes and medical records and observed care being delivered on the wards.

Summary of findings

Overall we rated medical care as Requires Improvement because;

The trust had not learnt from previous never events or incidents. The trust was not seen to be open and transparent. Relevant information was not shared with staff.

There was a culture of fear and staff did not feel confident that they could share concerns with senior managers.

There were occasions when the wards were short of a nurse who had not been replaced. The use of bank and agency workers was sometimes restricted by the trust.

There was a lack of respect and dignity in the way patients were treated and their needs were not always met appropriately. Patients' safety had been compromised through omissions in risk assessments, and through inconsistencies and inaccuracy in completing care records and observation charts. Patients' nutritional and hydration needs were not being met appropriately due to incorrect recording in the food and fluid charts.

The trust had an impressive dementia strategy but most of it had not been implemented. Staff were not completing mandatory training, including safeguarding. Basic dementia awareness training had not been completed by 40.6% of staff working in the wards for older people. There was no dementia champions/link

Medical care (including older people's care)

nurses in the wards to support staff. Patients were therefore exposed to the risk of not receiving appropriate care and treatment. Similar findings were reported in a CQC report in 2014.

The trust had recently participated in four national audits. The Sentinel Stroke National Audit Programme (SSNAP) gave comparable results to the national standard. The other three national audits Heart Failure, Myocardial Ischaemia National Audit Project (MINAP), and Diabetes Inpatient Audit (NaDIA) showed performance well below the national standard.

However;

The wards had good consultant support and availability and the number and skill mix of medical doctors was satisfactory. There was a daily multidisciplinary team meeting and good team working in patient care and on ward rounds.

Are medical care services safe?

Requires improvement 

We rated the safety of medical care as Requires Improvement because;

- There was a never event in 2015. Lessons had not been learnt from two similar never events that occurred in 2013 and 2014 respectively. Staffing incidents had not always been reported.
- Although the trust had applied the safer nursing tool to calculate the planned staffing level, this level of staffing had not always been maintained.
- Nursing and care staff had not completed mandatory training in all the topics specified, including safeguarding. Some staff were unclear about the process for raising concerns and not all nursing staff were aware of the referral forms in use.
- Patients' care records had not been maintained appropriately and confidential information was not protected. Risk assessments were sometimes omitted or not fully carried out. There were inconsistencies in maintaining observation, food and fluid charts. Written care plans were not produced following risk assessments.
- Trained staff had not been following the medication policy in the safe storage, recording and administration of medicines.

However;

- There was an adequate number and skill mix of doctors, with good consultant support and availability.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. Lessons had not been learnt, as similar never events had occurred previously in 2013 and 2014.

Medical care (including older people's care)

- Staff confirmed they used the online incident reporting system to report incidents. Staff said they had stopped reporting incidents of staff shortage as management had not responded to them in the past.
- The trust had a process for ensuring all incidents reported over the last 24 hours on the online incident reporting system, were reviewed in the morning by the risk management team. This meeting was attended by a board member and matrons attached to the clinical business units (CBUs). A preliminary investigation was conducted within 48 hours before the incidents were categorised and root cause analysis was begun, if required.
- There were 32 serious incidents reported between March 2015 and February 2016. Six of these were due to delayed treatments, five due to falls, four were due to providing suboptimal care to a deteriorating patient, three were due to delayed diagnosis, five were due to pressure ulcers and nine others were due to other causes.
- The matrons we spoke with confirmed they had conducted root cause analysis (RCA) for every grade 3 and 4 pressure ulcer. The RCA report was reviewed by a panel who looked at areas for improvement. One matron told us that there were times when the initial grading of pressure ulcers was wrong and lessons had been learnt and improvements had been made, such as staff retraining.
- Senior staff had been trained in duty of candour, and the trust's policy was available online to all staff. This ensured that if a significant adverse event occurred the patient or their relatives would be informed within 10 days, following the correct formal procedure.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to patient falls, pressure ulcers, new catheter-associated urinary tract infections and venous thromboembolisms (VTE).
- We reviewed NHS Safety Thermometer data between November 2015 and March 2016. In T8 ward, there were 3 hospital-acquired pressure ulcers but no falls with

harm, no catheter-related UTIs and no new VTEs. In Charles Coward ward, there was 1 hospital-acquired pressure ulcer and 2 catheter-related UTIs but there were no falls with harm and no VTEs.

Cleanliness, infection control and hygiene

- All the wards we visited were visibly clean.
- Staff wore appropriate personal protective equipment (PPE) and followed 'bare below the elbows' guidance in clinical areas.
- Clear signs were in place at the entrance to side rooms in use for patients with an infection, giving staff and visitors information on the precautions to be taken when entering those rooms. We noted a patient with MRSA and diarrhoea being barrier-nursed in a side room in one ward. We observed that the correct infection control procedures were followed.
- We observed staff washing their hands before attending to patients. We saw staff wearing aprons and gloves before giving personal care and these were changed in between patients.
- We observed a nurse wearing gloves to give intravenous antibiotics to a patient but the nurse did not wear an apron.
- We observed two domestic staff carrying out their daily schedules in one ward we visited. One of them said their contractual company had carried out regular cleaning audits and there was an action plan to address any shortfalls. Staff confirmed their supervisor carried out an audit on 7 April 2016 which found the cleaning service was 99% compliant.
- The domestic staff were conversant with the requirements for cleaning the area.
- Patients told us they felt the wards were clean. We received positive comments from patients such as, "The ward is very clean. The cleaners were here every day and they did a good job". and "Staff wash their hands before attending to us and they wear aprons and gloves."
- There were adequate hand washing facilities and hand gel for use at the entrance to the wards, the bays and clinical areas. There was prominent signage reminding people of the importance of hand washing.

