

North Middlesex University Hospital NHS Trust

Inspection report

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Requires improvement 

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

Summary of findings

Background to the trust

The North Middlesex University Hospital NHS Trust is a medium-sized acute trust with over 540 beds, serving more than 600,000 people living across Enfield and Haringey and the surrounding areas, including Barnet and Waltham Forest.

The hospital has been on its present site for over 100 years and was established as an NHS trust by statute in December 1990. Most of the trust's services are provided on the North Middlesex University Hospital site, although some clinics and services are based in the community and at partner hospitals. They provide services in collaboration with a range of partners, including local GPs, acute, mental health and community health service providers.

In 2017/18 the trust had an annual revenue of around £278 million, and reported a deficit of £28.9 million. The trust reported employing more than 3,200 staff. In 2017/18 the trust reported activity figures of 401,072 outpatient attendances, 175,167 Accident and Emergency attendances, 79,608 inpatient admissions, 37,642 operations and procedures and 4,707 babies born.

The trust provides a full range of adult, elderly and children's services across medical and surgical disciplines. The specialist services in the trust include stroke, HIV/AIDS, cardiology (including heart failure care), haematology, diabetes, sleep studies, fertility, orthopaedics, and sickle cell and thalassaemia department. In addition to the full range of cancer diagnosis and treatment services, the Helen Rollason Cancer Support Centre is based on site and provides services to support cancer patients' wellbeing, such as massage. This is one of only two such centres in London. The trust offers integrated sexual health services in Enfield along with Enfield Council. The clinics offer free and confidential sexual health screening and/or treatment and general advice to all patients regardless of their age, sexuality or where the patients patient.

We inspected all eight core acute services including: urgent and emergency care, medicine (including older people's care), surgery, critical care, maternity, services for children, end of life care and outpatients service.

We last undertook a comprehensive inspection at the trust in September 2016 when we rated the trust as requires improvement overall.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement



What this trust does

Urgent and emergency services consisted of urgent care centre with 24/7 emergency nurse practitioners and a GP service from within ED. Adult and paediatric ED provided care 24 hours 7 days a week. The department saw average of 500 patient attendances per day with 100 ambulances per day.

Medical care service provided acute medicine, cardiology, respiratory medicine, care of elderly, gastro, rheumatology, stroke unit, diabetes and endocrine among others.

Surgical services had ten theatres, eight of them run lists for ophthalmology, urology, general surgery, orthopaedics and gynaecology and are housed within a single theatre complex in modern premises less than five years old. There was a dedicated trauma list with 24-hour emergency cover and one theatre dedicated to interventional radiology. There were three surgical wards, a pre-assessment unit, day surgery unit, surgical assessment unit and emergency ambulatory surgical assessment unit.

Summary of findings

Critical care service operated a flexible model in response to the acuity level of the patients. The critical care complex (CCC) comprised both high dependency unit (HDU) and intensive care unit (ICU) with a commissioned bed base of 17 beds, with capacity for up to 10 patients that could be ventilated simultaneously.

Over 94% of maternity services were delivered from new or newly refurbished buildings that were less than six years old. The department catered for about 5,000 deliveries per year. There was one antenatal/postnatal ward with 36 beds. There was a consultant led obstetric services with three high dependency rooms fully equipped with continuous cardio-respiratory monitors, 12 delivery rooms, 4 bed capacity induction/ambulatory HDU suite on the labour ward, two operating theatres, four bedded recovery suites, and a bereavement suite on the labour ward.

Services for children and young people comprised a paediatric assessment unit open 24/7, nine bedded short stay ward (up to 48 hours), general paediatric ward, paediatric day unit seeing elective children for procedures or review, neonatal unit with 22 cots taking special care of high dependency and intensive care infants, children outpatients department and children community nursing team.

End of life care was provided by the palliative care team comprising clinical nurse specialist (CNS) team lead by three palliative care consultants who also provided community palliative care support. North Middlesex Hospital was the lead provider of the Haringey Community Palliative Care Service (PCS) delivered in collaboration with four other providers in the Haringey area.

Outpatients department hosted clinics for a wide range of specialities managed across the three clinical divisions with the trust.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected all services provided by this trust because at our last inspection in September 2016 we rated the trust overall as requires improvement.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed Is this organisation well-led?

What we found

Overall trust

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

Summary of findings

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good. We rated three of the trust's eight services as good and five as requires improvement.
- We rated well-led for the trust overall as requires improvement.

Our full inspection report summarising what we found and the supporting evidence appendix containing detailed evidence and data about the trust is available on our website.

Are services safe?

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

- There was no written protocol or policy for staff to follow in order to prevent patients at risk of suicide from leaving the emergency department before they were assessed and treated.
- There was no separate mental health awareness training provided for staff.
- The trust did not keep numbers of episodes of restraint or monitor its use. This meant that the trust did not have oversight of the use of restraint.
- The trust did not provide full cover for an out of hours rota to cover gastroenterology. This was due to vacant consultant posts. This meant patients were at risk of delay to treatment should they experience upper gastrointestinal bleed during out of hours. The trust told us that approximately 20% of the May and June out of hours on-call rota for gastroenterologists was unfilled. This meant they were non-compliant with recommendations issued by the National Patient Safety Agency, Royal College of Physicians and the British Society of Gastroenterology related to out of hours endoscopy provision. The trust informed us that they reviewed arrangement shortly after our inspection and had implemented a fully covered out of hours rota for 2018.
- The trust has taken too long to develop and implement Local Safety Standards for Invasive Procedures (LocSSIP) that met the requirements of the National Safety Standards for Invasive Procedures (NatSSIP). This was highlighted as a risk in August 2016 but the trust has still not started implementation at the time of our inspection.
- There was no 'frequent attenders' policy.
- Senior managers could not be assured that outpatients staff were learning from incidents across the trust.
- Staff in outpatients reported that they did not feel able to report incidents of verbal and physical abuse against them and did not feel they had as they had the same rights as patients.
- During our previous inspection we reported that individual venous thromboembolism risk assessments (VTE) were not fully completed. During this inspection we identified that staff were still not recording VTE assessments fully. However, in mitigation the trust had identified this and work was in progress on the rolling out of new VTE assessment tools to simplify recording processes.
- Most areas of the maternity service we visited were tidy but not all were visibly clean during our inspection and we were not assured control were effectively in place to prevent the spread of infection. Women we spoke with said the maternity department was not always clean.
- There was not always an advanced paediatric life support (APLS) trained nurse on shift in services for children and young people. This was not in line with guidance from the Royal College of Nursing.
- Services for children and young people faced challenges in providing care for children and young people who presented with mental health conditions.
- In emergency department staffing vacancy rates were high for medical and nursing staff.

Summary of findings

- Medical care services reported a nursing vacancy rate of 14.1% in medicine; this is worse than the trust target vacancy rate of 7.5%. Managers often struggled to fill uncovered shifts and staffing levels frequently fell below the required establishment.
- Records we reviewed in emergency department and medical care services were inconsistent and of variable quality.

However:

- Overall, there was improved incident reporting.
- There was evidence of learning from 'never events'. In our previous report dated September 2016 we reported that actions in response to never events were not fully implemented. However, during this inspection we found the trust had addressed this and clear action plans were in place and monitored by the trust.
- The trust reported 57% reduction of hospital acquired pressure ulcers (grade 3 and above) since the panel was established. They established weekly 'harm free panel' meetings in March 2017 to prevent pressure ulcers and improve overall safety awareness amongst staff.
- The introduction of the fast initial treatment zone in the emergency department meant patients were streamed by a consultant or senior doctor most of the time.
- Nurse staffing levels in the critical care service consistently met minimum standards set by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). The matrons had significantly reduced nurse vacancies in the previous 12 months.
- Risks to women were well-identified and managed by staff in antenatal care, intrapartum and postnatal care.
- In critical care, we found consistently good standards of risk assessment in patient documentation and in practice observations, including in relation to sepsis management.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- Overall, the trust performed worse than expected in The National Cancer Patient Experience Survey with only 15, out of 59, responses similar to the England average and 44 worse than expected. The trust did not respond promptly to the National Cancer Patient Experience Survey published in July 2017.
- The trust made us aware of 85 clinical audits, carried out March 2016 to May 2018, which were related to medical specialities. In 45% of cases, no outcomes report or action plan was created.
- Some of the data from trust's pain assessment audit indicated that patients were not always offered sufficient analgesia or underwent regular pain assessment.
- The trust did not meet NICE guidance on falls assessment and prevention (2013) and delirium (2010) and National Patient Safety Agency (NPSA) guidance on the prevention and management of inpatient falls.
- The trust did not have complete oversight over how many patients were placed on Deprivation of Liberties Safeguards authorisations (DOLS) in the hospital as the ward staff did not inform the safeguarding lead of all the authorisations that were signed by staff.
- Mental capacity assessments had not always been completed by the clinician before filling out the best interests document. Some staff were unclear who had the responsibility to carry out a mental capacity assessment should patient's capacity be called into question.

Summary of findings

- Palliative and end of life care (EOLC) patients not under the care of the Specialist Palliative Care Team (SPCT) did not always have a mental capacity assessment (MCA) completed prior to a do not attempt cardio pulmonary resuscitation (DNACPR) order being considered.
- Staff felt there were limited opportunities for progression within the outpatients services. Staff also reported there were limited development opportunities and felt they were missing out on professional development.

However:

- Overall, we observed and heard about effective and positive multidisciplinary team working and good relationships and communication amongst various professionals involved in patients care and treatment.
- Results in the 2016 Heart Failure Audit were better than the England and Wales averages for two of the four of the standards relating to in-hospital care.
- The overall performance for elective admissions was better than the England average.
- Surgical patients' pain was managed effectively. The staff told us they had good access to pain management advice from the trust's acute pain service following patients' surgery.
- Women's care and treatment in the maternity service was planned and delivered in line with current evidence-based guidance. There was an effective system in place to ensure staff were aware of updated guidelines.
- The maternity service met expected patient outcomes for women in most areas, and in some areas exceeded these, for example in having a low rate of planned caesarean sections.
- The maternity service managed medicines and women's pain well. They met the national standards for obstetric anaesthesia.
- There was protected teaching time for doctors of all grades and there was a Royal College of Emergency Medicine accredited teaching programme in place.

Are services caring?

Our rating of caring improved. We rated it as good because:

- We observed staff being kind and caring to patients.
- Patients and relatives felt they were treated with courtesy, respect and compassion by staff.
- Patients felt able to speak about their worries and said staff at the hospital were compassionate.
- Staff were sensitive to the needs of children and young people, and their families.
- Women in the maternity service were positive about their care and treatment. They were treated with kindness, compassion, dignity and respect. Women felt involved in their care and were given an informed choice of where to give birth. Women we spoke with were happy with their care and praised staff for being inclusive and supportive.
- We observed staff ensured patients' privacy and their dignity was respected.
- Patients told us staff helped them to understand their care and treatment, and that medical staff took time to ensure they answered their questions and felt confident in treatment.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The emergency department did not achieve the four hour Department of Health standard on any occasion between May 2017 and April 2018.

Summary of findings

- The average length of stay for medical elective patients at the trust was 7.7 days, which is higher than the England average of 5.8 days.
- The outpatient department did not monitor waiting times for patients, and this was one of the main concerns raised by patients that we spoke with during the inspection. Patients told us that their waits had varied from 15 minutes to an hour.
- Across the outpatient department we saw little evidence of health promotion information available for patients.
- The outpatient department did not have a dedicated room that could be used when breaking bad news or holding private conversations.
- Not all palliative or EOLC patients were given a treatment escalation plan (TEP). The SPCT also felt they needed to improve their processes to ensure all palliative and EOLC patients were offered advanced care planning (ACP) options to ensure they achieved their preferred place of care (PPC)/ preferred place of death (PPD).
- The chaplaincy and faith provision within the trust was mainly available for Christian and Muslim faiths. Some other religions were catered for by way of a religious script, however this was not always seen or available.
- Signage on lifts and corridors in the hospital's tower block did not direct patients, staff and visitors to the correct surgical service.
- Complaints were not always closed in accordance with timescales set out in the trust's complaints policy.

However:

- The maternity service provision met the needs of local people. They worked closely with commissioners, clinical networks and service users to plan and improve the delivery of care and treatment for the local population.
- There was increased awareness of the needs of patients with dementia and learning disabilities.
- There was a good handover process for medical patients placed on surgical wards and surgical patients on medical wards (outliers).
- During our previous inspection, we found there was a lack of clarity in how changes to theatre lists were communicated to doctors and theatre staff. During this inspection we found this had improved as theatre lists indicated any changes implemented to the lists following dissemination to staff.
- In our previous inspection in September 2016 we reported that theatre utilisation was low. In response theatres were monitored to determine reasons for delays. For example, theatre start and finish times were monitored.
- The urgent care centre and the paediatric emergency department performed well in the Department of Health four-hour standard.
- The outpatient department was meeting the referral to treatment time of seeing patients within 18 weeks.
- The acute stroke unit had introduced innovative approaches to improve care; this included a candle like flickering LED light and an explanation being placed on the reception desk of each ward that had an EOLC patient. This alerted other people to the situation so that they were more mindful and would keep the ward more peaceful for the patient and their family.
- The trust had a community children's nursing team which included clinical nurse specialists who undertook home visits and school visits, and held community outreach clinics.

Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

Summary of findings

- The clinical governance structure was not yet fully embedded.
- The outpatient department leadership team advised it did not have any risks on the divisional risk register and did not hold a local risk register. This meant that the department had no sight of any risks within the department which did not reflect our findings on inspection such as staffing levels, paediatric patients being treated in the OPD, and lost or missing records.
- There was a concern that current improvements in emergency department were not sustainable since there remained a heavy reliance on locum or agency medical and nursing staff.

However:

- Staff spoke positively of the leadership team.
- Most divisional and team leaders had the capacity and capability to run a service providing quality sustainable care.
- Overall, there was a supportive, honest and open culture among staff. Candour, openness, honesty and transparency were evident throughout the service.
- At the previous inspection, we found poor relations between different groups of staff and a bullying culture within the maternity service. At this inspection, there was a positive culture, which was focused on improving patient outcomes and experience. Staff were committed and proud to work at the trust.
- Since our last inspection there had been significant improvements in the working culture of the critical care unit which resulted in more motivated staff and a stabilised team.
- The critical care unit was highly rated in most areas by a critical care network peer review in November 2017.
- In critical care, a dedicated audit and research team led innovative projects and studies to identify strategies to improve patient care and outcomes. They also contributed to the Intensive Care National Audit Research Centre (ICNARC) and ensured the audit programme effectively benchmarked practice.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, and for the whole trust. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in surgery, critical care, maternity and services for children and young people. For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including 12 breaches of legal requirements that the trust must put right. We found 77 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. For more information, see the Areas for improvement section of this report.

Action we have taken

We issued a warning notices to the trust. For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

Summary of findings

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found examples of outstanding practice at North Middlesex University Hospital.

Trust level

- Alongside the incident reporting system, a number of departments used a 'learning from excellence' reporting system. This system enables examples of good practice to be reported, analysed and shared with other staff. The scheme aimed to recognise staff and teams for excellent care of service.
- The trust awarded funding to 15 projects put forward by staff to improve patient care in a 'Dragons' Den' style competition. All staff were invited to present their ideas for spending of £200,000 made available by the trust's charity to spend on improvements to patient care.
- In 2017, the trust formed a clinical partnership with another NHS trust. This enabled the trust to share best practice and experiences and ensure they had consistent approaches to designing and delivering care based on evidence and best practice

Surgery

- Staff at NMUH had developed a '10 things about me' initiative where each inpatient with dementia at the trust had a card at the end of their bed listing ten things about their preferences and their background. This information helped the patient to build and maintain relationships with ward staff and other staff they came into contact with.
- Urology were involved in an NHS Improvement (NHSI) initiative "getting it right first time" (GIRFT). The ambition of the programme was to identify innovative and efficient service delivery. This would be achieved by the programme looking at divergence from the best evidence based urological care. The programme would culminate in a report and a set of National recommendations aimed at improving the quality of care and reducing expenditure.

Critical care

- Link nurses were proactive in responding to learning from incidents by designing, developing and implementing new strategies and tools to improve safety and patient experience. Each link team demonstrated their work through evidence-based presentations, policy documents or tools and audit nurses worked with them to establish the efficacy of each initiative. This was demonstrative of the drive and motivation the team showed for continual improvements.

Maternity

- The service was especially caring and responsive to parents who had suffered a loss, such as miscarriage, stillbirth or neonatal death. They were committed to continually improving the care and services they provided for bereaved parents. The bereavement midwife had received two national awards and a national nomination for excellent and outstanding care and support for bereaved families.
- We saw that the service developed a CUSS (I am concerned, I am uncomfortable, this is not safe, stop) escalation tool to encourage staff and teams to raise issue, concerns and poor practice to improve the service culture.
- The trust had implemented a scheme for carers who supported vulnerable patients. Staff we spoke to told us that the trust was the first hospital to introduce the carer passport scheme.

Summary of findings

- The service was one of the six UK participating hospital sites in the multi-centric Clinical Research Network (CRN) portfolio of studies in pre-eclampsia (ASPRE, SPREE).
- The women's ambulatory day unit (WADU) was open seven days a week. It had scanning facilities on site and we noted the service was the only hospital in the region whose WADU opened seven days a week.
- A translation icon on the trust website could translate vital information on the website to 11 languages such as Chinese, Turkish, Japanese and German.

Services for children and young people

- The child protection lead was nominated for BASPCAN and NSPCC Award for Child Protection trainer of the year and reached the top three in the country.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with legal requirements. This action related to trust level and four services.

Trust level

- The trust must follow the death review process and comply with the national guidelines.

Urgent and emergency services

- The trust must ensure that the restraint of patients is carried out by suitably trained staff, and that the episodes of restraint are recorded and monitored by the trust.
- The trust must ensure that patients with mental illness are cared for by staff trained in mental health. The trust must ensure that patients presenting to the hospital who are at risk of suicide are kept safe.

Medical care

- The trust must ensure an oversight over Deprivation of Liberties Safeguards authorisations (DOLS) process within the hospital. Where the DOLS authorisation is extended more than once this must be done in accordance with legislation.
- The trust must ensure mental capacity assessments are completed by the clinician as part of the best interest process.
- The trust must ensure all shifts are covered and staffing levels always meet the required establishment to ensure patients' needs are met and risk is prevented.
- The trust must provide a full cover for an out of hours gastroenterology rota to minimise the risk of delay to treatment.