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- The wards had display boards with key infection prevention and control messages such as a flowchart for the management of diarrhoea and *Clostridium difficile*.
- Hand hygiene compliance was audited for T8 ward and Charles Coward ward over the 4 week period between 5 October 2015 and 1 November 2015 and found to be 100%.

Environment and equipment

- The environment in the wards we visited was clean and generally uncluttered.
- The entrance doors to the wards were installed with an intercom system. There was a receptionist at the main reception desk who ensured all visitors were greeted and their identity was verified on entry. Staff used electronic swipe cards to gain entry to ward areas.
- Staff confirmed there was sufficient equipment available to meet the needs of the patients receiving care.
- Equipment that was not available on the ward was provided in a timely manner.
- The equipment we examined was visibly clean and labelled to indicate it had been cleaned.
- We noted resuscitation equipment was stored on resuscitation trolleys on each ward and each trolley had been checked twice daily by a trained nurse.
- Systems were in place for the segregation, storage and labelling of waste. We saw the appropriate disposal facilities in place in the clinical areas.
- In T8 ward, patients said that televisions in the ward were not working properly and often the appropriate remote controls were missing.
- The resuscitation trolleys were audited on 17 February 2016. In T8 ward the trolley had not been checked within 24 hours and action had been taken to retrain the nurse concerned. In Charles Coward ward the trolley had been checked within 24 hours.
- Medicines were stored in locked cupboards or medicine trolleys and kept in the clinical room, which was kept locked at all times and accessed using a keypad. However, we found a medicine trolley unlocked and unattended.
- In the clinical room we noted there was a medicine order book and separate locked units were used for delivered drugs and drugs waiting for disposal.
- We noted the controlled drug cupboard had limited space and the drugs were not organised neatly. Controlled drugs were checked twice a day and appeared correct in number. The drug fridge temperature was checked daily and recorded.
- We observed medicine rounds in progress and noted a member of staff wearing a 'protected time' apron. This ensured they would not be disrupted by other tasks whilst administering medicines to patients.
- We saw a nurse giving a patient their own medicines stored in an individual patient locker by the patient's bed; the nurse ensured the patient had taken the medicines. The nurse asked the patient what flavour of medicine they would like and checked the patient's name with the patient but had not checked the patient's name band on their wrist prior to administering the medicines.
- We noted the member of staff had signed the drug chart before giving the medicines to a patient and had not signed for one of the medicines given. The appropriate procedure for the administration of medicines had not been followed.
- We checked five drug charts and found information on a patient with known drug allergies was recorded but the VTE section was not completed.
- Between 1 October 2015 and 20 April 2016, there have been four medication errors. Staff were retrained and the errors were discussed at staff meetings.
- An audit of pharmacy and medicine management was carried out in March 2016 and had 35 indicators. T8 ward failed on 8 indicators. Charles Coward ward failed on 10 indicators. Appropriate actions had been taken. One indicator that failed related to a medicine trolley that was left unlocked. We found the same at the time of our inspection. Clearly lessons had not always been learnt and practice improved.

Medicines

Charles Coward Ward

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- An audit was carried out on the storage and handling of controlled drugs, with 4 indicators. T8 ward scored 86%, 79%, 100% and 100% respectively. Charles Coward Ward scored 71%, 57%, 100% and 86%. Areas of non-adherence were identified; actions were taken and lessons were learnt.

T8 ward

- In T8 ward, we found medicines were left at the side of a patient's bed; these were oral and intravenous antibiotics. Medicines were not always given on time. For one patient, we observed intravenous antibiotics were given at 15:00 hours instead of 14:00 hours.
- One patient said that medicines required for tests had not been obtained in time. Another patient experienced 4-5 hours delay in obtaining a prescription.
- There have been 7 medication errors between 1 October 2015 and 20 April 2016. In all cases action taken included staff retraining and discussion at staff meetings.

Records

- Nurses used paper documentation to record the results of a standard range of risk assessment tools, such as Falls Risk Assessments, Malnutrition Universal Screening Tool (MUST) assessments, Waterlow Risk Assessments (for pressure ulcer risk) and the Infection Prevention and Control Risk Assessment Tool. These tools were all found in the 'Admission Risk Assessment Booklet' and kept in a blue folder together with guidance on management/care plans.
- Other documents were also kept in the blue folder, including the National Early Warning Score (NEWS) charts, food and fluid charts and the mental health assessment document. Each blue folder was labelled with the patient's name and kept at the end of the patient's bed or in the record trolley in each bay.
- We found inconsistencies and incomplete and inaccurate documentation in the risk assessment forms, the mental health assessment form, and the observation charts. However, the NEWS charts were satisfactory. We had not found written care plans in all the folders we reviewed except the care plan for 'sepsis' and the 'handling care plan.' These care plans were not detailed.

- In Charles Coward ward, we checked seven patients' care (blue) folders and found the completion of the booklets was variable. For example, for one patient, the fluid chart was incomplete for 12 and 13 April 2016; the food chart was incomplete for 13 April 2016, with only the breakfast section completed and there was no food chart for 14 April 2016. The Waterlow score was last completed on 09 April 2016. The MUST, the falls risk assessments, the NEWS chart and the mental health assessment had been completed. However, the mental health assessment showed conflicting information; the form showed low risk in terms of needs but the risk status had been ticked as 'high' and the patient had been shown to be both 'confused' and 'alert.' An intravenous cannula site had a dirty dressing and this had not been checked on 13 April 2016. There were no care plans seen in the patient's care folder.
- We checked the records for another patient in Charles Coward ward and found that not all the documents had been completed. The patient had been refusing food since 9 April 2016 but the Malnutrition Universal Screening Tool had not been completed since 26 March 2016. It was not clear whether the patient had been referred to a dietitian. One document for pressure care had not been completed. The patient's fluid chart and NEWS chart had been completed but there were no written care plans in the care folder.
- In the case of a patient in Charles Coward ward who was living with dementia, the NEWS chart and 'Behaviour that Challenges' form and the food and fluid charts had been filled in appropriately and the patient had appropriate risk assessments; the Waterlow score had been updated and MUST had been reviewed. We saw a 'handling care plan' which stated 'Due to dementia, needs prompting.' There were no other details and no other care plans found in the patient's care folder.
- In T8 ward we found there was inaccurate recording in the fluid chart for a patient on percutaneous endoscopic gastrostomy (PEG) feed: the fluid chart recorded 150 ml every three hours but the infusion rate was set at 65 ml per hour or 195 ml every three hours. The Enteral feed regime had not been written up since 04 April 2016. The wound dressing record had not been written up since 3 April 2016. However, we

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found the blood glucose level had been recorded regularly; the NEWS and Waterlow score had been done. We saw the 'sepsis' care plan but we could not find any other care plans in the folder.

- For another patient in T8 ward, we found the falls risk assessment, MUST, catheter surveillance and intravenous monitoring had been completed but the Waterlow score was not recorded for 26 March 2016 and 9 April 2016. The fluid balance chart showed the indwelling catheter had not been emptied since 6am on the day of our visit (at 3pm).
- We noted the Dementia Friends Logo was used on one of the blue forms entitled 'Ten important things about me'. We were told this dementia form was designed by the consultant lead for dementia and was used for patients who suffered from dementia. However, we found these forms were in the front of every patient's care folder. This would indicate every patient had dementia, which was not the case. We noted these forms had not been filled in.
- It would have been difficult to identify the personal and nursing care needs of patients from the documents we saw. Patients were therefore at risk of not receiving appropriate care and treatment.
- In Charles Coward ward, we found three medical record trolleys unlocked, one in each of two bays and one for the side rooms kept in the ward reception area. We observed there were occasions when there was no member of staff present in these bays, so patients' confidential information was easily accessible to anyone.
- We checked three Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms which had been signed and dated by the patient, the consultant and another doctor. One form was completed correctly. However, in another form, the Mental Capacity Act (MCA) section had not been filled in and in another the MCA assessment had not been completed.
- We reviewed the medical notes of three patients in Charles Coward ward. Generally, the medical notes were well maintained with regular doctor's entries, including communications with the relatives. However, there was a lack of blood results in a patient's medical notes and a missing VTE proforma in another, but in the drug chart the VTE prophylaxis

drug had been prescribed. We could not find the prescription for oxygen and there was no documentation in the notes to explain why oxygen was started and there had been no investigation of why oxygen was needed. We noted the patient was prescribed one litre of fluid per day but there was no medical plan regarding what was in their best interests long term.

Safeguarding

- Staff had access to the adult safeguarding policy and the adult safeguarding team were available to provide advice and guidance, when required.
- Safeguarding training was mandatory for staff and different levels of training were provided, according to job role.
- The trust data showed all staff in T8 ward had received training in safeguarding adults (levels 1 and 2) and safeguarding children (levels 1 and 2).
- In Charles Coward ward, 82.9% of staff had been trained in safeguarding adults level 1 but no staff had been trained in safeguarding adults level 2. Also 78.6% of staff had received training in safeguarding children level 1 and 76.1% of staff had been trained in safeguarding children level 2.
- We spoke with 11 staff from various disciplines and they were able to identify the potential signs of abuse but not all of them were confident about the process for raising concerns and making a referral. Some said they would report the incident to the person in charge of the ward at the time; one person said they would question the member of staff first. They also said they would report the incident on the online reporting system.
- Staff said they received safeguarding training by e-learning and there was a link nurse for safeguarding. Not all the staff were able to tell us who the safeguarding lead for the Trust was.

Mandatory training

- Mandatory training covered a range of topics, including safeguarding (adults and children), health and safety, infection control, food hygiene, moving and handling and fire safety. Staff told us some mandatory training was through e-learning only.