Services for children and young people

- The trust must ensure that the service achieves mandatory training compliance.

Summary of findings

- The trust must ensure that there is at least one nurse per shift in each clinical area (ward/department) who is trained in APLS/EPLS.
- The trust must ensure that staff have appraisals in line with trust policy.
- The trust must ensure the door to Rainbow ward is secure.

Outpatients

- The trust must ensure that risks are held on the divisional or a local risk register and risk are monitored and reviewed regularly.

Action the trust SHOULD take to improve

Provider level

- The trust should develop leadership strategy or development programme which includes succession planning.
- The trust should develop, implement and measure progress against an equality, diversity and inclusion strategy. The trust should ensure the strategy equally considers all protective characteristics
- The trust should continue to work on improving diversity and equality across the trust and at board level.
- The trust should continue working on cultural issues and staffs' perception of discrimination.
- The trust should improve transparency of the recruitment process.
- The trust should proactively use information to not only to seek assurance but also to drive improvement.
- The trust should improve their liaison and communication with families and carers during and following investigations of deaths and serious incidents.
- The trust should improve time it takes to respond to formal complaints.

Urgent and emergency services

- The trust should seek to improve patient outcomes especially in relation to severe asthma.
- The trust should ensure that medical and nursing staff are compliant with mandatory training.
- The trust should ensure that nursing staff are compliant with adult and paediatric life support.
- The trust should ensure medical and nursing staff adhere to appropriate hand hygiene practices.
- The trust should ensure that patients do not spend in excess of four hours on a trolley.
- The trust should ensure that medical and nursing staff vacancies are reduced.
- The trust should ensure that patient records are fully completed.
- The trust should ensure that episodes of restraint are monitored.
- The trust should ensure that nurses are appraised.
- The trust should ensure that nurses are facilitated to attend training.
- The trust should ensure that patient confidentiality is not compromised in the 'fit to sit' area.
- The trust should ensure that the governance structure is robust, including through the introduction of mortality and morbidity meetings.

Medical care

Summary of findings

- The trust should reduce variability in medical records quality and ensure care plans are implemented to support patients with falls, pressure ulcers and dementia.
- The trust should ensure all risks are identified and appropriately mitigated and where possible addressed in a timely manner.
- The trust should ensure there is a standardised approach in identifying and assessing patients living with dementia, implement suitable care plans and reduce local variation in the process related to caring for patients who live with dementia.
- The trust should ensure patients are cared for in line with NICE guidance on falls assessment and prevention (2013) and delirium (2010). They should fully comply with National Patient Safety Agency (NPSA) guidance on the prevention and management of inpatient falls, national clinical guidelines for management of multiple sclerosis, Parkinson's disease and epilepsy.
- The trust should ensure all wards report the Friends and Family Test data every month, and where response rate and scores are low act to improve patients' experience.
- The trust should address shortcomings in cancer patients' experience as guided by the National Cancer Patient Experience Survey 2017.

Surgery

- Swipe card entry systems should be restricted to theatre staff.
- Medical and dental mandatory training should be updated promptly and in accordance with the trust's policy on mandatory training.
- Rooms where medicines are stored should have ambient room temperatures recorded.
- Codes to medicines storage cupboards should be kept securely.
- The Resuscitation Council recommends that all staff working in acute areas should complete advanced life support training.
- Policies and guidelines should have a reference list of where information has been sourced.
- Signage on lifts and corridors should be replaced to ensure patients, staff and visitors are directed to the correct service.
- Surgical services should further develop Local Safety Standards for Invasive Procedures (LocSIPP) to ensure compliance with National Safety Standards for Invasive Procedures (NatSIPP).
- Complaints should be dealt with and closed in accordance with timescales set out in the trust's complaints policy.
- The trust need to monitor wards where there is a higher than National median line in regard to catheter urinary tract infections (CUTI) and develop ward based action plans where findings indicate increased risks.

Critical care

- The trust should ensure improvements to fire safety continue and that they have assurance all members of staff understand procedures in the event of an emergency or evacuation.
- The trust should increase the number of physiotherapists available to ensure patients receive prompt initial review and assessment and to ensure they receive adequate on-going rehabilitation.
- The trust should ensure monthly fire safety checks and audits carried out by critical care staff are accurate, truthfully representative of their findings and that results are immediately acted upon.

Summary of findings

Maternity

- The trust should ensure staff have completed mandatory and maternity specific training.
- The trust should ensure staff have completed the appropriate level of safeguarding adults and children training.
- The trust should review the cleaning provision of the service to ensure the cleaning environment and equipment are clean to prevent the risk of infection.
- The trust should ensure all serious incidents are reviewed and investigated in a timely manner, as per trust guidance.
- The trust should ensure that daily checks of controlled medicines and medicine storage temperatures are completed in line with trust requirements and that there is a system in place for ensuring these are completed.
- The trust should ensure complaints are reviewed and closed in a timely manner, as per trust guidance.

Services for children and young people

- The trust should ensure that the service is able to book follow up appointments for all clinics in outpatients.
- The trust should ensure that staff have adequate mental health training including the Mental Health Act.
- The trust should consider getting mobile devices for community nurses to allow them to work more effectively and see more patients.
- The trust should ensure the children's board meets regularly and that actions are completed.
- The trust should ensure continued oversight of young people over the age of 16 who are in adult wards. They should also ensure the children's service has oversight of children being seen in other non-paediatric areas of the hospital.

End of life care

- The trust should ensure mortuary staff and portering staff are trained fully on mortuary SOP's and IPC procedures.
- The trust should remove phenolic disinfection solutions from use throughout the trust, in line with European Directive EU/528/2012.
- The trust should use single use disposable equipment where possible within the mortuary, to reduce the risk of sharps injuries.
- The trust should ensure risk assessments are written for the mortuary and post mortem suite, including the storage of specimens in formalin, its ventilation and the provision of fire extinguishing procedures. It should also include provision for clean and dirty utilities as per the Health and Safety Executives guidelines.
- The trust should ensure there are clear guidelines and policies in place for monitoring fridge and freezer temperatures within the mortuary.
- The trust should ensure they have a fully staffed SPCT; this would mean that the full complement of both CNS's and consultants were in post.
- The trust should ensure palliative and EOLC training is rolled out to all appropriate staff in line with their targets.
- The trust should ensure bereavement officers receive full training and ongoing support in their role.
- The trust should ensure they provide a seven-day face to face palliative and EOLC service, in line with national guidance.
- The trust should ensure all palliative and EOLC patients have access to psychological support regardless of their diagnosis.

Summary of findings

- The faith areas should be more accessible to patients, relatives and carers who do not have a swipe card available to them.
- The trust should ensure the risk register for palliative and EOLC is kept up to date.

Outpatients

- The trust should ensure that OPD staff are learning from incidents across the trust.
- The trust should ensure waiting times for patients are monitored.
- The trust should ensure staff are encouraged and supported to report incidents of verbal and physical abuse against them.
- The trust should ensure staff have access to learning and development.
- The trust should ensure that all OPD staff are trained to safeguarding adults level 2 and safeguarding children level 2.
- The trust should ensure that Phlebotomy staff meet the trust targets for mandatory training.
- The trust should ensure that daily clinical and environmental schedules are in place and the children's play areas are incorporated.
- The trust should ensure that paediatric resuscitation equipment and paediatric resuscitation medications are in place where paediatric patients are seen.
- The trust should ensure that staffing levels in the outpatient clinic are reviewed.
- The trust should ensure there are appropriate pain assessment tools for patients that were non-verbal, with learning disabilities, or dementia.
- The trust should ensure that health promotion information is available for patients in English and other languages.
- The trust should ensure that patients cannot be overheard when checking in at the main reception desk.
- The trust should ensure there is a dedicated room available that could be used when breaking bad news.
- The trust should ensure that the OPD is working towards seven day working.
- The trust should ensure that signage in the OPD is clear and patients are able to navigate around the department.

Is this organisation well-led?

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

Our assessment of well-led at the trust-wide level included trust board and executive-level leadership and governance, the effectiveness of non-executive directors, the overall organisational vision and strategy, organisation-wide governance and management, and organisational culture and engagement (with patients, staff, stakeholders and so on).

Summary of findings

We took account of what we found in all the core service inspections. We explored the flow of information, assurance, and governance from 'ward to board and board to ward', and how trust-wide strategies and leadership were reflected in services. We considered cross-trust systems and processes alongside local and service-level leadership, systems and processes.

We rated well-led at the trust as requires improvement because:

- We found that governance lacked clarity, consistency and robustness. For example, the divisions were largely unsupported in their role as there was no dedicated governance team aligned to each division. Insufficient governance support led to a backlog of serious incidents investigations. Another example was a gap in the oversight of the management of patients presenting with an acute gastrointestinal bleed which should have been identified and acted on if there were effective governance processes in place.
- We noted that most of the risks in the board assurance framework (BAF) had remained static in the months before our inspection, with no risk being added since November 2017. It was not always clear who had done what and what the next steps were. We also noted that two risks depended on the newly established divisional triumvirate making an impact; risks related to staff retention and culture referred to an outdated staff survey which was carried out under the old management and progress against some risks was overdue. Board members also told us the BAF lacked proportionality by, for example, assigning higher than necessary risk scores to certain risks, and that it was an automatic process rather than a dynamic tool to manage risks.
- We found that trust's risk management processes were ineffective, lacked timeliness, accountability and challenge, and was often reactive. We noted that medical representation at some of the divisional risk and governance meetings was low. In December 2017 there was no medical representation on surgery and cancer division risk and governance meeting. We also noted there was no clinical representation at the board finance and investment sub-committee.
- The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services to their local community. However, there had been frequent executive leadership changes which had affected staff morale and trust performance. Since 2015 many of the executive and non-executive directors had changed. The trust had an interim medical director since February 2018. There had been three chief executive officers (CEOs) with the current CEO having joined the trust in December 2017.
- Portfolios and the range of responsibilities amongst the executive team as well as their accountability was not always aligned with roles. For example, there was too much reliance on the finance director for operational issues.
- There was inconsistency in non-executive directors (NEDs) oversight. At board meetings we observed NEDs did not always offer scrutiny and seek detailed assurance from executive directors. We noted there was a tendency to rely on reassurance from executive directors rather than evidence to provide detailed assurance.
- We found limited evidence of succession planning and a talent management system within the trust. Access to development opportunities was a concern raised in the staff survey. We did not see any evidence of an active and deliberate talent management approach with the focus on future leaders.
- The 2017/18 financial year was another challenging year for the trust which saw a deterioration in their financial position. In the year ending 31 March 2018, the trust was unable to meet its control total (an annual financial target that must be achieved to unlock access to national funding and other financial benefits) and reported a retained income and expenditure deficit of £28.9m. Some of the contributing factors identified by the trust were continued pressures on the emergency services and significant agency costs resulting from ongoing challenges in recruitment and retention of staff.

Summary of findings

- At the time of the inspection the trust did not have a long-term strategy. The last version was from 2014 when it was formulated to support its foundation trust application. At the time of the inspection, the trust was formulating a 'case for change'. In the past two years there had been a great deal of uncertainty amongst staff regarding the future of the trust. Staff told us they did not feel well informed and consulted.
- Some staff reported a lack of transparency during recruitment, and said that recruitment policy and processes were not consistently applied. Although the trust had investigated all staff complaints made to them and found no evidence of bias trust leaders recognised there were issues with an unprofessional and inappropriate "Management style" amongst some managers and recognised a need for training in performance management. They also recognised that there was "A long way to go in ensuring recruitment of managers is done in line with trust policies".
- The lack of a stable, reliable and well-resourced HR team in the past two years meant a number of areas were ineffectively managed. For example, slow and lengthy recruitment processes, disciplinary proceedings that lasted too long (sometimes as long as a year or more before being completed), or lack of internal mediation as there were not enough business partners to support the process.
- We found many issues with the repository and accessibility of clinical guidelines, policies and standard operating procedures. The documents were not always easy to find, we saw a number of policies published on the trust's intranet, ready for staff to obtain guidance from, but before there had been formally ratified. Some policies were out of date or there were different versions of the same policy and inconsistent naming conventions. The trust was aware of this issue and told us work was underway to rectify the problem and to update the process of maintaining the documents and its repository.
- The trust had a backlog of SIs and rapid incidents reviews. There was a limited capacity within the divisions and the central governance team to address this backlog. This meant the trust was not always able to promptly analyse incidents, complaints and patients' feedback to fully understand trends and risks in safety and quality.
- The trust took too long to investigate serious incidents with many incidents taking over a year to complete an investigation. For example, we noted that there were 26 overdue rapid incident reviews shown on a recent agenda. We noted that in one case the 48 hours review took nearly 12 months to complete. This meant the trust was unable to promptly comply with their responsibilities set out under the duty of candour (DoC) regulation as they were unable to assess if the regulations would apply without carrying out investigations. Managers told us the trust did not provide duty of candour training to any staff. It was not part of induction or additional training.
- The work on National Safety Standards for Invasive Procedures (NatSSIPs) and development of Local Safety Standards for Invasive Procedures (LocSSIPs) had taken too long to implement and had been put on hold due to limited resources and capacity. At the time of the inspection, the trust was in the process of recruiting a lead for NatSSIPs with a view to improve safety for interventional procedures.
- We saw a document submitted to the mortality review group in March 2018 which indicated there were 604 overdue death reviews as at end of February 2018. The document noted that 25% (rather than all) of those cases were to be reviewed during individual specialities' mortality and morbidity (M&M) meetings. Non-executive directors were not aware of the issue and the board was not involved in the decision-making process.

However:

- The trust had continued to make improvements since the last inspection in September 2016, despite experiencing an unsettling period of changes in the executive team. The executive team had the confidence of most staff and were seen as visible and supportive. The trust leadership team had taken action to increase their visibility and positively

Summary of findings

engage with staff which was welcomed and appreciated by staff we spoke with. For example, all staff could attend 'staff conversation' events to raise issues and discuss concerns with executive team. There was a weekly 'tea and talk' sessions for all staff to talk to executive team members. In addition, there was a chief executive hotline which gave staff an additional avenue to share their concerns directly with the CEO.

- We were assured the trust CEO and chairman understood the unique qualities and needs of their team. They were aware of the development needs the leadership team relating to skills, experience, knowledge and capacity, and actions were being taken to address these. There was an ongoing work to review leadership capacity and portfolios, and development programme had been put in place.
- The trust leadership team had a good understanding of the financial deficit position of the trust and the planned cost improvement plans (CIPs) for the current financial year were transformational.
- We found the divisional leadership teams to be knowledgeable, willing, capable and robust in leading and managing their areas of activity. Most of staff we spoke with told us they felt supported by the divisional managers and described them as visible and approachable. We did not hear about systemic cultural concerns as we did during the 2016 inspection and staff were largely positive about the culture within the trust.
- The trust had a clear vision and set of values, it was: 'to provide outstanding care for local people'. The trust's values promoted positive behaviours and encouraged staff to be 'caring, helpful, open, honest, and encouraged teamwork.
- The trust had recently become a clinical partner with another NHS trust. All staff we spoke with were positive and enthusiastic about this collaboration. They told us the clinical partnership was about embedding quality and improvement by tapping into their partner's experience. They were also proud to emphasise that the relationship was mutual. The trust clinicians were leading on a number of clinical pathways.
- We found staff to be passionate about delivering good care. Staff told us about improved communication and feeling motivated to drive improvement. We heard several positive examples of kindness, team work, and supportive and appreciative relationships among staff. For example, we were told about three instances when clinicians voluntarily agreed to share gaps in medical rota or share their colleague's workload to support them.
- The board reviewed performance reports that included data about the services. The information provided was reliable and sufficiently detailed to support informed decision making. The trust had developed clear operational performance quality indicators and had effective monitoring systems to allow reporting and support better understanding at divisional and board levels. The trust regularly shared performance data with staff.
- The trust had recently launched 'listening into action' programme to obtain more up to date and timely views from staff about working in the trust. Staff were encouraged to complete a 'pulse check' survey. The response rate and results were more positive than the results of NHS Staff Survey 2017. The response rate within three weeks of the survey was 51% (in comparison to 41% response to NHS Staff Survey 2017). Fourteen out of 15 questions scored above the average in comparison to other 90 trusts that had been through the programme nationally.
- The trust proactively engaged and worked with a number of external partners. We found the relationship to be positive and collaborative. The trust was willing to build a shared understanding of challenges to the wider healthcare system and needs of the population they serve. The trust was open and transparent with partners.
- In the last 12 months prior to the inspection, the trust's staff had won several awards. These included; 'Nurse Leader of the Year' awarded to a critical care matron by the 'Nursing Times' for their work in addressing cultural conflict on ITU; Bereavement midwife, won 'Best Hospital Bereavement Service' in Butterfly Baby Loss Awards. They were also runner up in the British Journal of Midwifery Midwife of the Year; Education supervisor of the year was awarded to consultant paediatrician by the Royal College of Paediatrics; Paediatric department was awarded Paediatric Awards for Training Achievements best training award.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ May 2018	Requires improvement ↔ May 2018	Good ↑ May 2018	Requires improvement ↔ May 2018	Requires improvement ↔ May 2018	Requires improvement ↔ May 2018

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

Ratings for North Middlesex University Hospital NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Sept 2018	Good ↑ Sept 2018	Good ↔ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↔ Sept 2018
Medical care (including older people's care)	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Good ↑ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018
Surgery	Good ↑ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Requires improvement ↓ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018
Critical care	Requires improvement ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
Maternity	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Services for children and young people	Requires improvement ↓ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↑ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018
End of life care	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Good ↑ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018
Outpatients	Requires improvement Sept 2018	N/A	Good Sept 2018	Good Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018
Overall*	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Good ↑ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018

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

North Middlesex University Hospital

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Key facts and figures

The trust provides a full range of adult, elderly and children's services across medical and surgical disciplines. Every day, on average, the hospital sees 480 patients in A&E; 13 babies are born in the maternity unit; about 450 inpatients are cared for on the wards; about 100 patients have major or minor surgery in one of the 10 operating theatres; and about 1100 people attend outpatients clinics.

In 2017/18 the trust reported activity figures of 401,072 outpatient attendances, 175,167 Accident and Emergency attendances, 79,608 inpatient admissions, 37,642 operations and procedures and 4,707 babies born.

We inspected all eight core acute services including: urgent and emergency care, medicine (including older people's care), surgery, critical care, maternity, services for children, end of life care and outpatients service.