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- The training and workforce dashboard, provided by the trust on 20 April 2016, showed that, in T8 ward, there were five mandatory training topics but not all staff had received training. The percentages of staff receiving training were: Fire Safety (62%), Infection Prevention and Control (68%), Information Governance (72%), Moving and Handling (68%) and Adult Resuscitation (63%).
- The training data for Charles Coward Ward showed that all staff had been trained in 4 out of 15 topics. More than 80% of staff had been trained in 5 other topics. More than 60% of staff had been trained in another 5 topics, including Adult Resuscitation (64%). Moving and Handling 58% of staff had been trained.
- The mandatory training schedule in T8 ward showed fire safety and infection control were done through e-learning but there was an IT problem with acknowledging completion of each module. In the case of cardiopulmonary resuscitation (CPR) training there were 10 staff out of 32 who required refresher updates.
- The ward manager informed staff who needed to update in certain topics by e-learning. We were told the matron analysed training needs and arranged for specific staff to attend courses held either internally or externally.
- Staff told us dementia training was not a mandatory training module. We found not all the staff had received 'dementia awareness' training, which was given by either a geriatrics consultant or a nurse. 75% of staff in T8 ward had received training in dementia and 59.4% of staff in Charles Coward ward had received training in dementia.
- The trust used the safer nursing tool but they did not consistently achieve the level of staffing indicated by the tool.
- We were told all matrons attended bed management meetings three times a day. Each matron had to assess the acuity of each patient and submit a form by 8am stating the dependency level and additional staff required, such as for one to one care.
- Staff told us the ward managers were responsive when they identified the need for additional staff. However, matrons and ward managers had no autonomy to approve the use of agency nurses which had to be approved by the executive team. We were told sometimes the approval was delayed and other times the approval had a restriction which stated that extra staff were approved for the day shift but not for the night shift. Staff in T8 ward told us requests for additional staff for one-to-one care were sometimes refused.
- The acuity review report dated October 2015 showed that for T8 ward, the safer nursing tool indicated 33.71 whole time equivalent (wte) registered nurses were required. This figure included a 20% allowance for training, annual leave and sick leave. The Trust found that they could work with a smaller allowance than this. The trust budgeted for 30.7 wte. The worked hours were 31.2 wte.
- Similarly, for Charles Coward ward, the safer nursing tool indicated 36.3 wte were required. The trust budgeted for 36.2 wte. The worked hours were 39.8 wte.
- Despite the safer nursing tool data, we observed that staff appeared pressurised when the number of trained staff per shift was reduced. For example, in T8 ward, which had 22 beds including 4 side rooms, the number of trained staff per shift varied. There were 5 nurses for the morning shift, 4 for the late shift and 3 for the night shift. The nurses were supported by 2 healthcare support workers for each shift. Staff told us the trust had announced there was going to be a reduction in the staffing levels for T8 ward, from 5 nurses to 4 nurses for the morning shift. Staff said they were struggling to cope already without the reduction. It was not clear when this change would be implemented.

Assessing and responding to patient risk

- The National Early Warning Score (NEWS) chart was used to assess patients whose condition was deteriorating.
- We looked at the NEWS charts for two patients who suffered from dementia and found that they had been filled in appropriately.
- The NEWS chart for a diabetic patient had also been completed correctly.

Nursing staffing

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- We noted Charles Coward ward had been short of one nurse (band 5) per shift for a few weeks due to sickness and annual leave. We were told the established staffing number was 5 nurses per shift during the day with three health care support workers (HCSW) to assist. We were told bank or agency nurses would be requested following e-rostering, which was done two months in advance. However, sometimes the ward was still short because of delays in authorisation or restrictions by the trust, and other times the bank or agency services had no staff available to fill the gap.
- During our inspection, we observed that Charles Coward ward was short staffed on that day. There were only two nurses to care for 29 patients as one nurse had gone off sick and one nurse was sent to help in another ward by 11am. As a result, the deputy manager (band 6) who was managing the ward had to cover one bay of 5 patients for the rest of the 12 hour shift and supervise a new recruit (band 5) who was being inducted. On the same day, there was one HCSW to assist until 11am when an HCSW from another ward came to help out until 17:00 hours.
- Several patients told us that staff were very busy, especially in the afternoons and at weekends.
- According to the acuity review report dated October 2015, the safer nursing tool for each nursing grade, the worked hours were compared with the budgeted hours. The difference was taken to indicate how the staff numbers for the grade may need to be adjusted. This indicated that for T8 ward there were more band 5 and band 7 nurses than required, but there was a shortage of band 6 nurses (0.58 wte) and HCSW band 2 (0.35 wte). For Charles Coward ward there were sufficient Band 5 and Band 7 nurses but there was a shortage of Band 6 nurses (0.70 wte) and HCSW Band 2 (0.99 wte).
- Charles Coward ward had five staff vacancies, which have now been filled, subject to satisfactory Disclosure and Barring Service (DBS) checks. Some of the new recruits (band 5) would be starting in two months' time. One started on the week of our visit.

- Staff told us there were handovers every morning from the night staff to the day staff. Following handovers, the senior nurse allocated the tasks and the bays and side rooms to each member of staff.

Medical staffing

- Staff felt consultant cover was adequate. In Charles Coward ward, the consultant level had been increased from one to two consultants since 11 April 2016. There was consultant cover daily and a consultant was on call out of hours.
- There was a medical consultant who covered the whole of the medical service at weekends but only to see new admissions and very ill patients.
- There is a consultant on the ward daily. Between 9am -5pm there was a minimum staffing level of two junior doctors working with the consultant. After 5pm there were two junior doctors covering the medical service in the Pymmes building and the Tower. This is the same at weekends. The junior doctors were supported by a specialist registrar.
- Staff said there was a good medical team. They were supportive of nursing staff who felt confident to challenge doctors on any clinical issues.
- Junior doctors felt they had good support from consultants and registrars, who were approachable and easy to get on with. They said staffing was good and there was good cover. There were enough junior doctors to cover the medical roster.
- Medical handovers were occurred every morning at 8am undertaken by a specialist registrar (SpR) and a senior house officer (SHO). The consultant was not present for handovers but present at the Red, Amber Green (RAG) meeting every day at 10am.
- The RAG meeting was a multidisciplinary meeting where a senior nurse, an occupational therapist and a physiotherapist were also present to discuss patients' care and treatment and their discharge plans.
- We were told the medical team (SpR and SHO) conducted four ward rounds daily to see all patients.
- We observed the medical staff, including a medical student, working in the wards throughout the day.

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- We saw that allied healthcare staff, namely a physiotherapist and an occupational therapist, were present at various times throughout the day. We saw a speech and language therapist (SALT) visiting a patient; we were told a SALT would only see a patient when referred. Staff told us the number of allied healthcare staff, especially one physiotherapist allocated to Charles Coward ward per day, was insufficient and this had sometimes caused delay in discharging patients.