Summary of services at North Middlesex University Hospital

Requires improvement   

Our rating of services stayed the same. We rated it them as requires improvement because:

- The trust did not provide full cover for an out of hours rota to cover gastroenterology. This meant patients were at risk of delay to treatment should they experience upper gastrointestinal bleed during out of hours.
- The hospital needed to improve in providing care for children, young people and adults who presented with mental health conditions.
- The trust did not have oversight of the use of restraint.
- Staff in outpatients felt they were discouraged from reporting incidents of verbal and physical abuse against staff.
- Records we reviewed in medical care services were of variable quality. There were no care plans implemented to support patients with falls or dementia in the day hospital unit. Endoscopy patients sometimes underwent procedure under sedation but staff failed to ask them to sign a disclaimer form to confirm they understood risks related to it and that they should arrange to be escorted after the procedure.
- Not all areas in maternity services were visibly clean during our inspection and we were not assured control were effectively in place to prevent the spread of infection.

Summary of findings

- There was not always an advanced paediatric life support (APLS) trained staff member on shift in services for children and young people.
- Some of the data from trust's pain assessment audit indicated that patients were not always offered sufficient analgesia or underwent regular pain assessment.
- The trust did not have complete oversight over how many patients were placed on Deprivation of Liberties Safeguards authorisations (DOLS) in the hospital as the ward staff did not inform the safeguarding lead of all the authorisations that were signed by staff.
- Mental capacity assessments had not always been completed by the clinician before filling out the best interests document.
- The emergency department did not achieve the four-hour Department of Health standard on any occasion between May 2017 and April 2018.
- The outpatient department did not monitor waiting times for patients.
- Across the outpatient department we saw little evidence of health promotion information available for patients.
- The chaplaincy and faith provision within the trust was mainly available for Christian and Muslim faiths.
- Complaints were not always closed in accordance with timescales set out in the trust's complaints policy.
- The clinical governance structure was not yet fully embedded.
- There was a concern that current improvements in emergency department were not sustainable since there remained a heavy reliance on locum or agency medical and nursing staff.
- There was no board level lead for children's services.

However:

- Overall, we saw improvement in incident reporting and we saw evidence of learning from 'never events'
- Since the trust established 'harm free panel', the trust reported 57% reduction of hospital acquired pressure ulcers (grade 3 and above).
- The introduction of the fast initial treatment zone in the emergency department meant patients were streamed by a consultant or senior doctor most of the time.
- Risks to women were well-identified and managed by staff in antenatal care, intrapartum and postnatal care.
- In critical care, we found consistently good standards of risk assessment in patient documentation and in practice observations, including in relation to sepsis management.
- We observed effective multidisciplinary team working and good relationships and communication amongst various professionals involved in patients care and treatment.
- The surgical service contributed to national clinical audits for surgery. The overall performance for elective admissions was better than the England average.
- Women's care and treatment in the maternity service was planned and delivered in line with current evidence-based guidance.
- The maternity service met expected patient outcomes for women in most areas, and in some areas exceeded these.
- We observed and were told patients were treated with kindness, compassion, dignity and respect.

Summary of findings

- The maternity service provision met the needs of local people.
- There was increased awareness of the needs of patients with dementia and learning disabilities.
- There was a good handover process for medical patients placed on surgical wards and surgical patients on medical wards (outliers).
- The urgent care centre and the paediatric emergency department performed well in the Department of Health four-hour standard.
- The outpatient department was meeting the referral to treatment time of seeing patients within 18 weeks.
- Staff spoke positively of the leadership team.
- Since our last inspection there had been significant improvements in the working culture of the critical care unit and maternity services.

Urgent and emergency services

Requires improvement   

Key facts and figures

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

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

The service was previously inspected in September 2016 and was rated as 'requires improvement' overall. At the time, the caring and well-led domains were rated as 'good'. Safe, effective and responsive domains were rated as 'requires improvement'.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available and took place between 22 and 24 May 2018.

We looked at 33 sets of adult patient records and 23 sets of paediatric patient records. We spoke with 67 members of staff including doctors, nurses, managers, allied health professionals, support staff, administrative staff and ambulance crews. We also spoke with 14 patients and seven relatives who were in the department at the time of the inspection as well as two members of NHS Improvement. We reviewed and used information provided by the trust in making our decisions about the service.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- There was no written protocol or policy for staff to follow in order to prevent patients at risk of suicide from leaving the emergency department before they were assessed and treated.
- Nursing staff were not fully compliant with mandatory training.
- There was no separate mental health awareness training provided for staff.
- Staffing vacancy rates were high for medical and nursing staff.
- Record keeping was inconsistent.
- Appraisal rates for nurses were low.
- Mental health act training was not provided for staff.
- The department did not achieve the four-hour Department of health standard on any occasion between May 2017 and April 2018.
- There was no 'frequent attenders' policy.
- There was a concern that current departmental improvements were not sustainable since there remained a heavy reliance on locum or agency medical and nursing staff.

Urgent and emergency services

- The clinical governance structure was not yet fully embedded.
- The trust did not keep numbers of episodes of restraint or monitor its use. This meant that the trust did not have oversight of the use of restraint.

However:

- There was improved incident reporting.
- Medical and nursing staff were compliant with safeguarding adult training.
- Medical staff were compliant with adult and paediatric life support.
- There was increased awareness of the needs of patients with dementia and learning disabilities.
- There was protected teaching time for doctors of all grades and there was a Royal College of Emergency Medicine accredited teaching programme in place.
- We observed staff being kind and caring to patients.
- The urgent care centre and the paediatric emergency department performed well in the Department of health four-hour standard.
- The introduction of the fast initial treatment zone meant patients were streamed by a consultant or senior doctor most of the time.
- There was good multidisciplinary working and a good working culture in the department.
- Staff spoke positively of the leadership team.

Is the service safe?

Requires improvement ● → ←

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

- Following the CQC inspection in 2016 we told the trust that it must improve mandatory training levels for medical and nursing staff. During this inspection we found that mandatory training completion was still non-compliant with the trust standard although it was significantly improved upon since the last inspection.
- We told the trust that it must improve hand hygiene levels especially amongst medical staff. However, we observed many instances of poor hand hygiene during this inspection of both medical and nursing staff. The trust compliance standard with hand hygiene was 95%. Data submitted following this inspection showed that the average compliance with hand hygiene between November 2017 and March 2018 was 80%; varying each month between 63% in November and 90% in March.
- Nursing staff were non-compliant with Safeguarding Children (Level 2) as well as Adult Basic Life Support, Intermediate Life Support (ILS) and Paediatric intermediate life support (IPLS).
- There was no written protocol or policy for staff to follow in order to prevent patients at risk of suicide from leaving the emergency department before they were assessed and treated.
- Staff did not always monitor the administration of rapid tranquilisation medicine and the patient's vital sign observations afterwards.

Urgent and emergency services

- The environment in the general waiting area made it difficult for patients to hear when they were called by nursing or medical staff.
- The trust did not always ensure that emergency department patients who were on a trolley in excess of four hours were transferred to a hospital bed in line with hospital policy.
- The trust reported 219 ambulance handovers of greater than one hour between February 2017 and January 2018.
- The nursing vacancy rate in the paediatric ED was 34% and was 13.6% in ED majors compared with the trust standard was 7.5%.
- Similar to the last CQC inspection in September 2016, we found there was heavy reliance on locum consultants. The budgeted establishment was for 14 whole time equivalent (WTE) consultants of which seven posts were covered by locums.
- There was inconsistent completion of patient records; this included national early warning scores (NEWS and PEWS), sepsis 6 bundles, allergies and safeguarding information. We also found there were significant omissions in relation to the safe recording on care notes for five patients who had mental health issues.

However:

- We told the trust in 2016 that it must ensure learning from incidents was more robust and shared with all staff. During this inspection we found this had improved. Staff were more aware of incidents and learning was shared at daily safety huddles.
- We told the trust it must improve safeguarding adults level 2 training for medical and nursing staff. We confirmed during this inspection that doctors and nurses were compliant with this training.
- We told the trust it must ensure that all medicines and instruments associated with resuscitation were disposed of safely after use. During this inspection we found that this was no longer a concern; staff ensured they disposed of medicines and instruments safely after use.
- We told the trust it must ensure the renewal of advanced paediatric life support (APLS) certificates of those doctors and consultants whose certificates had expired. During this inspection we found there was 100% compliance with this training.
- The trust introduced a consultant led multiple parallel streaming model one aim of which was to enhance patient safety.
- The physical environment in the emergency department was visibly clean with regular cleaning occurring throughout the day.
- Medicines were stored safely and appropriately.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Following the CQC inspection in September 2016, we told the trust it must ensure medical and nursing staff were fully trained and able to identify and support the needs of patients living with dementia. Band 7 nurses took the lead on dementia awareness and staff told us they sought advice from the departmental dementia champion as required.

Urgent and emergency services

- We told the trust it must ensure medical and nursing staff were fully trained and able to identify and support the needs of patients with learning disabilities. During this inspection we were told that learning disability awareness training was delivered to ED nursing and health care assistant staff, with more planned for medical staff.
- The trust introduced additional pathways since the last inspection, including deep vein thrombosis, cellulitis, sepsis, urinary tract infection, stroke, low risk chest pain and low risk pulmonary embolism. We found these pathways were understood by staff and were being used effectively to manage patients' care.
- Patients were regularly offered fluids; those who were in the department for a length of time were offered sandwiches.
- A recent local audit demonstrated significant improvements in the Royal College of Emergency Medicine 2016/17 severe sepsis and septic shock audit. For example, there was 100% compliance on the screening requirements; 100% of blood cultures were achieved within one hour and 75% of antibiotics were administered within one hour of arrival.
- Doctors of all grades had protected teaching time and a teaching programme was introduced in November 2017 which was accredited by the Royal College of Emergency Medicine. Doctors spoke positively of this training provision.
- Emergency nurse practitioners in the urgent care centre spoke positively of the encouragement they were given to take an advanced clinical practitioner course.
- Medical and nursing rotas were planned to reflect a good skill mix and staff allocation to areas within the ED when on shift was also based on a good skill mix.
- There was evidence of good multidisciplinary team (MDT) working within the department and improved MDT working with other specialties.

However:

- Following the CQC inspection in September 2016, we told the trust it must improve appraisal rates of nurses. Although current appraisal rates were 79% which was below the trust standard of 90% this was an improvement on the last inspection.
- The trust failed to meet any of the standards in the Royal College of Emergency Medicine (RCEM) 2016/17 Moderate and Acute Severe Asthma report
- Nursing staff told us it was not always possible to get released for training due to staff shortages.
- There was no mental health act training provided for staff, including security staff, despite the frequency with which patients with mental health issues attended the department.
- We found the way in which policies, care and treatment pathways, and clinical protocols were stored was confusing and not easily accessible.

Is the service caring?

Good   

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

- Doctors and nurses introduced themselves to patients before commencing an examination.
- Doctors and nurses took great care to ensure patient dignity was not compromised.
- We heard doctors discussing with patients their preferred plan of care.

Urgent and emergency services

- We saw several examples of staff being caring and supportive to patients and their relatives.
- There were communication aids available to assist staff when supporting patients with special needs.

However:

- Friends and Family Test (FFT) performance was generally worse than the England average.
- The way in which the new fast initial treatment (FIT) zone in the majors area of the department was configured made it difficult at times to maintain patient privacy and confidentiality.

Is the service responsive?

Requires improvement ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The department did not achieve the Department of Health's standard for emergency departments where 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED between May 2017 and April 2018.
- There was no current plan in place to manage patients identified as frequent attenders.
- Patients with a mental health illness were not always seen within the one-hour standard by the psychiatric liaison team.
- The paediatric emergency department did not have a nappy changing area or paediatric commode.

However:

- We found that whilst the trust was still not meeting the 95% standard; there was steady improvement and performance was 84% at the end of April 2018. It averaged 79% between January and April 2018. The urgent care centre performance averaged 92% and the paediatric emergency department averaged 95% for this same time period.
- The introduction of the fast initial treatment zone meant there was consultant or senior doctor oversight of patients as they arrived and a strengthened streaming process.
- Multidisciplinary working with other specialties was significantly improved which led to better patient experience. For example, doctors from other specialties which included gastrology, endocrinology and care for the elderly, recently worked alongside ED staff on the shop floor as a way to share skills and experience.
- Children admitted to foster care from the emergency department were given a backpack which contained essential items including toiletries and pyjamas. Older children considered to be at risk of sexual exploitation or gang involvement were given a grab bag which contained a range of information on gang culture and sexual exploitation as well as toiletries and sanitary products.

Is the service well-led?

Requires improvement ● ↓

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

Urgent and emergency services

- The sustainability of departmental improvements was heavily dependent upon the recruitment and retention of medical staff similar to the situation at the last CQC inspection in 2016. Although there was an active recruitment campaign, 50% of the current consultant body and 30% of the middle grade body was made up of locums.
- There had been many changes to the leadership structures since the last inspection. Many staff told us this had been a challenging and destabilising time for them. Whilst they very much welcomed the current structure they remained wary that a decision to change it could be taken once more.
- The current governance structure had only recently been re-initiated and was not yet sufficiently embedded to give assurance that it will provide a robust framework of good governance.
- Staff told us they were not yet confident there was sufficient learning from incidents which meant that the department was often reactive rather than proactive.
- The department did not hold mortality and morbidity meetings and so had no way to seek assurance that patients were not dying as a consequence of unsafe clinical practices.
- The trust did not keep numbers of episodes of restraint or monitor its use. This meant that the trust did not have oversight of the use of restraint.
- The incident reporting policy did not specifically mention logging episodes of rapid tranquilisation medicine as an incident.

However:

- Leaders were realistic about the challenges they faced in order to continue to improve the delivery of service and make it more sustainable. They had a vision and a plan to achieve this, most of which was already in progress.
- The local leadership was visible and staff told us they had confidence in the ability of the leadership team to manage the department.
- There was a noticeably positive culture amongst all those staff whom we spoke with. They spoke of openness and a feeling of being valued. Managers told us they wanted staff to feel empowered to contribute to positive changes in the department.
- Staff were aware of the current departmental risks which were the same as those on the risk register.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Requires improvement   

Key facts and figures

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. The medical care service at the trust provides care and treatment for specialties including acute medicine, cardiology, elderly and frailty care, diabetes and endocrinology, renal medicine, respiratory and stroke. There are 288 inpatient beds spread across 23 wards. The site also has one community ward.

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

Admissions for the top three medical specialties were:

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

During our inspection we visited three elderly care wards, respiratory ward, stroke unit, acute assessment unit, acute medical unit, day hospital, gastroenterology and hepatology ward, general medicine ward, endoscopy unit, and hospital at home team. In addition, we spent time in the discharge lounge and attending some of the regular hospital meetings. A CQC pharmacist inspector visited Charles Coward Ward and respiratory medicine ward.

To come to our ratings, we spoke with 59 members of staff across clinical areas and services and management teams. We spoke with 20 patients and/or their relatives and looked at 28 patients' records. We also reviewed over 100 additional documents which included policies, clinical guidelines, staffing rotas, audits records and many other electronic records.

We last inspected medical services at North Middlesex University Hospital in September 2016. At that inspection we rated the service as requires improvement.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We identified there were gaps in an out of hours rota to cover gastroenterology. This meant patients were at risk of delay to treatment should they experience upper gastrointestinal bleed during out of hours.
- Learning from incidents was not robust.
- Staff told us they often did not have any pumps for pressure-relieving mattress in the equipment library.
- There was variation in the quality of records.
- The trust had scored worse than expected in The National Cancer Patient Experience Survey with only 15, out of 59, responses similar to the England average.
- The trust did not meet NICE guidance on falls assessment and prevention (2013) and delirium (2010) and National Patient Safety Agency (NPSA) guidance on the prevention and management of inpatient falls.
- Mental capacity assessments were not always appropriately documented.

Medical care (including older people's care)

- The trust did not have a good oversight over how many patients were placed on Deprivation of Liberties Safeguards authorisations (DOLS).
- Discharge processes, length of stay and general bed management needed improvement.
- There were a high proportion of patients remaining in hospital over 21 days.
- The trust did not meet their target to investigate and close complaints.
- There was a lack of joined up oversight and actions taken to improve areas of concern.
- The governance around monitoring risk assessments, action plans delivery, responses to complaints and investigating incidents was not sufficiently robust.

However:

- The trust reported 57% reduction of hospital acquired pressure ulcers (grade 3 and above) since the 'harm free panel' was established.
- Results in the 2016 Heart Failure Audit were better than the England and Wales averages for two of the four of the standards relating to in-hospital care.
- The hospital organised a number of GP hotlines to provide direct access to specialist advice.
- There was a medical day hospital, which provided rapid, multi-disciplinary assessments for elderly patients.
- Patients felt they were treated with courtesy, respect and compassion by staff.
- The trust's referral to treatment (percentage within 18 weeks - admitted performance: RTT) performance exceeded the England average between January to May 2017.

Is the service safe?

Requires improvement ● → ←

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

- The trust was unable to provide a full cover for an out of hours rota to cover gastroenterology due to vacant consultant's posts. This meant patients were at risk of delay to treatment should they experience upper gastrointestinal bleed during out of hours. The trust told us that approximately 20% of the May and June out of hours on-call rota for gastroenterologists was unfilled.
- The overall mandatory training completion rate for nursing staff was 79%, which did not meet the trust target of 90%. Similarly, mandatory training completion rate for medical staff was 84%, which was short of the required 90%.
- All patients used a standard pressure-relieving mattress without a pump (static), and pump could be attached for higher risk patients. Staff told us they often did not have any pumps in the equipment library and they had to obtain one from another ward or move another patient off one to free it up. Staff reported that they could wait up to 24 hours for a pump.
- The National Cancer Patient Experience Survey 2017, designed to monitor national progress on cancer care, indicated that only 54% of patients felt always / nearly always enough nurses on duty this was worse than the England average of 67%. We noted that managers were often struggling with filling uncovered shifts and staffing levels frequently were below the required establishment. The trust reported a nursing vacancy rate of 14.1% in medicine; this is worse than the trust target vacancy rate of 7.5%.

Medical care (including older people's care)

- Records reviewed were of variable quality. We have seen some records, such as body maps, were not dated others such as care plans incomplete. There were no care plans implemented to support patients with falls or dementia in the day hospital unit. Endoscopy patients sometimes underwent procedure under sedation but staff failed to ask them to sign a disclaimer form to confirm they understood risks related to it and that they should arrange to be escorted after the procedure.

However:

- Staff we spoke to knew how to report an incident using trust's electronic system. They provided examples where feedback was given after incident was investigated and spoke of lessons learnt.
- The trust reported 57% reduction of hospital acquired pressure ulcers (grade 3 and above) since the panel was established. They established weekly 'harm free panel' meetings in March 2017 to prevent pressure ulcers and improve overall safety awareness amongst staff.
- Equipment inspected by us was serviced and tested with labels indicating where the next test was due or last test carried out. This included clinical equipment, fire extinguishers and medical gas cylinders as well as other electronic equipment such as kitchen or office equipment.
- Resuscitation equipment was easily available on all wards visited. Staff checked it daily and kept record of checks to confirm readiness to use.
- Medicines were stored securely. Treatment rooms, medicine cupboards and medicine trolleys were locked. Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained.

Is the service effective?

Requires improvement ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- We found a lack of compliance with recommendations issued by the National Patient Safety Agency, Royal College of Physicians and the British Society of Gastroenterology related to out of hours endoscopy provision. During our visit, the trust told us that gastroenterologist provided cover on a "good will basis". We found there were significant gaps in the rota and the out of hours protocol did not explain what should be done in circumstances when the cover was not available. The trust informed us that they reviewed arrangement shortly after our inspection and agreed a fully covered out of hours rota for 2018.
- The trust made us aware of 85 clinical audits, carried out March 2016 to May 2018, which were related to medical specialities. In 45% of cases, no outcomes report or action plan was created (45%) which meant senior leaders and people responsible for monitoring performance and implementing changes were not aware of its findings.
- The pain management service was available seven days a week. They provided advice and assistance with acute pain, and chronic non-malignant pain conditions. Some of the data from trust's pain assessment audit indicated that patients were not always offered sufficient analgesia or underwent regular pain assessment. The National Cancer Patient Experience Survey 2017, designed to monitor national progress on cancer care, indicated that only 64% of patients felt hospital staff did everything to help control pain this was worse than the England average of 84%.
- Overall, the trust had scored worse than expected in The National Cancer Patient Experience Survey with only 15, out of 59, responses similar to the England average and 44 worse than expected.
- The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 24.6%, which was notably far worse than the audit minimum standard of 90%.

Medical care (including older people's care)

- The trust did not meet NICE guidance on falls assessment and prevention (2013) and delirium (2010) and National Patient Safety Agency (NPSA) guidance on the prevention and management of inpatient falls. The trust did not meet the national aspirational standard of 100% related to: proportion of patients who had a vision assessment (69%); patients who had a lying and standing blood pressure assessment (0%); patients assessed for the presence or absence of delirium (47%); patients with a call bell in reach (47%).
- The 2017 National Diabetes Inpatient Audit identified 87 inpatients with diabetes at the trust. Of those patients, 72% reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, this was worse than the England average of 83%.
- The trust did not have a complete oversight over how many patients were placed on Deprivation of Liberties Safeguards authorisations (DOLS) in the hospital as the ward staff did not inform the safeguarding lead of all the authorisations that were signed by staff. There were instances where the DOLS authorisation were extended more than once, which is not in accordance with legislation, and instances where patients were held in hospital after their DOLS urgent authorisation had run out. This meant that there was a risk of keeping patients who lacked capacity in the hospital without a legal justification for this.
- Mental capacity assessments had not always been completed by the clinician before filling out the best interests document. Some staff were unclear who had the responsibility to carry out a mental capacity assessment should patient's capacity was in question.

However:

- On wards we visited, we observed patients at all times had access to water or other drinks and it was within their reach. Staff clearly indicated if patient required additional support with eating or followed any special diet and could accommodate their dietary needs accordingly.
- Results in the 2016 Heart Failure Audit were better than the England and Wales averages for two of the four of the standards relating to in-hospital care.
- We observed effective multidisciplinary team working and good relationship and communication amongst various professionals involved in patients care and treatment.
- The trust improved provision of the Mental Capacity Act and Deprivation of Liberties Safeguards training within the medical wards.
- The hospital organised a number of GP hotlines to provide direct access to specialist advice with a view to promote best treatment outcomes within the primary care settings and prevent patient's admission.
- There was a medical day hospital, which provided rapid, multi-disciplinary assessments for elderly patients who required medical and social support but did not need hospital admission. Staff organised regular teleconferences with primary care doctors, social services and psycho-geriatrics to ensure seamless care and treatment was provided.

Is the service caring?

Good ● ↑

Our rating of caring improved. We rated it as good because:

- We observed several interactions between staff and patients and saw staff treated patients with compassion and kindness. Feedback from patients and relatives was generally very good and they felt they were treated with courtesy, respect and compassion by staff. Patients felt able to speak about their worries and said staff at the hospital were compassionate.

Medical care (including older people's care)

- Patients and relatives we spoke to expressed positive views related to staff working on medical wards. A relative of a patient told us “nurses were really kind and very respectful”, another patient said, “staff were always happy and friendly”; one another added, “nurses at night were always smiling and are kind”.
- We observed staff ensuring patients’ privacy and dignity was respected when providing care by closing the door to side rooms and drawing curtains in the main bay
- The trust organised support groups for patients and their relatives and carers with a view to promote self-care and offer emotional support. The ward had information leaflets on display advising carers on how to access additional support. They offered emotional support to patients and their relatives. Carers were also offered food discount at the hospital’s restaurant, concession car parking tickets, and could visiting their relatives outside of regular visiting times set out by individual wards.
- Patients had access to the hospital multi-faith chaplaincy service. The cancer support centre offered information about cancer and staff working there helped with answering questions about cancer. The centre was managed by a cancer nurse supported by trained volunteers.

However:

- The National Cancer Patient Experience Survey 2017 indicated that 75% of patients felt treated with dignity and respect while they were in the hospital this was worse than the England average of 82%. Only in 40% of cases, staff asked patient what name they preferred to be called by, this was worse than the average of 68%. Thirty-one percent reported that groups of doctors or nurses did not talk in front of them “as if they were not there” which was worse than the average eighteen percent. Other results indicated less than average number of patients felt: involved in their care and treatment; were given enough support from health or social services during treatment; were given clear written information about what should / should not do post discharge; they were told who to contact if worried post discharge.
- The Friends and Family Test (FFT) response rate for medicine at the trust was 20%, which was worse than the England average of 25% from December 2016 to November 2017. The response rate was the lowest on Michael Bates ward (6%) and Pymmes 0 ward (14%) and highest response rate on T5, T6, T7 and T8 wards (above 30%). Number of patients that would recommend the hospital to their friends and family varied with lowest scores achieved by Charles Coward Ward and T6 ward (87%) and best scores recorded for acute stroke unit and T8 ward (98% and 99% respectively). Wards have not reported the FFT data every month as required, with some of them reporting only for five out of 12 months (Michael Bates ward).

Is the service responsive?

Requires improvement ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- From November 2017 to May 2018, there were 130 out of hours hospital discharges from medical wards. This refers to patients discharged out of hospital at night (10pm to 7am). Sixty-four of those patients were discharged after midnight and before 6am, majority of them from the T7, T8 and T4 wards (12, 11, 10 patients respectively).
- The average length of stay for medical elective patients at the trust was 7.7 days, which is higher than the England average of 5.8 days. Similarly, for medical non-elective patients, the average length of stay was 7.7 days, which is higher than the England average of 6.5 days.
- From June 2017 to April 2018 there were 908 medical patients placed on surgical wards due to unavailability of an appropriate hospital bed on medical wards (approximately 91 patients per month). Majority of those patients had

Medical care (including older people's care)

fallen under the care of the elderly speciality (366). At the same time there were 700 surgical patients placed on medical wards with majority of them being general surgery patients (175). Those numbers were better to those reported in our previous report. There was a good handover process was in place for medical patients placed on surgical wards and surgical patients on medical wards (outliers).

- The trust took an average of 42 days to investigate and close complaints; this was not in line with their complaints policy, which states complaints should be resolved within 30 days.
- The day hospital's staff were not guided by any clear and objective indicators used to decide who needed a dementia assessment. The day hospital, which was used by elderly patients, also did not use any dementia specific care plan which would support standardised approach, highlight good practice, ensure alignment with relevant cross condition care plans and help to reduce local variation in the process.
- Patients on Charles Coward Ward did not have access to individual television screens or radios by their bedside. We observed that the activity room was not used by any of the patients. Staff said that they had restricted ability to support patients with leisure activities as they were frequently short staffed and needed to focus on basic care delivery.

However:

- The trust's referral to treatment (percentage within 18 weeks - admitted performance: RTT) performance exceeded the England average between January to May 2017.
- There was a good handover process was in place for medical patients placed on surgical wards and surgical patients on medical wards (outliers). Each medical team had their own base ward and was also responsible for one outlier ward, where they would attend and review all their patients daily with the responsible consultant.
- Staff were flexible with visiting times and were looking to meet needs of patients who had prolonged stay in the hospital. Carers of those patients were provided with a 'carer passport' which made more frequent visits easier by allowing cheaper car parking or discount on restaurant's food.
- Complaints were monitored and discussed at monthly divisional meetings with details of action points and learning identified. Staff provided examples where they adjusted their practice and the environment in response to the feedback provided by patients and their relatives.

Is the service well-led?

Requires improvement ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- We noted not all risks identified at the time of inspection were noted on the divisional risk register (medicine and urgent care risk register). For example, well known to senior leaders risk related to inability to provide on-call support to respond to upper gastrointestinal bleed was not noted on the register. The risk register identified 57 risks in total 11 of which were initially placed on the register in 2014 (19%) or before. Three risks related to lack of compliance with national clinical guidelines for management of multiple sclerosis, Parkinson's disease and epilepsy were listed there since 2007.
- The governance around monitoring risk assessments, action plans delivery, responses to complaints and investigating incidents was not sufficiently robust. At the time of the inspection, the governance team was short staffed and some staff were employed on temporary basis. There was no dedicated support to the division and it had hindered its ability to ensure effective management.

Medical care (including older people's care)

- Action plans to ensure improvement were not always developed promptly and were not sufficiently monitored. For example, trust did not respond promptly to the National Cancer Patient Experience Survey published in July 2017 where they scored worse than expected in 44 out of 59 indicators.
- Records quality was variable with some patients' records missing important information which should be routinely included. Information management systems did not include sufficient quality assurance to support delivery of care and treatment.

However:

- The trust prepared a divisional business plan for each of the specialities, which highlighted service objectives, and quality and clinical priorities. This was driven by key performance indicators, strengths, weaknesses, opportunities and threats analysis and by the demand and capacity assessment.
- Various teams were undergoing comprehensive Deprivation of Liberties Safeguards (DoLS) training which was broken into modules and focused on increasing staff awareness of the Mental Capacity Act and DoLS and improve the assessment processes linked to it.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Good   

Key facts and figures

North Middlesex University Hospital NHS Trust (NMUH) has three surgical wards, pre-assessment unit, day surgery unit, discharge lounge, and a surgical assessment unit (SAU) that assesses patients who have a confirmed or probable surgical condition. Patients are referred to the SAU by their GP or are admitted via the emergency department. There are emergency surgeons, a 24-hour emergency theatre and a dedicated daily trauma list.

NMUH has eight operating theatres including one dedicated to emergency cases and a theatre dedicated to interventional radiology. Surgery at the hospital has a stage one recovery area and a stage two recovery area, from which day patients are discharged.

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

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The trust had dealt with areas we highlighted as needing to be improved in our previous inspection in September 2016. For example, in our previous report we reported that patients with pressure ulcers had not had the incident electronically logged. During this inspection we found the trust had not had any incidents of grade 3 or 4 pressure ulcers in the previous 12 months. However, staff were aware of the procedure for logging pressure ulcers as incidents.
- In our previous report we reported that the reporting of actions from mortality and morbidity meetings was not formalised to allow learning and actions shared across the trust. During this inspection we found the trust had introduced actions logs and a named member of staff had responsibility for disseminating information across the trust.
- There was evidence of learning from 'Never Events' and incidents. In our previous report dated September 2016 we reported that actions in response to never events were not fully implemented. However, during this inspection we found the trust had addressed this and clear action plans were in place and monitored by the trust.
- Records were complete, well managed and stored securely. During our previous inspection, we found there was a lack of clarity in how changes to theatre lists were communicated to doctors and theatre staff. During this inspection we found this had improved as theatre lists indicated any changes implemented to the lists following dissemination to staff.
- During our previous inspection we reported that the hospital did not comply with national guidance, Health Building Note 26 (HBN 26). However, work was in progress on a review of the catheterisation laboratory (cath lab) location to ensure the hospital met the requirements of HBN 26.
- In our previous inspection in September 2016 we reported that theatre utilisation was low. In response theatres were monitored to determine reasons for delays. For example, theatre start and finish times were monitored.
- In our previous report we reported that the departmental risk register did not fully indicate
- how risks were mitigated and who was responsible for implementing actions. However, during this inspection we found the risk register contained mitigation of risk and a named person with responsibility for the risk.

Surgery

- We also found that staffing was sufficient to meet the needs of the patients. Staff moved across surgical services to ensure safe nursing staffing levels could be maintained. The trust used locum staff where required, there had been no unfilled medical shifts in the previous 12 months.
- Patients and relatives told us they felt involved in decisions about their or their loved-ones care and treatment. We spoke to 12 patients across the surgical wards who felt the staff were friendly and listened carefully to their needs.
- Patients' needs were assessed and care was evidence based. Care delivery reflected national best practice guidelines. The trust had introduced a range of new clinical pathways since our previous report in September 2016.
- Patients' outcomes were monitored and compared with similar services. The service contributed to national clinical audits. This had resulted in theatres reporting 100% compliance with the WHO checklist.
- The service contributed to national clinical audits for surgery. The overall performance for elective admissions was better than the England average.
- There was good multidisciplinary working within different speciality surgery services. Staff from the surgical assessment unit (SAU) attended bed meetings with staff from the emergency department (ED). Risk assessments were reviewed at the meetings for all 'outlier' patients; these are patients who are in hospital wards that do not provide specialist care for their conditions.
- Most staff had received annual appraisals. From February 2017 to January 2018, 90% of staff within surgery at the trust had received an appraisal compared to a trust standard of 90%.
- Patients pain was managed effectively. The staff told us they had good access to pain management advice from the trust's acute pain service following patients' surgery.
- Staff were caring and compassionate to patients' needs. For example, from February to April 2018 Ward S3 achieved a response rate of 58%, with 100% of these patients responding they would recommend the service.
- Patients we spoke with feedback were continually positive about staff and the care they received.
- Patients received care that was centred on their individual needs. The trust had good support arrangements for patients with additional needs.
- Divisional and team leaders had the capacity and capability to run a service providing quality sustainable care.
- There was a strategic vision for surgery. The surgery and cancer division had produced divisional objectives for 2018 and 2019.
- There was a supportive, honest and open culture among staff. Candour, openness, honesty and transparency were evident throughout the service.
- There was an effective governance structure in place. There was a divisional dashboard which included all key performance indicator (KPI) metrics. A divisional performance report was produced monthly and shared with the trust's board.

However:

- We found training compliance was not meeting the trust's standards in some mandatory training modules. For example, 54% of staff had completed PREVENT, this is training to identify and prevent radicalisation.
- During our previous inspection we reported that Individual venous thromboembolism risk assessments (VTE) were not fully completed. During this inspection we identified that staff were still not recording VTE assessments fully. However, in mitigation the trust had identified this and work was in progress on the rolling out of new VTE assessment tools to simplify recording processes.

Surgery

- In our previous report dated September 2016 we reported bowel cancer patients' related data suggested the risk-adjusted two-year post-operative mortality rate was much higher than the national average. Staff said the trust was of the opinion that there were discrepancies with the trust's data submissions. In response a data clerk had been appointed in 2017 to rectify the issue. The trust also highlighted that individual surgeons had published mortality outcome measures that fell within accepted ranges.
- During our previous inspection we reported average length of stay at the hospital was longer than the England average for elective trauma and orthopaedics, general surgery and urology patients. The trust said this was due to a coding issue and procedures in coding had been changed in response. However, the change in procedure wouldn't be reflected in results until 2018 data was published.
- Signage on lifts and corridors in the hospital's tower block did not direct patients, staff and visitors to the correct surgical service.
- Complaints were not always closed in accordance with timescales set out in the trust's complaints policy.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- There was a good overall safety performance in the service and a culture of learning to ensure safety improvements. For example, in our previous report, dated September 2016, we reported that actions in response to a never event were not fully implemented. However, during this inspection we found the trust had addressed this and clear action plans were in place and monitored by the trust.
- Patients were protected from abuse by effective safeguarding processes which staff knew how to use. Records indicated that across surgery services there was 91% compliance with safeguarding training, this was slightly better than the trust's 90% standard.
- Risks to patients were managed; Patients care was monitored in order to identify any deterioration. Comprehensive risk assessments were carried out for patients in accordance with national guidance. Theatre staff completed the appropriate safety checks before, during, and after surgery using the World Health Organization (WHO) surgical safety checklist.
- Patients received safe care and treatment; there were effective infection control and prevention practices in place which staff followed. Data supplied by the trust demonstrated 98% to 100% hand hygiene compliance between November 2017 and April 2018 across surgical wards and departments.
- Clinical staffing was mostly well managed and there were processes in place to ensure safe staffing levels based on staff working bank shifts and staff working flexibly across surgical services. Surgery had no unfilled shifts in the previous six months.
- In our previous report dated September 2016 we reported that patients with grade 3 and 4 pressure ulcers had not had the incident electronically logged. During this inspection we found the trust had not had any incidents of pressure ulcers in the previous 12 months. However, staff were aware of the procedure for logging pressure ulcers as incidents.
- Records were complete, well managed and stored securely. We reviewed 15 patient records. We found staff followed trust guidance on the completion of additional falls risk assessments.
- In our previous report, dated September 2016, we reported that the reporting of actions

Surgery

- from mortality and morbidity meetings was not formalised to allow learning and actions shared across the trust. During this inspection we found the trust had introduced actions logs and a named member of staff had responsibility for disseminating information across the trust.