Major incident awareness and training

- There was a Trust-wide major incident plan, reviewed every three years. A copy was in each department.

Are medical care services effective?

Requires improvement 

We rated the effectiveness of medical care as Requires Improvement because;

- The trust had recently participated in four national audits. The Sentinel Stroke National Audit Programme (SSNAP) was better than the England average. The other three national audits Heart Failure, Myocardial Ischaemia National Audit Project (MINAP), and Diabetes Inpatient Audit (NaDIA) showed performance well below the national standard. These results meant that patients may have received suboptimal care in these specialties.
- Staff knowledge of the Mental Capacity Act and the Deprivation of Liberty Safeguards was variable.
- There was consultant cover at weekends for new and very ill patients only.
- Patients' nutritional needs were not always assessed and the food and fluid charts were not always filled in correctly. This could have affected patients' care and treatment.

However;

- The trust followed national guidelines in its policies and clinical procedures and participated in a number of national audits.

- There was a multidisciplinary team involved in patient care with daily meetings on the wards.
- Patients received appropriate pain relief.

Evidence-based care and treatment

- Guidelines and policies used in the wards were in line with those issued by the National Institute for Health and Care Excellence (NICE), the Royal College of Nursing (RCN) and other professional bodies.
- From the minutes of the Clinical Business Unit governance meetings we saw that specific teams had carried out audits on incidents such as falls and pressure sores. The results of these audits fed into the governance meetings which drove improvements to care. For example, falls had been audited and between December 2015 and February 2016 there were 20 falls in T8 ward and 31 in Charles Coward ward.
- An investigation into a falls incident raised in a complaint by relatives led to an action plan and a change in documentation for falls risk assessment; any changes in practice were disseminated.

Pain relief

- Several patients we spoke with said that they were not in pain and felt that if they were the nurse would give them painkillers. One patient we spoke with said they were not in pain but they had been prescribed a mild medicine for pain in case they needed it. The drug chart showed the medicine was prescribed to be taken 'as required'. One patient said painkillers were given straight away when they needed them and another patient's relative confirmed this was the case.
- We observed patients in two bays and they appeared comfortable as they rested in bed.
- We found that the pain assessment section of the NEWS chart had been completed appropriately for a patient.

Nutrition and hydration

- A nutritional risk assessment using the Malnutrition Universal Screening Tool (MUST) was included in the nursing risk assessment for patients following their admission. However, we found that staff had not always completed the MUST form in the case of a

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patient who had been refusing food. It was not clear whether the patient had been referred to a dietitian. However, the patient's fluid chart had been completed.

- We noted food and fluid charts were used to record intake and output for patients who had lost weight, patients with a loss of appetite and seriously ill patients. However, we found that staff had not always completed these charts appropriately and accurately which could affect patients' care and treatment.
- For example, we found the fluid chart for a patient on PEG feed was recorded incorrectly; the chart showed 150 ml every three hours but the PEG infusion pump was set at 65 mls per hour. The Enteral feed regime had not been written up since 4 April 2016.
- In one patient's records which we reviewed we found the fluid chart was incomplete for 12 and 13 April 2016; the food chart was incomplete for 13 April 2016 with only the breakfast section completed and there was no food chart for 14 April 2016.
- We were told the menu had plenty of choices including choices for people from different religious and ethnic groups (kosher, halal, south Asian).
- Patients varied in their feedback about the food served; the majority said the food tasted good, the portions were fine and the food served was hot. However, two people in T8 ward said they did not like the food served. They told us the meals were not always served on time and as a result the food was cold and sometimes meals were served so late that the gap between meals was shortened, resulting in patients eating when they were not really hungry. A patient said that salt and pepper were not provided and that the bread was of poor quality.
- In Charles Coward ward, a patient said they were served sandwiches which were inadequate, consisting only of bread with a lump of butter in the centre. Patients said that adequate drinks were provided but two patients said the drinks served were placed out of their reach at times.
- In Charles Coward ward, we observed there was a jug of fresh water by each patient's bed and this was changed every morning. We observed a variety of hot drinks were provided at intervals throughout the day.

Patient outcomes

- The trust participated in the Sentinel Stroke National Audit Programme. From January 2015 to December 2015 the overall indicator level was A-B, which was comparable with other trusts.
- In the Heart Failure Audit in 2013/2014, the trust's performance on most indicators was comparable with the national average, but there were a few areas where the performance was well below the national average. Only 32% of patients received input from a consultant cardiologist, as compared with 60% nationally. Only 6% of patients received cardiology in-patient care, as compared with 49% nationally. Only 4% of patients received a referral to cardiac rehabilitation on discharge, as compared with 10% nationally. Only 34% of patients received discharge planning, compared with 51% nationally. This meant that heart failure patients might have received suboptimal care.
- The Myocardial Ischaemia National Audit Project (MINAP) looked at the care of non-ST segment elevation myocardial infarction (nSTEMI) patients over the period 2013-2014. The trust's performance was comparable with the national average for two indicators out of three. However only 2.5% of patients had been admitted to a cardiac unit or ward, as compared with 55.6% nationally. This meant that nSTEMI patients might have received suboptimal care.
- The National Diabetes Inpatient Audit (NaDIA) for 2015 showed that the trust was substantially worse than the national average on many indicators. There were medication errors for 53.9% of patients, compared with 37.4% nationally. There were prescription errors for 38.2% of patients, compared with 20.8% nationally. There were management errors for 36.8% of patients, compared with 22.6% nationally. There were insulin errors for 31.6% of patients, compared with 22.6% nationally. The percentages of patients given foot risk assessments at different times from admission were all very poor. Assessments within 24 hours, after 24 hours, and during the whole stay were monitored; the percentages for the trust were 8.0%, 1.1% and 9.2% respectively, compared with the national averages of 20.5%, 3.0% and 25.9% respectively.
- In June 2015, the trust was notified that they had unusually high adjusted mortality rates. The Hospital

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Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) in particular disease areas were above the national average and had an upward trend. The trust took a number of actions to investigate this finding and to seek to reduce the mortality rate.