However:

- We found training compliance was not meeting the trust's standards in some mandatory training modules. For example, 54% of staff had completed PREVENT, this is training to spot and prevent radicalisation.
- During our previous inspection we reported that Individual venous thromboembolism risk assessments (VTE) were not fully completed. During this inspection we identified that staff were still not recording VTE assessments fully. However, in mitigation the trust had identified this and work was in progress on the rolling out of new VTE assessment tools to simplify recording processes.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Patients' needs were assessed and care was evidence based. Care delivery reflected national best practice guidelines. The trust had introduced a range of clinical pathways since our previous report in September 2016.
- The service had effective processes to manage patients who were nil by mouth prior to undergoing surgery and the amount of time patients were nil by mouth was kept to a minimum in accordance with best practice.
- Patients' outcomes were monitored and the trust's performance compared well with similar services. The service contributed to national clinical audits.
- This had resulted in theatres having 100% compliance with the WHO checklist.
- Patients' pain was well managed. The staff told us they had good access to pain management advice from the trust's acute pain service following patients surgery
- Staff had the skills and knowledge to provide effective care and treatment. Most staff had received annual appraisals. From February 2017 to January 2018, 90% of staff within surgery at the trust had received an appraisal compared to a trust standard of 90%.
- Staff teams and services worked well together. There was effective multidisciplinary working within different specialities.
- The hospital delivered a full inpatient service for surgical services over seven days with timely access to diagnostics including 24 hour access to ultrasound scans.
- Patients were supported to live healthier lives. There was a range of health promotion initiatives.
- Staff obtained and recorded consent in accordance with relevant guidance and legislation. Staff were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

However:

Surgery

- During our previous inspection we reported average length of stay at the hospital was longer than the England average for elective trauma and orthopaedics, general surgery and urology patients. The trust said this was due to a coding issue and procedures in coding had been changed in response. However, the change in procedure wouldn't be reflected in results until 2018 data was published.
- In our previous report dated September 2016 we reported bowel cancer patients' related data suggested the risk-adjusted two-year post-operative mortality rate was much higher than the national average. Staff said the trust was of the opinion that there were discrepancies with the trust's data submissions. In response a data clerk had been appointed in 2017 to rectify the issue. The trust also highlighted that individual surgeons had published mortality outcome measures that fell within accepted ranges.

Is the service caring?

Good ● → ←

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

- Staff cared for patients with compassion. Patients and relatives we spoke with consistently told us about the kindness of the staff across the surgery division.
- We observed that patient dignity was respected by staff.
- The Friends and Family Test (FFT) response rate for surgery at North Middlesex University Hospital NHS Trust was 50% which was better than the England average. For example, February to April 2018 Ward S3 achieved a response rate of 58%, with 100% of these patients responding they would recommend the service.
- Patients and relatives told us they felt involved in decisions about their or their care and treatment.
- The service helped people and those close to them cope emotionally with their care and treatment. For example, the Helen Rollason cancer support centre helped patients emotionally and physically by providing complementary therapy services such as massage.

Is the service responsive?

Requires improvement ● ↓

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

- Surgical services had not fully developed Local Safety Standards for Invasive Procedures (LocSIPP) to ensure compliance with National Safety Standards for Invasive Procedures (NatSIPP).
- Signage on lifts and corridors in the hospital's tower block did not direct patients, staff and visitors to the correct surgical service.
- Complaints were not always dealt with and closed in accordance with timescales set out in the trust's complaints policy.

However:

Surgery

- The needs of the local population were identified, understood and taken into account when planning services. During our previous inspection in September 2016 we reported that the hospital did not comply with national guidance, Health Building Note 26 (HBN 26). However, work was in progress on a review of the cardiac catheterisation laboratory (cath lab) location to ensure the hospital met the requirements of HBN 26.
- In our previous inspection in September 2016 we reported that theatre utilisation was low. In response theatres were monitored to determine reasons for delays. For example, theatre start and finish times were monitored. On the 22 May 2018 theatre utilisation was 85%.
- From April 2016 to April 2018 the percentage of cancelled operations at the trust was better than the England average for the entire reporting period.
- For non-elective specialities the overall length of stay was better than the England average. The best performance was in trauma and orthopaedics, where the trust's average length of stay was almost three days shorter than that of the England average.

Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Divisional and team leaders had the capacity and capability to run a service providing quality sustainable care.
- There was a strategic vision for surgery. The surgery and cancer division had produced divisional objectives for 2018 and 2019.
- There was a supportive, honest and open culture among staff. Candour, openness, honesty and transparency were evident throughout the service.
- There was an effective governance structure in place. There was a divisional dashboard which included all key performance indicator (KPI) metrics. A divisional performance report was produced quarterly and shared with the trust's board.
- Risks to patients care were identified and managed. There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. For example, mortality and morbidity meetings discussed all deaths with complications. Learning from the meetings were recorded and escalated via the trust's electronic incident reporting system.
- In our previous report we reported that the departmental risk register did not fully indicate
- how risks were mitigated and who was responsible for implementing actions. However, during this inspection we found the risk register contained mitigation of risk and a named person with responsibility for the risk.
- Staff had access to information and systems to enable them in doing their jobs.
- Staff felt actively engaged and empowered in their roles.
- Managers and staff were committed to expanding and developing sustainable services.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Surgery

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Critical care

Good  

Key facts and figures

The critical care complex includes a high dependency unit (HDU) with 11 beds and an intensive care unit (ICU) with 12 beds. Patients are accommodated in individual side rooms or bed bays with up to four beds. The Intensive Care Society classifies patients' level of clinical need and dependency based on their acuity and the number of organs supported by clinical intervention. There are three levels of care; the HDU provides levels one and two and the ICU provides level three care.

A single clinical team works flexibly between both units, which are led by a team of consultants and two matrons. Critical care is a secure area with controlled access.

Between April 2017 and December 2017, staff cared for 714 patients with an occupancy rate between 50% and 100%. Of the total admission 12% were classed as high-risk with a need for life support for four or more organs. Of total patient admissions, 41% were unplanned from the emergency department, 38% were admitted from another ward and 20% were admitted from theatres following surgery.

During our inspection we spoke with 27 members of staff representing a range of clinical and non-clinical roles. This included staff who provided care to patients in critical care but were not permanently based there such as allied health professionals, site managers and human resources staff. We spoke with five patients and two relatives and looked at the nursing and medical records for 13 patients. Following our announced inspection, we returned to critical care and carried out an out of hours unannounced inspection during which we spoke with a further seven members of staff and reviewed three sets of medical and nursing records.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Nurse staffing levels consistently met minimum standards set by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). The matrons had significantly reduced nurse vacancies in the previous 12 months and at the time of our inspection there were no vacancies for staff nurses or senior staff nurses.
- Since our last inspection there had been significant improvements in the working culture of the unit which resulted in more motivated staff and a stabilised team.
- A new sustainability strategy included a nurse leadership development programme, an increase in the number of education and audit nurses and a new research programme from July 2018.
- Fire safety training and practices had been significantly improved since our last inspection and a dedicated fire officer led new strategies and standards. Where we found areas for more embedded improvement, we were assured of swift action.
- The unit was highly rated in most areas by a critical care network peer review in November 2017.
- In May 2018 the unit was rated as fourth highest performing area in the hospital's 'perfect ward' quality audit tool, reflecting 97% overall.
- A dedicated audit and research team led innovative projects and studies to identify strategies to improve patient care and outcomes. They also contributed to the Intensive Care National Audit Research Centre (ICNARC) and ensured the audit programme effectively benchmarked practice. The unit was not a national outlier in any measure.

Critical care

- We found consistently good standards of risk assessment in patient documentation and in practice observations, including in relation to sepsis management.
- The team demonstrated a proactive, motivated and multidisciplinary approach to learning from incidents, including the introduction of innovative or exploratory solutions.
- Feedback from patients and relatives overall was positive and people told us staff delivered care with privacy and dignity.
- Overall 2% of patients experienced a non-delayed, out-of-hours discharge to a ward. This was a significant improvement of 8% from the previous year.
- The unit received low levels of complaints, with six received between June 2017 and June 2018.
- There was a coherent leadership structure in place and all staff said they felt supported and respected.
- The senior team encouraged staff to be involved in audits and research, which they designed to improve patient experience and outcomes.

However:

- Doctor staffing levels did not meet FICM or ICS minimum standards during out of hours periods, including periods when the ratio of junior doctors to patients was 1:23.
- Although we saw several areas of improvement, we were not assured these were fully embedded or consistently followed. This included with regards to fire safety in the environment, infection control standards, dementia screening and application of the Mental Capacity Act (2005).
- The unit could not demonstrate consistently good practice in relation to infection control, including with hand hygiene.
- Staff did not classify incidents consistently, which meant the senior team did not have assurance of a tracking system to identify trends and themes.
- There was evidence from various sources of a need to further improve communication between doctors and nurses, including from incident reports and a critical care network peer review.
- We found inconsistent and variable understanding of the Mental Capacity Act (2005) and of mental capacity assessment protocols.
- The service had not successfully addressed long-term recurring instances of out of hours and delayed discharges.
- At our last inspection in September 2016 we rated critical care as requires improvement overall, which reflected good in effective, caring and responsive and requires improvement in safe and well led.

After that inspection we told they trust they should improve the following areas:

- Staff knowledge of safeguarding policies and procedures.
- Nurse to patient ratios.
- Support and supervision of staff.
- Demonstration of appropriate personal skills by staff when delivering care.
- Learning from infection prevention and control audits.

Critical care

At that inspection we also found several issues with fire safety in the unit, including a lack of named fire wardens, a lack of staff training, incomplete electrical safety testing and a risk assessment action plan that had not been completed. A large number of staff had spoken with us on the condition of anonymity to raise concerns about the working culture and leadership. At this inspection we found the trust and critical care team had begun to address these issues, with some areas still in progress.

To come to our ratings, we spoke with 27 members of staff in a variety of roles and levels of seniority as well as five patients and two relatives. We reviewed the care records of 11 patients and looked at over 45 other pieces of evidence, including the minutes of meetings and audit records. We spent time observing staff deliver care and attended handovers, ward rounds and meetings.

Is the service safe?

Requires improvement ● → ←

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

- Medial staffing levels of consultant and junior doctors did not meet FICM and ICS guidance overnight or at weekends.
- Although we found broadly improved fire safety standards, these were not fully understood by all staff and there was a lack of consistency in how they managed the environment for related risks.
- Staff did not always challenge colleagues who did not adhere to infection control standards on the unit, including hand washing on entry. In addition, hand hygiene audits indicated inconsistent practice that did not meet the trust target of 95% between April 2017 and April 2018.
- At the time of the inspection 85% of staff had up to date level 2 adults and children safeguarding children. Although this did not meet the target of 90% it was an average figure that reflected 91% completion for safeguarding adults training.
- Although staff used the aseptic non-touch technique (ANTT) for clinical practice during our observations, other areas of infection control were inconsistent. This included effective use of personal protective equipment and monitoring of the cleanliness of the environment and of equipment.
- It was common practice for staff to open windows in patient side rooms and store rooms to lower the temperature. In patient areas this reduced the effectiveness of the air pressure system and was against guidance issued by the estates and facilities team.
- We found areas of dust and dirt in patient environments and dirty equipment with 'I'm clean' stickers on them. We were not assured an effective monitoring system was in place.
- The ICU did not have enough ventilators for each patient if the unit was full and staff initiated a transfer in the event they could not provide safe care. This was because the unit regularly accommodated an additional three patients from their commissioned capacity.

However:

- The ratio of nurses to patients met standards set by the Faculty of Intensive Care Medicine and the Intensive Care Society.
- Learning from incidents and morbidity and mortality meetings had improved and processes were in place to provide more consistent communication and safer practice. This included the use of an ongoing audit to reduce the risk of the accidental remove of lines and tubes.

Critical care

- Life support training had been significantly increased and all band six and seven nurses had completed advanced life support training. All clinical staff had life support training commensurate with their grade.
- The most recent antibiotic audits indicated good standards of practice in line with trust standards, including a multidisciplinary approach to management and staff education. Monthly quality audits demonstrated consistently good practice in line with hospital policy.
- A new fire safety officer had significantly improved training for staff and introduced environment audits. They had updated major incident and evacuation policies and significantly improved training for staff.
- Link nurses had designed and implemented a range of tools and policy amendments to address areas in need of improvement. This included a medicines safety toolkit, new processes to improve tissue viability and assessments for the improvement of nurse-led aseptic non-touch technique.
- All clinical staff had up to date training on sepsis testing, treatment and risk management. This included the use of the national Sepsis 6 care pathway and the use of National Institute for Health and Care Excellence (NICE) guidance.
- Staff knowledge of the principles of safeguarding had improved since our last inspection and a safeguarding link nurse had prepared additional resources for staff to use in risk assessments.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Consultant cover was 24-hour, seven days a week and high-risk patients were reviewed within one hour of a consultant being called out.
- Opportunities for learning and clinical and professional development had significantly improved since our last inspection. An established practice development nurse was in post and a second had been recruited. Improving staff skills and knowledge was a key element of the critical care strategic plan for 2018/19.
- A dedicated audit team worked with the senior staff to developed audits to benchmark care and treatment standards in line with national guidance. Staff acted on audits and implemented improved working practice as a result.
- The trust used a 'perfect ward' quality monitoring system to enable each ward or clinical unit to benchmark care and treatment against the rest of the hospital.
- Nurses and healthcare assistants had developed a range of link, or specialist, roles to help them support colleagues in areas such as infection control and safeguarding.
- Most multidisciplinary teams, including chest physiotherapy, speech and language therapy and microbiology, provided seven-day services through an on-call system.
- Unplanned readmissions within 48 hours of discharge were consistently low and similar to, or better than, the national average.
- Staff monitored patients for malnutrition and dehydration using evidence-based tools and audited effectiveness monthly.
- Staff assessed pain and prescribed pain medicine in line with the Core Standards for Pain Management Services Faculty of Pain Management (2015).
- Patient mortality ratios were similar to expected based on national averages in similar units.

Critical care

- The critical care tissue viability group had implanted improvements in training, practice and monitoring following an increase in pressure ulcers in the unit.
- Critical care staff operated a follow-up clinic in line with Faculty of Intensive Care Medicine and Intensive Care Society guidance, including access to psychologist support.
- All doctors and 88% of nurses had an up to date appraisal.

However:

- Not all patients received a physiotherapy review within 24 hours of admission due to low numbers of permanent, experienced staff. This did not meet the London care standards.
- Staffing levels of occupational therapists, dieticians and speech and language therapists were insufficient to provide a continual service beyond Monday to Friday core hours.
- The trust did not provide staff with training in the Mental Capacity Act (2005) and we found variable knowledge of this amongst staff on the unit, including in relation to mental capacity assessments and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good   

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

- During all our observations staff treated patients and their visitors with kindness and compassion.
- Staff demonstrated an understanding of the anxiety and challenges people experienced in critical care and provided support accordingly.
- Patients had access to emotional support through the follow-up service, including with a clinical psychologist, after discharge.
- Patient and family experience link nurses had acted on feedback to improve the understanding and involvement of patients and their relatives. This included through printed information that helped people to understand critical care processes, the support available and what to expect after discharge.
- Matrons acted on feedback from the internal patient and relative's survey that indicated opportunities for improvement, such as reducing noise levels at night.
- Two nurses acted as dedicated patient and family experience links and helped to ensure people were well-informed about the work of the unit and the services offered.

However:

- Carers did not always have access to the range of benefits and support available to them through the passport scheme.
- Some relatives said they had not been kept informed of treatment plans or involved in care planning by doctors.
- Mortuary staff had submitted two incidents regarding poor adherence to dignity measures from critical care.

Critical care

Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- Between March 2017 and February 2018, 5% of discharges to an inpatient ward took place out of hours between 10pm and 7am. This was significantly better than the previously reported figure of 10% in 2015/16 and represented a continuing trend of improvement.
- Dedicated patient and family experience link nurses had significantly improved the information available to patients and their relatives. This included the production of a detailed, easy to understand publication with information about critical care.
- The average length of stay in the unit was four days, which was similar to the national average.
- Staff scored consistently well in line with trust standards in monthly audits that assessed the quality of discharge documentation.
- Staff were proactive in liaising with the specialist nurse organ donation (SNOD) to identify potential organ donors, which had resulted in five successful organ donations in 2017.
- Relatives had access to private waiting areas and facilities to make drinks and snacks. Staff facilitated overnight stays on request.
- The team had prepared and implemented a code of practice for patients living with mental health needs or reduced capacity.
- Patient and family experience link nurses had designed, developed and produced an informative information booklet for patients cared for in the unit and their relatives.

However:

- Between March 2017 and February 2018 9% of patients in the high dependency unit experienced a discharge delay of more than eight hours. This was significantly higher than the 1.2% reported in 2015/16 and worse than the national average of 5%.
- Monthly quality assurance checks indicated a need for improved consistency of dementia screening for patients over 75 years of age.

Is the service well-led?

Good ● ↑

Our rating of well-led improved. We rated it as good because:

- Leadership and working culture had significantly improved since our last inspection. This resulted in a more cohesive, satisfied and motivated staff team who said they felt valued and respected. Events and team building exercises were a regular feature of the unit's schedule and staff told us they felt previous issues of discrimination were no longer a problem.
- The presence of senior nurses on each shift had increased to provide more support and sustained leadership during the winter pressures period.

Critical care

- The clinical team led monthly morbidity and mortality reviews that were multidisciplinary and led to better understanding of care, treatment and outcomes.
- Staff were research active and had developed four in-house studies in 2017/18 in addition to engagement with the UK clinical research network. Staff focused on improving patient experience and outcomes in their research and dedicated audit and research staff provided support.
- The unit demonstrated a track record of improvement in the 'perfect ward' quality assurance and performance system. In May 2018 critical care was ranked fourth out of 23 in the hospital with an overall score of 97%, which was significantly better than the hospital average.
- Matrons had recruited additional band seven nurses to provide more consistent senior nurse presence and planned to have a nurse at this grade in charge of every shift by the end of 2018.
- Leadership in the unit had been recognised by the trust and nationally. In 2017 the matron was awarded by a national body as nurse leader of the year and senior nurses had won leadership awards in the trust's annual 'Oscar' nominations.
- The team had established a five-step critical care strategic plan for 2018/19 that focused on staff development, improving infrastructure and improved, broader engagement with the rest of the trust.
- The matrons had introduced an 'employee of the month' award to improve motivation amongst staff. This was a peer-nominated award that built on the work to improve relationships.
- The senior team led monthly governance days in the unit, which alternated between multidisciplinary audit and mortality-focused meetings.
- Previous patients in the unit were scheduled to attend staff study days as an engagement strategy. The patients would provide insight into their experiences of being cared for in the unit and contribute to staff development.

However:

- Considerable work had been completed in the unit to address bullying and harassment based on personal characteristics included in the Equality Act (2010). However, there was limited evidence this included all of our areas of concern and we were not assured the trust had staff with the skills to maintain and continue to improve this.
- Although overall, we found evidence of sustained improvements in the working culture of the unit, there were areas for improvement in communication between doctors and nurses.
- Weekly clinical governance meetings were well attended although we were not assured of a track record of learning from our discussions with staff.
- The site had a number of security challenges and risks, which were not consistently managed.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good ●

Key facts and figures

North Middlesex University Hospital (NMUH) NHS Trust provides maternity services to approximately 5,000 women in Enfield, Haringey, Middlesex and surrounding areas. Inpatient maternity services are provided solely at the North Middlesex University Hospital site. Outpatient maternity services are provided in the hospital and community. There are five community midwifery teams based in five locations across the hospital and the boroughs of Haringey and Enfield. The maternity service includes specialist clinics for women with diabetes, raised BMI, perinatal mental health, haemoglobinopathies, vaginal birth after caesarean section (VBAC), fetal abnormality screening or safeguarding concerns.

The maternity service at NMUH has 59 inpatient maternity beds and provides consultant-led and midwife-led care for both high and low risk women. The consultant-led delivery suite has a 14 beds, 11 delivery rooms and three high dependency unit (HDU) single rooms. There are two dedicated theatres with four recovery beds and a bereavement suite. The Birth Centre has eight delivery en-suite rooms, four with birthing pools and sofa beds, for women on the midwifery led pathway. The maternity service has a discharge lounge and 31-bedded joint maternity ward for antenatal women and postnatal mothers and babies. The service also has a maternity day assessment unit (six beds), triage unit (three single rooms) and four beds in the blue bay for induction of women with moderate risk. The antenatal clinic has a reception area, waiting area, six clinic rooms and a quiet room. The community midwives are aligned to local GP practices and children's centres.

The trust has a level 2 neonatal unit for babies needing extra medical and nursing care. This unit has 28 special care cots.

At the last inspection in September 2016, we rated four key questions for the service either inadequate (well-led) or requires improvement (safe, caring and responsive) so we re-inspected all five key domains. We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We visited all the maternity service areas including triage, theatre, antenatal and postnatal ward. We spoke to 23 women and their relatives, 73 members of staff and reviewed 37 sets of medical records as part of the inspection.

The inspection team consisted of two CQC hospital inspectors, one CQC mental health inspector, three specialist advisors (obstetrician doctor, matron and midwife), and an expert by experience.

Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The trust had taken note of concerns raised about the maternity service at the previous inspection and made improvements in the areas of culture, waiting time in triage, monitoring of VTE assessment, bare below the elbow practice, carrying out still birth rate audit and providing one to one care in labour to women.
- Risks to women were well-identified and managed by staff in antenatal care, intrapartum and postnatal care.

Maternity

- There were clearly defined and embedded systems and processes in place to keep people safe and safeguard them from abuse. Staff understood their responsibilities to safeguard patients from abuse and neglect, and had appropriate training and support. The service worked well with other healthcare professionals and agencies to ensure the needs of vulnerable women were met.
- There was an open culture of incident reporting and a willingness to learn from incidents.
- Staff understood their responsibilities to raise concerns and report patient safety incidents. There was a robust governance and risk management framework in place to ensure incidents were investigated and reviewed in a timely way.
- The midwife to birth ratio was 1:28 which was in line with national recommendations and was achieved by the use of temporary staff.
- Women's care and treatment was planned and delivered in line with current evidence-based guidance. There was an effective system in place to ensure staff were aware of updated guidelines. National and local audits were carried out and actions were taken to improve care and treatment when needed. The service performed better than the national average in a number of audits.
- The service met expected patient outcomes for women in most areas, and in some areas exceeded these, for example in having a low rate of planned caesarean sections. The service assessed themselves against external standards in published reports and sought continuous improvement.
- Trainee doctors and student midwives were very positive about the support and teaching they received from senior clinicians, and mentors, and obstetric training and midwifery posts were sought after.
- The service managed medicines and women's pain well. They met the national standards for obstetric anaesthesia.
- The governance arrangements were systematic and well understood. There was a responsive audit programme clearly focused on improving outcomes for women.
- Staff engagement was strong and all staff shared the same aims and vision for the service.
- Women were positive about their care and treatment. They were treated with kindness, compassion, dignity and respect. Women felt involved in their care and were given an informed choice of where to give birth. Actions were taken to improve service provision in response to complaints and feedback received.
- Women we spoke with were happy with their care and praised staff for being inclusive and supportive. Service provision met the needs of local people. They worked closely with commissioners, clinical networks and service users to plan and improve the delivery of care and treatment for the local population.
- Leadership was strong, supportive and visible. The leadership team understood the challenges to service provision and actions needed to address them.
- At the previous inspection, we found poor relations between different groups of staff and a bullying culture. At this inspection, there was a positive culture, which was focused on improving patient outcomes and experience. Staff were committed and proud to work at the trust.
- The service had a vision of what it wanted to achieve and clear objectives to ensure the vision was met.

However:

- Staffing levels were often lower than planned and the service relied on bank and agency staff to meet planned staffing numbers. However, staffing levels were regularly reviewed by senior staff and women generally received one-to-one

Maternity

care in labour. Community midwives reported having high caseloads and the staffing needs in relation to the acuity of women were not regularly reviewed. The trust told us they did not provide caseload midwifery, rather they provided group practice care within the geographical area, with allocation to a named midwife clinic. The annual average number of women having post-natal care varies from 700 to 900 women per team.

- Most areas of the maternity service we visited were tidy but not all were visibly clean during our inspection and we were not assured control were effectively in place to prevent the spread of infection. Women we spoke with said the maternity department was not always clean.
- We were not assured effective governance arrangements were in place on the ward level to ensure safe storage of medicines and to check storage temperatures daily. Staff did not have systems to identify and replace out-of-date medicines were acted upon, when indicated.
- There were inconsistencies in the monitoring of emergency equipment to ensure it was safe and effective for patient use.
- Mandatory training was below the trust target for medical and midwifery staff. Although 94% of senior doctors including consultants had completed their mandatory training which was better than the trust target of 90%.
- Safeguarding training was below the trust target for medical and midwifery staff. Although junior medical staff achieved 92% on the safeguarding adult level 2 which was better than the trust target of 90%.
- Maternity specific training compliance did not always meet trust targets, such as cardiotocography (CTG) interpretation. Although staff had completed the CTG training, some had not completed the CTG competency assessment.
- Not all staff had received an annual appraisal.

Is the service safe?

Requires improvement

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- The safety concerns from the previous inspection in relation to staffing, medicine management had not been resolved. Women were not always cared for in a clean environment, and medicines were not always stored and managed appropriately.
- We were not assured effective governance arrangements were in place to ensure safe storage of medicines and storage temperatures were checked daily, and that out-of-date medicines were replaced, when indicated.
- The service provided mandatory training in key skills to all staff. However, mandatory training compliance within the maternity service was generally lower than the trust target.
- Compliance with important maternity specific mandatory training, such as cardiotocography interpretation, was generally below the trust target.
- Although staff understood how to protect patients from abuse and the service worked well with other agencies to do so, not all medical and midwifery staff had up-to-date training in safeguarding adults and children. However junior medical staff achieved 92% on the safeguarding adult level 2 which was better than the trust target of 90%.
- Emergency equipment was not always stored securely and checked daily.

Maternity

- Midwifery staffing levels were low in relation to the acuity of women. However, staffing levels were regularly reviewed and staff were redeployed within the maternity unit when needed, to keep patients safe from avoidable harm and to provide the right care and treatment. The trust recognised midwifery and junior medical staffing was a risk and actions had been taken to mitigate this risk. Women always received one-to-one care in established labour.
- We had concerns on the cleanliness of the environment and equipment and we were not assured control were effectively in place to prevent the spread of infection. Women we spoke with said the maternity department was not always clean.

However:

- The service had systematic and established systems in place for reporting, investigating and acting on incidents and serious adverse events. There was an open culture of reporting, and learning was shared with staff to make improvements. However, there had been a delay in the investigation of serious incidents.
- We observed consistent adherence to good hand hygiene practice and bare below the elbow practice. We saw examples of midwives and doctors carrying out hand hygiene appropriately before and after care. This was an improvement from the previous inspection.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. Staff had access to patient information and could make informed decisions on patients care, management and treatment.
- The service had a comprehensive system in place to investigate perinatal mortality and morbidity cases and ensuring learning was shared, and actions were taken to improve the safety and quality of patient care.
- There was an effective system in place to assess, respond and manage risks to women who used the service. Staff could recognise and respond to signs of deterioration health and emergencies.
- The midwife to birth ratio was 1:28 which was in line with national recommendations and was achieved by the use of temporary staff.

Is the service effective?

Good 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment to women. There was an effective process and system in place to ensure guidelines and policies were updated and reflected national guidance and improvement in practice.
- Senior managers monitored patient outcomes continuously through the use of a rolling maternity dashboard and national and local audits, thereby having a clear assurance of quality against identified goals.
- The maternity audit schedule was comprehensive and audit plans included audit of risks rated as high on the risk register. The local and national audits were completed and actions were taken to improve care and treatment when indicated. The number of unexpected term admissions to neonatal care - was consistently lower (better) than the national average. The service performed better than England average in the National Neonatal Audit programme. The service had systems in place to reduce (improve) its perinatal mortality rate.

Maternity

- Women received support and advice for breastfeeding their babies. The breastfeeding initiation rates were better than the national average.
- Staff assessed, monitored and managed women's pain on an individual basis and regularly. The service met all national standards for obstetric regional anaesthesia, including the length of time women waited for an epidural to be sited in established labour. Women we spoke to told us they had received good pain relief and were reviewed quickly by an anaesthetist.
- The multidisciplinary team worked together to benefit patients. Doctors, midwives and other healthcare professionals supported each other to provide good care.
- Out-of-hours services were available to women 24 hours a day, seven days a week. Women could self-refer to the hospital via the emergency department or directly to the maternity unit.
- The service supported staff to maintain their professional skills and experience. Staff told us they had good access to study days, external training and career progression. Student midwives and medical trainees had access to comprehensive teaching and training to facilitate their learning. Staff had attended in-house human factor training and weekly CTG review to help improve their competency and improve serious incidents.
- Staff had taken part in simulation skills training and drills to support their response to emergencies, and spoke positively about the training using a birthing simulator, which helped improve their learning experience.
- Staff supported women who accessed the maternity services to live healthier lives and manage their own health, care and wellbeing.
- Midwifery staff and students were supported to maintain and further develop their professional skills and experience by an active practice development midwife and clinical practice facilitator who provided support and supervision.

However:

- Current appraisal rates for maternity staff were 83% which was below the trust standard of 90%.
- The stillbirth rate was higher (worse) than England average, which makes the service an outlier among its peer. However, the service has taken action to address this such as through the implementation of the growth assessment protocol.
- The smoking assessment audit showed poor compliance in the number of pregnant women who had their carbon monoxide level monitored and offered smoking cessation.

Is the service caring?

Good ●

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Staff treated and cared for patients and their families with compassion, patience and respect. Feedback from patients confirmed that staff treated them well and with kindness. Partners were made to feel welcome and involved in their partner's pregnancy, labour and birth.
- We observed staff giving compassionate care to women. Staff protected the dignity and privacy of women in all areas of the service.

Maternity

- Staff provided emotional support to patients and their relatives to minimise any distress. Women had access to specialist staff such as perinatal mental health team, psychologist, psychiatrist, talking therapies and a bereavement midwife. The support provided also included sensitive management of loss for women suffering miscarriage or stillbirth.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Women had continuity of care before and after birth from a local team of community midwives which enabled them to establish trusting relationships.
- The Friends and Family Test is a measure of patient satisfaction. Findings showed women and their families had a good experience on the antenatal period and postnatal period in the community but a less good experience at birth. During inspection, women and their partners we spoke to were positive about the service and told us they would recommend the service to others.

However:

- In the 2017 CQC maternity survey, the trust scored worse than England average on three out of the 16 questions asked. These were; women who had skin to skin contact post birth, treated with kindness and understanding, and spoken to in a way you could understand.

Is the service responsive?

Good 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service was planned and provided in a way that met and supported the needs of local people, including those with complex or additional needs. The trust worked closely with commissioners, the local authority, clinical networks and other stakeholders to plan the delivery of care and treatment for the local population.
- Antenatal care was easily accessible to pregnant women and was sensitive to the needs of women and the local community. Women could register for antenatal care online, and refer themselves to the MAU for some concerns such as reduced fetal movement.
- From April 2017 to March 2018, an average of 89% of women had accessed antenatal care by 12 weeks and six days gestation, which was better than the England average of 81%.
- The trust implemented a carer passport information booklet, which was a scheme for carers who supported vulnerable patients. Staff told us that the trust was the first hospital to introduce the carer passport scheme.
- The service had improved the support and provision for bereaved families following patients and community feedback. Bereaved women were able to take the baby remains the same day in order to ensure timely burial in line with the Muslim religion.
- The service had improved the care provision and waiting time in triage. Since the last inspection, a registrar was in triage from 8am to 8pm seven days a week to improve the flow.
- There were arrangements in place to support people with complex or additional needs and those who were in vulnerable circumstances with good access to specialist midwives.
- Partners were able to stay overnight if they wished on the maternity ward.

Maternity

- There was translation service in place to support women whose first language was not English. Patients had access to telephone or face to face translation, as well as a Turkish and Romanian link worker. There was a website translation icon on the trust website which can translate vital information on the website to 11 languages such as Chinese, Turkish, Japanese and German.
- We saw a range of information on display in community and hospital clinics including aspects of maternity care as well as on breastfeeding, safety, safeguarding and how to raise a concern. Most information was available in other languages to meet the diverse needs of families in the area.

However:

- Women could generally access the right care at the right time. During inspection, we observed that women appointments at the antenatal clinic were mainly delayed in relation to the use of interpretation services during consultation.
- Not all complaints were dealt with in a timely manner. However, the service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff. As a result there had been reductions (improvement) in the number of complaints received about the service.
- Bed occupancy was higher than the England average for the period July 2016 to December 2017. This was related to the complexities of the social needs, safeguarding, emergency caesarean and still birth rate.

Is the service well-led?

Good 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The maternity service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Staff told us the executives and senior leaders were visible and approachable.
- Staff told us they felt listened to and well supported by managers and specialist midwives and were confident to raise any concerns they had.
- The service used a systematic approach to continually improving the quality of its services and ensuring high standards of care. The arrangements for governance were now clear and operated effectively. Staff understood their roles and accountabilities. Since the last inspection, a maternity improvement plan had been put in place to address our concerns and risks they identified in their review of the service.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning both when things went well and when they went wrong, promoting, training, research and innovation. The service worked collaboratively with other hospitals in the region and carried out various innovation and improvement work to improve maternity care provision for the local population. As well as improve the culture and address the bullying and harassment that we noted during the last inspection to improve patient safety.

However:

Maternity

- We were not assured there was a comprehensive governance processes in place at ward level, because emergency equipment and management of medicines were not always checked daily.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Services for children and young people

Requires improvement   

Key facts and figures

The children's inpatient ward, Rainbow Ward, has 25 beds including seven single rooms, three four-bedded bays and up to six high dependency spaces. The Starlight ward has two four bedded bays and two high dependency spaces. It also has 12 beds which includes a three-bedded bay as part of the paediatric day assessment unit. The hospital has a dedicated paediatric outpatient department separate to the main adult department, and a paediatric day assessment unit.

The neonatal unit has 22 cots in total with 3 cots in each of the four bays, and within the intensive care unit there are two cots for intensive care and four cots for high dependency cases. There is one spare cot for emergency admission if needed.

During our inspection, we spoke with 41 members of staff including doctors, nurses, allied health professionals and administrative staff. We visited Rainbow Ward, Starlight Ward, the paediatric assessment unit, the paediatric outpatient department, the paediatric day assessment unit and areas of the hospital where children are also seen including the fracture clinic. We spoke with 23 patients and relatives.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service was not meeting the trust target for mandatory training compliance. The overall completion rate for nursing and midwifery staff in services for children and young people was 78% which did not meet the trust target of 90%. The target was also not met for paediatric junior medical staff, with a compliance rate of 73%.
- There was not always an advanced paediatric life support (APLS) trained staff member on shift. This was not in line with guidance from the Royal College of Nursing.
- There was a high vacancy rate and high turnover rate for nursing staff. From February 2017 to January 2018, the trust reported a vacancy rate of 18.4% in children's services. This was higher than the trust target of 7.5%. In the same period the trust reported a turnover rate of 24% in children's services, compared to the trust target of 15%.
- The service had a backlog of patients who required follow up appointments but were unable to book into outpatient clinics.
- We noted from the meeting minutes of the children's board in May 2018 that the changes relating to oversight of young people age 16 to 18 were only very recent changes.
- The service faced challenges in providing care for children and young people who presented with mental health conditions. There was often a delay in accessing child and adolescent mental health services (CAMHS), particularly at weekends as they only worked 9am-5pm Monday to Friday. If a child was admitted on a Friday afternoon they would be likely to be there until at least the following Monday. The divisional risk register detailed this risk and the trust were working with the local CCGs and mental health trust to address the issues.
- There was a board level lead for children's services in line with the Department of Health National Service Framework for Children.
- Whilst the service had introduced a children's board since the last inspection, the board had not met regularly. There had been only three meetings, with no meeting between June 2017 and May 2018.

Services for children and young people

However:

- We saw evidence of good multidisciplinary team working. Clinical teams worked well together to provide patient-centred care.
- Staff treated patients with kindness, dignity, respect and compassion. Feedback from parents and carers was positive. Staff were sensitive to the needs of children and young people, and their families.
- During the last inspection, we found that the trust did not have sufficient oversight of the care and treatment of 16-18 year old people, particularly in relation to them as inpatients. The trust policy was still that these patients were admitted to adult wards, however they now included the identification of these patients as part of the daily bed meeting. Staff told us that paediatricians and children's nurses were involved in their care if required. Staff also told us that the adult wards had new guidance to ensure that staff knew what to do should they require support from paediatric staff.
- The service achieved 97% for the 18-week referral to treatment standard from April 2017 to March 2018.
- During our last inspection we found there was a lack of specialist nursing staff to provide effective asthma and allergy clinics. There was now an additional whole time equivalent (WTE) allergy nurse who had been in post for 6 months in addition to the 0.8 WTE nurse. The service also had two GPs with a special interest (GPSIs) in allergies on the team.
- The trust had a community children's nursing team which included clinical nurse specialists who undertook home visits and school visits, and held community outreach clinics.
- At the last inspection we found that there was no children's board. However, since the last inspection the trust had created a children's board which reported to the clinical quality and patient safety committee.