Competent staff

- There were clinical nurse specialists within the trust to support the delivery of care to specific groups of patients, such as patients with pressure sores and diabetes.
- Staff undertook mandatory training as well as other relevant training on topics such as dementia care and tissue viability. However, not every member of staff had completed the required training such as in safeguarding and moving and handling. Some staff had not received training in basic dementia awareness, which is not in accord with the trust's Dementia Strategy Action Plan, which requires 100% of staff to receive this training.
- Staff said they had received regular appraisals and clinical supervision. Doctors and nurses underwent revalidation, as required by regulation.

Multidisciplinary working

- Staff said there was good multidisciplinary working with doctors, other internal services and external organisations, including social services and the transportation team.
- Allied healthcare professionals and a Macmillan nurse said they worked closely with the consultants and their teams.
- Staff said there was a daily Red Amber Green (RAG) meeting on the wards involving consultants, doctors, the ward manager, the physiotherapist, the occupational therapist and the discharge team. There was a comprehensive discussion about patients, the assessments they needed and the plan for their discharge.

Seven-day services

- The wards had consultant cover during weekdays and had out-of-hours access to consultants.

- At weekends there was a medical consultant who covered the whole of the medical service. They visited the wards but they only saw new admissions and very ill patients.
- Since April 2016, a second consultant had been allocated to Charles Coward ward and the doctors conducted four ward rounds daily to ensure all the patients were seen.
- Patients had access to the physiotherapist and the occupational therapist daily. The speech and language therapist (SALT) attended to patients by referral only. There was a SALT on call from home at weekends.
- The pharmacy was available daily.

Access to information

- Staff had access to information, clinical guidelines and trust policies through the intranet.
- They also received trust information and updates through emails.
- Information was communicated and shared through ward meetings and multidisciplinary meetings.
- We found there was access to a range of information on the trusts website.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was taken from patients appropriately. We saw documents were in place for consent to treatment and interventions.
- We observed staff explaining what they were about to do and checking patients' wishes prior to providing care.
- Patients told us staff asked their permission before providing care and treatment.
- We asked staff on the wards about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff knowledge was variable. Senior nursing staff had knowledge of the MCA and DoLs, best interest decisions and the role of Independent Mental Capacity Advocates (IMCAs).

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- We noted two DoLs applications to authorise the use of mittens to stop patients removing nasogastric tubes.
- Doctors carried out Mini Mental State Examinations (MMSE) to assess capacity.

Are medical care services caring?

Requires improvement 

We rated caring in the medical service as Requires Improvement because;

- Some patients' accounts of their experience of care and treatment indicated that staff were not providing good quality care.
- A patient reported being left sitting on a bedpan for over an hour.
- A relative of another patient said that in spite of telling staff, the patient was left for four hours before being changed.
- Patients said some nursing staff were heavy handed when giving treatment.
- Although there was some positive feedback, patients' comments overall showed there was a lack of compassion, respect and dignity shown to patients. Patients reported that some staff were not behaving in a way compatible with the decorum of the ward.
- The wards had good results in the friends and family test, but staff should try to improve the response rate to make the results more robust.

Compassionate care

- The NHS Friends and Family Test (FFT) asked patients using each hospital service if they would recommend the hospital to their friends and family. The hospital achieved a 25.1% response rate in the NHS Friends and Family Test in comparison to a national response rate of 28.5% (February 2015 to January 2016).
- We examined Friends and Family Test (FFT) data for the period from October 2015 to February 2016. 92% of patients in Charles Coward ward would recommend

the service and 100% in T8 ward. These results are good, but the data would be more representative if the response rates were improved from 12% and 18% respectively.

- We spoke with 12 patients in Charles Coward ward and we found that their experience varied. Some patients said the care was satisfactory while others had some misgivings.
- Three patients in Charles Coward ward told us that nurses did not come within a reasonable time when they rang the call bell. One said they were sometimes ignored when they called a nurse. We were also told nurses repeatedly said they would return soon and then forgot to return.
- Also in Charles Coward ward, one patient said staff were rough and 'very aggressive' when they put the blood pressure cuff on the patient's arm. Another patient said that the nurses washed them every day but did not help shave them. One patient was concerned that the toilet floor was left wet and slippery after it had been cleaned.
- We were told staff rowed with each other and were heard screaming, "I am not doing that or you are doing that." in front of the patients. A patient said they could hear a member of staff screaming at a relative in the corridor during the night.
- In T8 ward, we spoke with seven patients and a relative and found patients' experience varied. Four patients were positive about the care provided and a relative commented that consultants, doctors and nurses were very good. However, three patients gave negative feedback about the care and treatment they received from the nursing team.
- For example, a patient said that nurses were rough in turning their head. Another patient said that a nurse was very heavy-handed in putting a cannula in their arm and used excessive force.
- Another patient said that they had been left on the bedpan for over an hour and nurses did not respond to the call bell. A patient said that nurses mentioned personal care matters when visitors were present. A patient's relative said that she told a nurse that the patient needed changing but the nurses only dealt with it 4 hours later.

Medical care (including older people's care)

- We observed staff interaction with some patients in the wards we visited and noted that patients were shown respect and their privacy was maintained; we observed that the curtains were drawn before personal care was given.
- We heard staff asking patients for their permission before care was given and staff explained what they were going to do before treatment began. We observed patients being offered choices; we heard a member of staff asking patients what flavour of drink they preferred.
- Patients' names and their named clinicians are written on whiteboards which are visible to visitors on the ward. This could potentially risk patient confidentiality, however, this risk is mitigated as clinical information did not appear alongside patient names on the publically visible whiteboards.

Understanding and involvement of patients and those close to them

- Most patients told us they felt involved in decisions about their care and treatment and that staff kept them informed and were straight and upfront with them.
- In T8 ward, patients said their privacy was respected when providing treatment. However, one patient felt that nurses could be more open in discussing their condition and treatment, and could provide them with more accurate information.
- Patients told us visitors were welcomed and felt there were no restrictions on the number of visitors they could have. Some patients were confused over the number of visitors allowed.

Emotional support

- We found little information in patients' care records about the emotional wellbeing of patients and the emotional support provided.
- Staff told us patients would be referred to the psychiatric team or the confidential counselling service if required.
- We were told assistance was provided for believers of most faiths. There was a bereavement counselling service available for patients' relatives. There was access to a chaplaincy service.

Are medical care services responsive?

Requires improvement 

We rated responsiveness for medical care as Requires Improvement because;

- The trust had a dementia strategy, most of which had not been implemented, so patients' needs may not have been met.
- Discharges had been delayed due to an insufficient number of physiotherapists to assess patients. This had reduced patients flow and the availability of beds.

However;

- Information was available in different languages and interpreters were available to support patients.

Service planning and delivery to meet the needs of local people

- Staff felt they had worked well with local GPs, the local authorities and other healthcare providers, and that communication among the multidisciplinary team was effective.
- Information leaflets were available in different languages, representing local cultural groups. Interpreters were also available, if needed. Menus were in different languages and included cultural dishes reflecting the local community.

Access and flow

- Patients were admitted through the Emergency Department (ED). Patients were transferred either through the acute assessment unit (AAU) or directly to a medical ward. This provided flexibility for the service, but also resulted in several moves for some patients. This depended on the patients' medical conditions and the type of specialist care needed.
- From Monday to Friday, there was a daily ward MDT meeting attended by the consultant and his team, the occupational therapist, the physiotherapist and a senior nurse to discuss each patient's progress and the plan for patients due to be discharged.

Medical care (including older people's care)

- We saw three discharge summary forms filled in by doctors who signed and dated the forms, giving their grade. A copy of each patient's form was sent to their GP following their discharge.
- We were told the flow of patients slowed down in Charles Coward ward due to insufficient physiotherapists to cover the 29 bed ward. Therefore patients who were being discharged either to their own home or to a rehabilitation centre, had their discharge delayed until the physiotherapist was available to assess them.
- We reviewed the discharge or transfer of patients over the 4 week period from 13 July 2015 to 7 August 2015. In Charles Coward ward, no patients were discharged or transferred within 24 hours, 4 between 24 hours and 48 hours, and 50 after 3 days or more. In T8 ward, 12 patients were discharged or transferred within 24 hours, 9 between 24 hours and 48 hours, and 43 after 3 days or more.

Meeting people's individual needs

- The hospital had a dementia strategy to ensure patients with dementia were fully cared for. One aspect was to train all staff in dementia awareness. However, data showed only 75% of staff in T8 ward had received the training and in Charles Coward ward only 59.4% of staff had been trained.
- We were told the dementia link nurse for Charles Coward ward left two months ago and had not been replaced.
- In T8 ward there was no dementia link nurse.
- This meant that patients with dementia may not have received appropriate care and support.
- We saw evidence of the doctor's assessment of a patient's mental health condition.
- We were told clinical nurse specialists were available for patients who needed them, such as a dementia specialist, a tissue viability specialist and Macmillan nurses.
- The hospital worked closely with the Macmillan Cancer Support charity to provide additional support

for patients requiring palliative care. There were three Macmillan nurses based in the hospital and we saw one working in Charles Coward ward, assessing a patient for discharge.

- Volunteers from a local charity provided support to vulnerable patients by accompanying them home following discharge from hospital if they have no relatives to support them.

Learning from complaints and concerns

- The trust's information to CQC dated 20 April 2016 showed that between 4 June 2015 and 20 April 2016 there had been five complaints in T8 ward, of which three were dealt within the prescribed time.
- Between 16 August 2015 and 20 April 2016 there had been 10 complaints in Charles Coward ward, of which eight were dealt within the prescribed time. Two of them resulted in staff receiving additional training. The other two were discussed at the ward team meeting with a view to improving practice.
- Staff we spoke with were not aware of any learning from serious incidents or never events that had occurred in the trust. Staff were not able to say how the trust shared learning from incidents and complaints.

Are medical care services well-led?

Requires improvement 

We rated leadership in medical care as Requires Improvement because;

- The executive team were rarely visible in the wards. Staff were vague about the trust vision and strategy and they felt that communication was one way.
- The trust's dementia strategy had been only partially implemented. There were regular trust and divisional governance meetings, but the trust had not always been forthcoming in sharing information with their staff.
- There was a culture of fear and staff were afraid to speak up. Some staff had been reprimanded for requesting extra staff to support patient care.