Is the service safe?

Requires improvement ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- The service was not meeting the trust target for mandatory training compliance. The overall completion rate for nursing and midwifery staff in services for children and young people was 78% which was below the target of 90%. The compliance rate for paediatric junior medical staff was also below the target, at 81%.
- There was a high vacancy rate and high turnover rate for nursing staff. From February 2017 to January 2018, the trust reported a vacancy rate of 18.4% in children's services. This was higher than the trust target of 7.5%. In the same period the trust reported a turnover rate of 24% in children's services, compared to the trust target of 15%.
- During our last inspection data provided by the trust showed that the service was not meeting the trust target of 90% for paediatric immediate life support (PILS) training. The clinical director told us that PILS training was still an issue for nursing staff and they were still not meeting the target. Data provided by the trust confirmed that Rainbow Ward and paediatric junior medical staff were still not meeting the target, with 72% and 73% compliance respectively.
- The service was below the target for other mandatory training areas including infection prevention which was 69% against a target of 90%.
- Not all staff were trained in advanced paediatric life support (APLS). Managers said that ideally there was always one member of staff on shift within the whole service who was APLS trained, but this was not part of a rota and so was not always the case. This was not in line with guidance from the Royal College of Nursing which stated, "At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need."

Services for children and young people

- There were medication errors that had exposed patients to risk of harm. Senior staff told us that they had introduced a penalty system as a result of the errors. If staff made three errors their competency was taken away and they had to undergo retraining.
- Managers told us there were issues with documentation in patient records on the wards. When reviewing records, we found inconsistencies in the recording of risk assessments and safety briefings.
- The door to the main paediatric ward, Rainbow Ward, did not always close and lock properly and therefore was not always secure.
- Staff did not always have enough time to report incidents. Feedback and sharing of lessons learned was not consistent.

However:

- Staff displayed good knowledge of safeguarding procedures and were supported by the safeguarding team.
- Staff knew how to report incidents. A hospital-wide incident review meeting was held daily and was led by the head of nursing and attended by matrons in the women and children's division
- The environment appeared clean and equipment was regularly serviced.
- In our last inspection we found that a resuscitation grab bag was missing vital equipment and there was no difficult airway box on the neonatal unit. The service now had these in place and it was trust policy to conduct monthly checks.
- The paediatric service used the paediatric early warning score (PEWS) tool to monitor patients and detect signs of deterioration.

Is the service effective?

Good ● → ←

Our rating of effective stayed the same. We rated it as good because:

- The service participated in local and national audits including the National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12), the National Paediatric Diabetes Audit (NPDA) and the National Neonatal Audit Programme (NNAP) - Neonatal Intensive and Special Care. Results were in the expected range for most outcomes.
- The trust's performance was within the expected range for the 2017 NNAP audit in all areas except babies with gestation at birth of less than 30 weeks who had received documented follow-up at two years gestationally corrected age.
- We saw evidence of good multidisciplinary team working. Clinical teams worked well together to provide patient-centred care.
- The service had improved the level of support provided by play specialists.

However:

- Play specialists were not available at weekends and there were no weekend outpatient clinics.
- The service was not meeting the trust target for appraisals. In some areas the rate was as low as 50%.

Services for children and young people

- The trust's performance for babies with gestation at birth of less than 30 weeks who had received documented follow-up at two years gestationally corrected age was 29.6%, which was substantially worse than the national aggregate of 61.2%.
- The trust did not provide Mental Health Act (MHA) training. Staff we spoke with told us they were frustrated by their lack of knowledge concerning the MHA and mental health generally because they often had to care for patients who had mental illness.

Is the service caring?

Good ● → ←

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

- Staff treated patients with kindness, dignity, respect and compassion. Feedback from parents and carers was positive.
- Staff made time to interact with patients and their parents or carers and were sensitive to the needs of children and young people.
- Emotional support and information was available to patients.
- Staff communicated with children and young people in a way that was suitable to their needs.
- Parents and carers, and patients where appropriate, were involved in decisions about their care and were kept informed.

Is the service responsive?

Good ● ↑

- Our rating of responsive improved. We rated it as good because:
- During our last inspection we found there was a lack of specialist nursing staff to provide effective asthma and allergy clinics. Patients were waiting a long time for appointments and in some cases not receiving follow-up appointments. There was now an additional whole time equivalent (WTE) allergy nurse who had been in post for 6 months in addition to the 0.8 WTE nurse. The service also had two GPs with a special interest (GPSIs) in allergies on the team. However, patients were still experiencing long waits for allergy appointments.
- The trust had a community children's nursing team which included clinical nurse specialists - four for diabetes, two for sickle-cell, one for HIV, two for allergy, one for asthma and one for epilepsy. They undertook home visits and school visits and held community outreach clinics. This reduced the need for children to go to hospital and meant they could be seen nearer to where they lived, or in their home. The community nurses had strong links with the paediatric consultants and many also held joint clinics and nurse-led clinics at the hospital.
- The service achieved 97% for the 18-week referral to treatment standard from April 2017 to March 2018.
- There was a fast track pathway for patients who required readmission, including oncology and sickle cell patients. This allowed them to be admitted directly to the ward rather than going through the paediatric emergency department and/or the paediatric assessment unit.

However:

Services for children and young people

- The paediatric outpatient had an ongoing issue with not being able to book follow up appointments for several clinics. This was on the divisional risk register.
- The service faced challenges in providing care for children and young people who presented with mental health conditions. However, the trust was working with the local clinical commissioning groups (CCGs) and mental health trust to address the issues which were largely due to the availability of child and adolescent mental health services particularly at weekends.

Is the service well-led?

Requires improvement ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Whilst the service had introduced a children's board since the last inspection, the board had not met regularly. There had been only three meetings, with no meeting between June 2017 and May 2018.
- There was no clear strategy for children and young people's services within the trust.
- Some risks were not included on the divisional risk register, such as mandatory training non-compliance.
- There was limited evidence that peoples' views and experiences were gathered and acted on to shape and improve the service. Staff, patients and their relatives did not have an opportunity to contribute to plans for the future of the service. Patient survey response rates were still low.

However:

- The service had improved oversight of children's services by introducing a children's board. The board reported to the clinical quality and patient safety committee. Minutes showed that items addressed by the board included oversight of 16-18 year olds and access to child and adolescent mental health services.
- There was a positive, supportive and patient-centred culture among staff. We observed good team working amongst staff of all levels. Staff spoke highly of a staff recognition system that had been implemented at the trust.
- Staff said leaders within the service were supportive and approachable. Staff in the neonatal unit commented that there had been recent improvements in the management of the unit.
- The service had made minor improvements in patient engagement, such as the 'tops and pants' board initiative in Rainbow Ward.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

End of life care

Requires improvement   

Key facts and figures

Palliative care is offered to patients that have a terminal or life limiting illness, and require medical assistance and symptom control to continue to live as fully as possible. EOLC patients are those that are believed to be entering into their last year, days or hours of life.

The trust has 515 inpatient beds within the hospital. There were two designated end of life care beds on Podium ward. All other end of life care (EOLC) or palliative care patients were nursed on other wards. Patients that were coming towards the end of their life were accommodated on wards and side rooms, if they were available, and in line with the patient's preference.

EOLC and palliative care patients are cared for by ward staff, however, if their needs are complex, the patient is referred to the SPCT (Specialist Palliative Care Team). Not all EOLC and palliative care patients are referred to the SPCT, as the wards have EOLC Link nurses; this enabled the wards to manage patients' symptoms and pain.

The SPCT was a team of three consultants (1.6 WTE) and three CNS's (clinical nurse specialists) that worked Monday to Friday, 9am until 5pm.

The reporting structure for this team was under surgical service. For consultant cover, the clinical lead reported to the clinical director of oncology and palliative care; they then reported to the divisional director of clinical services. For nursing, the matron of haematology, oncology, sickle cell, stroke, radiotherapy and palliative care reported to the divisional head of nursing.

Within the mortuary, the lead consultant for histopathology reported to the medical director, who then reported to the chief executive.

The trust reported 1,094 deaths between April 2017 and March 2018 244 of which had been seen by the SPCT.

Our announced inspection was conducted three days; we spoke with all three palliative and EOLC consultants and all three palliative and EOLC CNS's. This made up the SPCT.

We also spoke with eight doctors, 11 registered nurses, one HCA (healthcare assistant), three chaplains, five members of the SLT (speech and language therapist) team, six OTs (Occupational Therapists), two physiotherapists, two Bereavement staff, three porters and four patients. We did not get to speak with any relatives or friends of patients, as they were either unavailable or did not wish to speak with us at the time.

We visited all wards within the hospital, the mortuary (including the two viewing rooms), the chaplaincy including the chapel, multi-faith room and Muslim prayer room, the Patient Advice and Liaison Service (PALS) office and the porters office. We also spoke with the infection prevention and control (IPC) lead, the mortuary interim lead and the lead health and safety officer.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The SPCT operated Monday to Friday 9am until 5pm. During our previous inspection, they were working the same hours; this does not follow national guidance which states a seven day face to face service should be provided for palliative and EOLC patients. The trust had approved a business case to allow this service to comply with national guidance, however the SPCT was still to fully recruit.

End of life care

- We found cleaning fluids that should not be in use following a European Directive, were still being used by the trust. Sharp and dangerous items were being washed by hand in this disinfectant and this posed a health and safety risk. There were no risk assessments, SOP's or IPC policies associated with the mortuary. Items of equipment were being reused, when disposable items were available and should have been used.
- Within the mortuary, we found specimens stored in formalin were being kept in a non-ventilated room with no immediately accessible fire extinguisher. We were informed an IPC assessment and a risk assessment of the mortuary would take place as soon as possible.
- Palliative and EOLC patients not under the care of the SPCT did not always have a mental capacity assessment (MCA) completed prior to a do not attempt cardio pulmonary resuscitation (DNACPR) order being considered.
- Not all palliative or EOLC patients were given a treatment escalation plan (TEP). The SPCT also felt they needed to improve their processes to ensure all palliative and EOLC patients were offered advanced care planning (ACP) options to ensure they achieved their preferred place of care (PPC)/ preferred place of death (PPD).
- Psychological support was available to all patients that were palliative and end of life; however, patients with cancer were offered counselling as a separate service and those patients with a terminal non-cancer diagnosis were offered counselling with the SPCT or chaplaincy instead. This was not an equivalent service and therefore non-cancer patients did not receive the same level of psychological care as those with a cancer diagnosis.
- The chaplaincy and faith provision within the trust was mainly available for Christian and Muslim faiths. Some other religions were catered for by way of a religious script, however this was not always seen or available. We commented on this during our previous inspection, however no changes had been made.
- We noted during our 2016 inspection that the multi-faith room was used as a trust meeting room. This meant it was unavailable to those who may have required access at various times. We brought this to the attention of the chaplaincy, however, we found on this inspection the room was still being used for meetings.

However:

- Incidents and complaints for palliative and EOLC were being recognised by the trust and the SPCT. They had worked with the complaints team to capture trigger words that would send the incident to the SPCT. They were reviewed, investigated, and the learning was disseminated to the rest of the team and the trust. This was an improvement since our last inspection.
- The trust had introduced innovative approaches to improve care; this included a flickering LED candle and an explanation being placed on the reception desk of each ward that had an EOLC patient. This alerted other people to the situation so that they were more mindful and would keep the ward more peaceful for the patient and their family.
- Controlled drugs (CD's) and syringe drivers were appropriately maintained, stored and used by the SPCT and wards. The CD's were checked daily and in line with national guidance.
- Pain relief was available as and when required by all palliative and EOLC patients. To cover out of hours situations, the SPCT did anticipatory prescribing for their patients as appropriate.
- Since the 2016 inspection, the speech and language therapists (SLT) team had become more involved with patient care and decision making than before. They were more involved with palliative and EOLC patients.

Is the service safe?

Requires improvement   

End of life care

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

- The SPCT team comprised of three palliative care consultants, two CNS's and one trainee CNS. There were two CNS posts not filled at the time of the inspection.
- The specialist palliative care team (SPCT) had experienced staff shortages. For an eight month period, the team were operating with one consultant and one clinical nurse specialist (CNS); The team establishment is three consultants and five CNS's. This in turn meant all end of life care (EOLC) training was put on hold, until more staff were recruited. There was no out of hours (OOH) cover for the SPCT; they were available Monday to Friday between 9am and 5pm.
- The mortuary did not have an infection prevention and control (IPC) policy or standard operating procedures (SOPs). This meant there were no IPC audits available for the mortuary. No risk assessments or IPC assessments had been carried out in the mortuary. The last IPC policy for the mortuary had been written in 2007. This was due for yearly review, however, there was no evidence of any review having taken place since.
- Within the mortuary, sharp instruments were being cleaned by hand which was a health and safety risk; these were washed with a cleaning fluid removed from use under a European Directive. This solution was used extensively throughout the mortuary and post-mortem suite.
- None of the reusable mortuary equipment had been disinfected and sterilised in line with The Health and Safety Executive (H&SE) guidelines for mortuaries; there were no clearly demarcated areas within the mortuary to show the clean and dirty utility. All areas were classed as 'semi clean/semi dirty'.
- There was no ventilation within the storage compartment for specimens stored in formalin, and there was no fire extinguisher close to this storage room; there was no evidence available to confirm portable appliance testing (PAT) had taken place. We found battery pack chargers that had wires bound with electrical tape as they were not intact. We also found no evidence to show any incorrect mortuary fridge and freezer temperatures had been monitored or rectified once they had been initially checked for that day. If the temperatures fell outside of the normal range required, staff did not document any steps taken to mitigate this risk.
- Hospital staff swipe cards allowed all staff to access the mortuary without question or reason for their attendance.
- There was no out of hours cover for the SPCT as described in national guidance; the funding had been secured via business case, however the trust had problems recruiting clinical nurse specialist (CNS's).

However:

- Incidents and complaints were properly identified, so that they would be sent to the correct service; the SPCT had worked with the complaints team to ensure incidents and complaints reached their team, for review, investigation and learning.
- The mortuary had made some improvements since our last inspection. They had removed the limescale from the sinks and work surfaces.
- Different wards and services throughout the hospital were able to explain to the inspection team about an incident that occurred within palliative and EOLC. They were able to state the learning from this incident.
- Medicines were stored and prescribed in line with national guidance. This was reviewed by a pharmacist and specialist advisors. We saw evidence that all controlled drugs (CDs) were checked daily.
- We were given evidence of syringe drivers being checked, maintained and stored appropriately.

End of life care

Is the service effective?

Requires improvement ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- The SPCT did not provide a seven day face to face palliative or EOLC service, as set out in national guidance. The funding had been provided, however the team were unable to recruit fully. At the time of our inspection, the team were awaiting a CNS that had been appointed, to start in July 2018. There was still one vacancy outstanding. The seven day service was intended to be a CNS lead service. Until all positions were fully recruited, we were advised that this would not be possible.
- There was no out of hours cover for the SPCT. Once the seven day service is running, there will be provision for a telephone advice line outside of normal working hours. At the time of the inspection, there was no provision.
- Palliative and EOLC patients not under the care of the SPCT did not always have a mental capacity act (MCA) assessment and form completed prior to an issue of a do not attempt cardio pulmonary resuscitation (DNACPR) order; this was against trust policy. We did find DNACPR orders reviewed for patients under the care of the SPCT were completed correctly, and where appropriate, mental capacity act (MCA) forms had been filled out appropriately. This was inconsistent across the trust for EOLC patients.
- Treatment escalation plans (TEP) and advanced care planning (ACP) were areas the trust felt they needed to improve; we saw evidence that supported this statement in their annual general meeting (AGM) presentation facts and figures. They were working towards enhancing this service and to make it part of the routine care palliative and EOLC patients receive. This is to ensure patient care plans were based on the patients wishes, as well as assisting to ensure the patients preferred place of care (PPC) or preferred place of death (PPD).
- The SPCT and trust had started to utilise the individualised priorities for end of life care (iPELC) document for those recognised as end of life care patients. This document was used to bring a holistic approach to patients in their last year to hours of life. It was also a guide to the clinician as to the medications, assistance and care that a patient may require at this stage of life. The iPELC had been rolled out across the trust and usage of the document had increased since 2016. The SPCT noted that the iPELC was not as widely used as they would have wished.
- The SPCT multi-disciplinary team (MDT) meeting did not include allied health care professionals, social workers or medical/nursing staff from other service areas. This was a meeting between the SPCT consultants, SPCT CNS's and the chaplain. Physiotherapists and SLT team members were only invited if there was a specific patient that required discussion.
- Electronic care records had been used more frequently than in 2016. This was a scheme that the trust had trialled; patient details were recorded on a system and these were accessible those that had access to the patient. Patients were able to call an ambulance or attend the hospital and receive continuity of care from the service, as they had access to the patients care plan and medical records. The increased usage was very small and only four records had been updated over the past 12 months. The system had not been utilised fully due to staff shortages.
- We were unable to access mandatory training figures for porters. We were told that porters had been trained by mortuary staff for mortuary duties, however we were not provided with evidence.
- Mortuary staff were not provided with SOPs to work to. If they were unsure as what to do in a particular situation, they would call other trusts and request their opinion. From the opinions collated, they told us they would decide what course of action to take. There was no official policy or guidance from the trust.

However:

End of life care

- The oncology and medical teams were available to assist wards and colleagues with palliative and EOLC patients outside of normal working hours, when the SPCT were unavailable.
- The speech and language therapists (SLT) team were more valued and involved with care plans and patient care decisions than during our 2016 inspection. This was reflected in patient care plans and assessments that we reviewed.
- Patients were able to access pain relief as and when required. These were appropriately prescribed and available at all times. For those patients that came under the care of the SPCT, if required, the team prescribed anticipatory medications to cover evenings and weekends when there was no access to the SPCT.
- The bereaved carers survey had been given out to relatives of deceased patients, except those that had their case referred to the coroner. The results were collated by the SPCT lead CNS and entered into a database. A training initiative took place as a result of feedback from the survey. Lunches were held over three days during the 'dying matters' week, and phrases were created to use with bereaved families by staff. This was so bereaved families felt compassion and care from those looking after their relatives.
- The trust had joined a scheme set up by National Health Service Improvements (NHSI) to enhance the care of palliative and EOLC patients attending the emergency department. The trust undertook a survey to establish how many palliative or end of life patients had a care plan and DNACPR in place, when they arrived at the hospital. The outcome showed that no patients had this in place. The NHSI scheme incorporated the electronic records. This was to ensure all documentation and care plans were in place for palliative and EOLC patients, when they arrived at the emergency department.
- SPCT CNS's and lead consultant had all completed their mandatory training and had yearly appraisals. Clinical supervision took place monthly for CNS's. The lead consultant obtained this elsewhere as part of her yearly appraisal.