Medical care (including older people's care)

Vision and strategy for this service

- A strategic objective of the trust was to be an employer of choice with a workforce that was efficient and compassionate, acting as ambassadors for the trust. Achieving this objective was hampered by a shortage of staff. Staff found it challenging to provide compassionate care because the wards were understaffed and the staff were too busy.
- Another strategic objective was to ensure positive experiences for patients and GPs. The trust had drawn up a comprehensive dementia strategy but in January 2016 the RAG indicators showed that only 7 of the 21 goals had been achieved and 10 had been only partly achieved. The dementia strategy mentioned in the CQC inspection report in June 2014 had not been fully implemented. This meant that the needs of patients living with dementia were unlikely to be fully met.
- Staff we spoke with were unsure of the trust's vision and strategy. Staff said they had received emails providing general information on the trust's direction, but nothing specific to their roles.

Governance, risk management and quality measurement

- We were told that medical consultants had not been involved in the trust clinical governance meetings; only the medical directorate clinical lead attended. Minutes from these meetings had not been cascaded down to the medical consultants.
- Staff told us a completed Peer Review Report in 2015 and two completed review reports on Acuity/Staffing Levels in medical wards in previous years had not been cascaded down to ward managers and matrons. Repeated requests had been made but the trust was unresponsive to these requests. We were told there was another acuity report due in 2016. This demonstrated that the trust was not open and transparent in sharing relevant information to enhance its performance.
- Matrons attended monthly CBU meetings, which were focused on incidents, risks and complaints.
- We were told matrons attended a meeting every morning with the director of nursing and the risk and governance teams to discuss incidents from the previous day. A matron stated that it was a good opportunity to see what was happening in other areas of the hospital and whether they faced similar issues.

- Matrons also attended bed management meetings four times a day, totalling 2.5 hours. They said this was time consuming and felt their time would be better spent on quality and safety audits, addressing shortfalls and looking into how to support their staff. They had to cancel meetings and put on hold important tasks such as investigating safeguarding concerns, complaints, incidents and conducting root cause analysis investigations.
- There was a 'pressure ulcers' meeting approximately every six weeks attended by the matrons, the infection control lead nurse, the Deputy Director of Nursing and the tissue viability nurse, at which all pressure ulcers were reviewed and the team discussed areas for improvement and learning.
- Many staff told us they did not think that the way in which data was gathered or presented reflected the true inadequacies of certain aspects of service provision.

Leadership of service

- Staff told us the trust executive team was not visible on the wards; staff said they saw the Chief Executive formally once at a meeting in 2015.
- Staff felt they had to keep justifying and explaining to the trust executive team why they needed a bank or agency staff member. Senior ward staff said they had no autonomy to make their own discretionary decisions in order to keep patients safe.
- Frontline staff felt supported by their local managers and by the consultants and doctors.
- The trust had been slow at replacing dementia lead nurses on the two wards we visited.

Culture within the service

- We were told there was a new policy about bullying, harassment and whistleblowing which was good.
- Most staff whom we spoke with told us that morale was very low amongst the majority of clinical and nursing staff, prompting many experienced staff to leave.
- Staff told us that despite feeling overwhelmed most of the time by the pressure of work, they were deeply committed to offering the best care they could to patients.
- The trust organised executive question time meetings as an opportunity for staff to ask questions but staff said they felt afraid to speak up and afraid to request anything which required funding as they would be reprimanded.

Medical care (including older people's care)

Staff and public engagement

- Staff felt they did not have a voice and there was no advocate on their behalf at the executive level. We were told Band 8s used to have regular meetings but this was stopped by the trust. We were told the last time the nursing and midwifery board met was in November 2015.
 - Staff said they supported each other and kept the ward functioning smoothly. We observed a new member of staff being integrated effectively on to the ward.
 - Ward managers commented that the frontline staff were good and that they supported each other and were enthusiastic to improve things.
- The medical care service has been involved in some innovative projects. Schwartz Rounds have been introduced. Schwartz Rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim was to offer staff a safe environment in which to share their stories and to offer support to one another. This had enabled staff to cope with the emotional pressure of the work and therefore to provide better care to patients.
 - We were told one medical consultant was working on dysphagia policy for elderly care with a view to 'roll it out' for the whole hospital

Innovation, improvement and sustainability

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure all patients attending the ED are seen more quickly by a clinician.
- Ensure that the more seriously ill patients are properly identified and seen more quickly by a doctor.
- Ensure middle grade doctors take greater leadership in clinical decision making and supporting junior colleagues.
- Provide the ED with greater leadership and support from other specialties to ensure effective pathways and improve patient flow.
- Seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders to evaluate the service and drive improvement.
- Take action to improve staff training – both mandatory and non-mandatory.
- Ensure there is an adequate supply of equipment, especially vital and life sustaining equipment which is fit for purpose.
- Ensure key data, such as waiting time performance and clinical outcomes, are recorded and used to drive improvement.

Action the hospital **SHOULD** take to improve

- Ensure that ED staff undertake risk assessments for those patients at risk of falls or pressure sores.
- Review arrangements for the consistent capture of learning from incidents and audits and ensure that learning and audit data is always conveyed to staff.
- Ensure consistent ownership and knowledge of the risk register across all nursing and medical staff.
- Improve multi-disciplinary team working with medical teams from other parts of the trust.
- Undertake auditing of patient outcomes.
- Endeavour to recruit full time staff in an effort to reduce reliance on agency staff.
- Complete annual appraisals for all eligible nursing staff.
- Consider including Mental Capacity Act 2005 as part of mandatory training.
- Establish multi-disciplinary panels to review serious incidents and performance breaches.
- Review how patient dignity can be improved in the UCC during the reception process.