Is the service caring?

Good  

Our rating of caring improved. We rated it as good because:

- All of the patients that we spoke with who were under the care of the SPCT were very pleased with their care. They felt that the nurses were kind, helpful and listened to them. We asked patients to describe the care they had received. We were told "Really good, one million percent!" another patient stated, 'I don't see how you can improve it, it's fairly good, you can't wish for more really'.
- At our last inspection, the care patients and their relatives experienced fell below the expected level. Relatives were left without refreshments and foldable beds when staying with patients. Some patients reported that they had not been offered services such as physiotherapy because they were EOLC patients. During this inspection, we observed patients being cared for in a kind and dignified manner. Patients reported their care and experiences had been very good and positive and could only have improved if the television signal was better or the call bell answered slightly quicker on occasions. We saw fold up beds were available and fridges were provided on some wards for relatives to store their own food. Refreshments were available for EOLC relatives on all wards. This was an improvement to the level of care we observed during our last inspection.
- We observed the SPCT providing dignified, caring and kind attitude to palliative and EOLC patients.
- The SPCT as well as other hospital staff were helpful and mindful of palliative and EOLC patients' relatives and carers. They provided fold up beds or comfortable recliner chairs with foot stalls for relatives staying with patients. Refreshments were also available to them.

End of life care

- The chaplaincy was on hand to provide emotional and spiritual care to both, patients, relatives and staff alike. The chaplaincy attended wards and spoke to patients, to offer companionship, prayer and support. The chaplaincy also had a number of volunteers of different faiths who also attended the patients.
- All of the SPCT CNS's were level 2 counselling trained. This meant they were able to assist patients and their relatives with their psychological needs. If a patient was known to have mental health issues, they were able to access the mental health team for treatment and advice.
- Relatives and carers were entitled to a carers passport. This allowed the carer to park at the hospital for £1 per day, as well as giving them 20% discount off food within the hospital restaurant.

However:

- Where side rooms were not available, and patients had relatives staying with them over night, there was not as much privacy for the family, as well as other patients on the ward.
- Psychologists were only available for palliative or EOLC patients who were diagnosed with cancer. All non-cancer palliative and EOLC patients had their psychological care via the SPCT and chaplaincy, unless referral to the mental health teams was appropriate.

Is the service responsive?

Requires improvement ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The SPCT was only available Monday to Friday 9am until 5pm. There was no out of hours cover provided by this service.
- The team showed evidence at their AGM of ongoing improvements in ACP for palliative patients since 2015. They set themselves a new annual target to improve this further, and also to launch a trust-wide ACP policy.
- Side rooms were not always available to palliative or EOLC patients, as those that posed a high infection risk had to take priority to protect the rest of the ward.
- The multi-faith area was set out as a meeting room rather than a place to sit and reflect or pray. The trust used this for team meetings, and during those times, the room was unavailable to those that may wish to use it for pastoral purposes. The multi-faith area was also used by Muslim women to pray, as the Muslim prayer room was for men only.
- We found in all religious areas, not all faiths were provided for. There was predominantly a Christian and Muslim faith majority, with other religions under represented.
- We were informed by the chaplaincy, the multi-faith room and the Muslim prayer room were locked outside of normal working hours; patients, relatives and friends would need to request for a member of staff to allow access to these areas. This was for security purposes. This situation made it difficult for those who wished to have some time within one of the faith or spiritual areas. We raised this during the previous inspection, however this arrangement had not changed.
- All forms that needed to be completed for the local authority, once the patient had died were in English only. No alternatives were available. Family members were required to bring a friend or relative that spoke English to translate for this purpose.

However:

End of life care

- The SPCT had worked with the complaints team to ensure they were receiving all palliative and EOLC complaints; therefore, they could be reviewed, investigated and learning taken from the event.
- The Chaplaincy had good links with local communities and faith leaders of many faiths. They were able to contact and request an alternative faith leader at any time. The call out time was generally within one hour.
- Translation and interpretation services were available at the trust 24 hours a day, seven days a week. There were some resident translators for Turkish and Polish speakers, however other languages were available on request. If time was of the essence, telephone translation services were used.
- Booklets were available to relatives and carers of patients that were in their last days or hours of life. These were in 'easy read' format to enable relatives of all cultures and different languages to understand the details. These booklets were available to explain to relatives and carers what to expect during the patients last days and hours of life.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The trust leadership for palliative and EOLC had changed since the previous inspection. There had been positive changes and moves forward, however many of the problems faced by the team remained the same. Staffing levels had been agreed to allow a seven-day service to commence, and the business case agreed although the team found it difficult to recruit. The team remained short staffed. The team were short staffed and not fully recruited during our last inspection. This impacted on the service the SPCT was able to provide; without a full complement of staff, the team were unable to provide a seven-day face to face service set out in national guidance.
- The trust did not have an advanced decisions policy available at the time of the inspection. The SPCT were aware of this, and said they would be working to produce this policy in the near future.
- The mortuary did not have any IPC policy or SOPs, therefore, the mortuary staff had no framework or reference for their roles or safety. There was also no risk assessment for the mortuary or post-mortem suite.
- The Health and Safety Executive standards for the mortuary provide information on cleaning and sterilisation of mortuary equipment. This guidance was not followed by the trust and we were not aware of any risk assessments for this.

However:

- The SPCT and lead consultant were very visible throughout the trust, and all staff that we spoke with either knew of the team members by name or how to get in touch with them. They were visible on the wards and always available to assist where possible with any palliative or EOLC patients.
- Since our last inspection, the trust and SPCT had produced and ratified a vision and strategy. This was adopted and modified from another hospital the trust worked alongside within Palli8. During our 2016 inspection we found the trust did not have a vision or strategy. This was an improvement.
- The trust listened to feedback regarding noise on the wards and this disturbing EOLC patients. The trust introduced an LED 'flickering candle' and an explanation poster onto all wards. When a ward has an EOLC patient resident, a candle is lit and placed on the reception desk to alert staff and visitors that this is the case. This also serves as a reminder to all to try to keep the ward as quiet and calm for the patient and their relatives during this time.

End of life care

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Requires improvement ●

Key facts and figures

The outpatients services at the North Middlesex University Hospital come under the surgery division. The gynaecology OPD is under the women's and children division and is operated out of the women's centre.

All outpatient services were open Monday to Friday 9.00am to 5.00pm with ophthalmology offering appointments on occasional Saturday's to manage the waiting lists. The Phlebotomy clinic (blood tests) was available from 7.30 am each morning to 5.45pm on Mondays, 6.45pm on Tuesdays and Thursdays, and 4.45pm on Wednesdays and Fridays.

The outpatient services included clinics in gynaecology, ophthalmology medicine and care of the elderly, trauma and orthopaedics, urology, general surgery, cardiology, rheumatology, thoracic medicine, cardiothoracic surgery, general medicine dermatology, oral surgery, neurology and gastroenterology.

We visited a range of clinics in OPD 1,2,3,4,5,6,7, and the gynaecology OPD. We met with people who use services and carers, who shared their views and experiences of the OPD service. We spoke with 33 patients and two relatives who used the services and looked at 16 patient records. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We spoke with a number of members of staff including doctors, nurses, administrative and ancillary staff. We also spoke with the OPD management team.

Summary of this service

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- The OPD leadership team advised it did not have any risks on the divisional risk register and did not hold a local risk register. This meant that the department had no sight of any risks within the department which did not reflect our findings on inspection such as staffing levels, paediatric patients being treated in the OPD, and lost or missing records.
- The OPD leadership team had a plan to improve patient services and an implementation plan in place. Both programmes were in the early stages of being rolled out. The leadership team was new with the clinical lead and acting head of OPD being in post less than 3 months and not yet had the time to make the improvements. This was similar to the last inspection.
- The matron for the OPD was not responsible for all the clinics that operated out of the department which mean there was lack of oversight across the whole department.
- Senior managers could not be assured that OPD staff were learning from incidents across the trust. A review of OPD nursing, administrative and phlebotomy staff meetings showed incidents were not discussed.
- The trust did not monitor waiting times for patients, and this was one of the main concerns raised by patients that we spoke with during the inspection. Patients told us that there waits had varied from 15 minutes to an hour.
- Staff reported that they did not feel able to report incidents of verbal and physical abuse against them and did not feel they had as they had the same rights as patients. They did not report these incidents at times because they did not think their voice would be heard.

Outpatients

- Staff felt there were limited opportunities for progression within the OPD as it was a small staff team. Staff also reported there were limited learning and development opportunities and felt they were missing out on professional development. This was similar to the last inspection.
- Staff we spoke with did not always demonstrate understanding of the safeguarding process. Staff in areas where children under age 18 attended were not aware who held Safeguarding level 3 training.
- Safeguarding adults level 2 training were below the trust target of 90% for the fracture clinic (86%) and phlebotomy staff (40%). Safeguarding children level 2 level training for phlebotomy staff (81%) was also below the trust target.
- Mandatory training in key skills for staff within the phlebotomy was below the trust targets of 90% in seven of the eight core areas. The overall completion rate was 50%.
- There was no clear responsibility of who oversaw the cleaning of the children's play areas or documentation to support this. Daily clinical and environmental schedules were not available in all the clinics, which meant the trust could not be assured that daily cleaning was being undertaken by staff in outpatients. This was similar to the last inspection.
- Paediatric resuscitation equipment or paediatric resuscitation medications were not in areas where paediatric patients were seen.
- There was no baseline acuity tool for nursing staff in outpatient clinic as staffing levels were based on the number of clinic that are run. Senior staff advised that the staffing levels within the OPD clinics were had not been reviewed whilst the number of clinic operating had increased. This was similar to the last inspection.
- We did not see any evidence of appropriate tools for patients that were non-verbal, with learning disabilities, or dementia. In the pain management clinic there were no standardised pain assessment tools available.
- Nursing staff we spoke with reported there were some limited learning and development opportunities, but frequently they were unable to attend due to staff shortage and there was not cover.
- Across the OPD we saw little evidence of health promotion information available for patients.
- During the inspection we observed that people could be over heard when reception staff checked people's personal data on the electronic record, there was no signage asking people to wait at a discrete distance from the reception.
- The outpatient department did not have a dedicated room that could be used when breaking bad news or holding private conversations.
- Signage in the department was not always clear; it was not always clear where patients should sit in the main waiting areas. We also observed that patients were getting lost as some of the signage directing patients to clinics were not clear.
- There were very few information leaflets for patients, relatives and carers available in other languages other than English. This was similar to what we found at the last inspection.

However:

- The Trust was meeting the cancer waiting times for people seen within 2 weeks of an urgent GP referral performing better than the 93% operational standard for the period January to December 2017 for people being seen within two weeks of an urgent GP referral. Performance deteriorated in the latest two quarters from July to December 2017 although it was still above the operational standard.

Outpatients

- The trust was meeting the referral to treatment time of seeing patients within 18 weeks. From March 2017 to February 2018 the trust's referral to treatment time (RTT) for non-admitted pathways was consistently better than the England overall performance. The latest figures for February 2018 showed that 92.6% of patients were treated within 18 weeks versus the England average of 88.9%.
- Staff described good team and peer support; they felt they worked well as a team. We observed good interactions between nursing, administrative, medical staff, patients and relatives working together to achieve good outcomes for patients.
- We found that suitable arrangements were in place for the secure storage of prescription sheets and FP 10's prescription pads as these were locked away at night and put into rooms at the start of clinics.
- Records reviewed showed evidence that consent was gained for care and treatment where appropriate.
- Staff were aware of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). Staff knew how to contact mental health liaison service
- Staff provided treatment and care in a kind and compassionate way and treated people with respect. Staff were seen to be very considerate and empathetic patients. Patients we spoke with were positive about the staff that provided their care and treatment.
- Patients who were living with dementia, had a learning disability, or suffered from mental ill health would be identified on their patient records and given priority in clinic to be seen quickly.
- Staff were able to signpost patients to chaplaincy and counselling to patients who needed them, and nursing staff were available in some clinics to offer support.
- Patients told us staff helped them to understand their care and treatment, and that medical staff took time to ensure they answered their questions and felt confident in treatment.

Is the service safe?

Requires improvement

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- Staff we spoke with did not always demonstrate an understanding of the safeguarding process. Staff in areas where children under age 18 attended were not aware who held Safeguarding level 3 training.
- Safeguarding adults level 2 training were below the trust target of 90% for the fracture clinic (86%) and phlebotomy staff (40%). Safeguarding children level 2 level training for phlebotomy staff (81%) was also below the trust target.
- Mandatory training in key skills for staff within the phlebotomy was below the trust targets of 90% in seven of the eight core areas. The overall completion rate was 50%.
- There was no clear responsibility of who oversaw the cleaning children's play areas or documentation to support this. Daily clinical and environmental cleaning schedules were not available in all the clinics, which meant the trust could not be assured that daily cleaning was being undertaken by staff in outpatients. This was similar to the last inspection.
- Paediatric resuscitation equipment or paediatric resuscitation medications were not in areas where paediatric patients were seen in the OPD.

Outpatients

- The OPD did not have clear pathways and processes for the assessment of people within the outpatient clinics or who were clinically unwell and required hospital admission. The trust advised they did not have a policy for deteriorating patients in the OPD.
- There was no baseline acuity tool for nursing staff in outpatient clinic as staffing levels were based on the number of clinic that are run. Senior staff advised that the staffing levels within the OPD clinics were had not been reviewed whilst the number of clinic operating had increased. This was similar to the last inspection

However:

- We found that suitable arrangements were in place for the secure storage of prescription sheets and FP 10's prescription pads as these were locked away at night and put into rooms at the start of clinics.

Is the service effective?

We do not rate this domain.

- We did not see any evidence of appropriate tools for patients that were non-verbal, with learning disabilities, or dementia. In the pain management clinic there were no standardised pain assessment tools available.
- Nursing staff we spoke with reported there were some limited learning and development opportunities, but frequently they were unable to attend due to staff shortage and there was not cover.
- Across the OPD we saw little evidence of health promotion information available for patients.
- Records reviewed showed evidence that consent was gained for care and treatment where appropriate.
- Staff were aware of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). Staff knew how to contact mental health liaison service.

Is the service caring?

Good ●

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Staff provided treatment and care in a kind and compassionate way and treated people with respect. Staff were seen to be very considerate and empathetic with patients. Patients we spoke with were positive about the staff that provided their care and treatment.
- Staff were able to signpost patients to chaplaincy and counselling to patients who needed them, and nursing staff were available in some clinics to offer support.
- Patients told us staff helped them to understand their care and treatment, and that medical staff took time to ensure they answered their questions and felt confident in treatment.

However:

- During the inspection we observed that people could be over heard when reception staff checked people's personnel data on the electronic record, there was no signage asking people to wait at a discrete distance from the reception.

Outpatients

- The outpatient department did not have a dedicated room that could be used when breaking bad news or holding private conversations.

Is the service responsive?

Good ●

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The Trust was meeting the cancer waiting times for people seen within 2 weeks of an urgent GP referral performing better than the 93% operational standard for the period January to December 2017 for people being seen within two weeks of an urgent GP referral. Performance deteriorated in the latest two quarters from July to December 2017 although it was still above the operational standard.
- The trust was meeting the referral to treatment time of seeing patients within 18 weeks. From March 2017 to February 2018 the trust's referral to treatment time (RTT) for non-admitted pathways was consistently better than the England overall performance. The latest figures for February 2018 showed that 92.6% of patients were treated within 18 weeks versus the England average of 88.9%.
- The OPD took account of people's needs. The OPD offered a range of services for patients, this included audiology, ENT, dermatology, breast surgery, podiatry, respiratory, trial without catheter and fracture clinics.
- Patients who were living with dementia, had a learning disability, or suffered from mental ill health would be identified on their patient records and given priority in clinic to be seen quickly.
- Interpreters offering both face to face and telephone interpreting could be pre-booked for patients where English was not their first language. The electronic records system had an option for interpreter required to be ticked

However:

- Signage in the department was not always clear; it was not always clear where patients should sit in the main waiting areas. We also observed that patients were getting lost as some of the signage directing patients to clinics were not clear.
- There were very few information leaflets for patients, relatives and carers available in other languages other than English. This was similar to what we found at the last inspection.

Is the service well-led?

Requires improvement ●

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- The matron for the OPD was not responsible for all the clinics that operated out of the department which mean there was lack of oversight across the whole department.
- The OPD leadership team had a plan to improve patient services and an implementation plan in place. Both programmes were in the early stages of being rolled out The leadership team was new with the clinical lead and acting head of OPD being in post less than 3 months and not yet had the time to make the improvements. This was similar to the last inspection.

Outpatients

- The OPD leadership team advised it did not have any risks on the divisional risk register and did not hold a local risk register. This meant that the department had no sight of any risks within the department which did not reflect our findings on inspection such as staffing, paediatric patients being treated in the OPD, and lost or missing records.
- Senior managers could not be assured that OPD staff were learning from incidents across the trust. A review of OPD nursing, administrative and phlebotomy staff meetings showed incidents were not discussed.
- The trust did not monitor waiting times for patients, and this was one of the main concerns raised by patients that we spoke with during the inspection. Patients told us that their waits had varied from 15 minutes to an hour.
- Staff reported that they did not feel able to report incidents of verbal and physical abuse against them and did not feel they had as they had the same rights as patients. They did not report these incidents at times because they did not think their voice would be heard.
- Staff felt there were limited opportunities for progression within the OPD as it was a small staff team. Staff also reported there were limited learning and development opportunities and felt they were missing out on professional development. This was similar to the last inspection.

However:

- Staff described good team and peer support; they felt they worked well as a team. We observed good interactions between nursing, administrative, medical staff, patients and relatives working together to achieve good outcomes for patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Our inspection team

Nicola Wise, CQC Head of Hospital Inspection chaired this inspection and David Harris, CQC Inspection Manager led it.

The team included eight lead inspectors, two mental health inspectors, a pharmacy inspector, CQC's national professional advisor, an executive reviewer, 29 specialist advisers, and four experts by experience.

National professional advisors provide advice and leadership on how we inspect and regulate health and social care services across England. Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.