

North Middlesex University Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at North Middlesex Hospital on 20 January 2020, in response to concerning information we had received in relation to care of patients in this department.

We did not inspect any other core service or wards at this hospital, however we did visit the winter pressure operations centre to discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

This was a focused inspection to review concerns relating to the emergency department. It took place between 12pm and 7pm on Monday 20 January 2020.

We did not inspect the whole core service therefore there are no ratings associated with this inspection.

Our high level findings were:

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- Risks to patients were assessed and their safety monitored and managed so they were supported to stay safe.
- Although there was a relatively high vacancy rate within specific bands, there were enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.
- There were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.
- Patients could access the service when they needed to.
- The service had managers with the right skills and abilities to run a service which provided high quality, sustainable care.
- The service had a vision for what it wanted to achieve and a strategy to turn in it into action, develop with stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. There was an appetite among staff to deliver outstanding care which was evidence based and improved patient outcomes.
- Staff felt respected, supported and valued. There were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to North Middlesex University Hospital

The North Middlesex University Hospital NHS Trust is a medium-sized acute trust with over 443 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 the year ending 31 March 2019, the trust reported a retained income and expenditure deficit of £3.2 million, compared to £29 million in the prior year. In 2018/19 the trust had a total annual income of £320.7 million. The trust reported employing more than 3,300 staff.

In 2018/19 the trust reported activity figures of 426,824 outpatient attendances, 181,135 urgent and emergency care attendances, 83,432 inpatient admissions, 40,445 operations and procedures and 4,564 babies born.

Between 1 January 2019 and 31 December 2019, the trust reported a total of 187,967 attendances to the urgent and emergency care service.

The emergency department (ED) at North Middlesex University Hospital (NMUH) provides emergency care and treatment for all illnesses and injuries 24 hours a day seven days a week. There is a dedicated paediatric service provided 24 hours a day seven days a week.

The trust has an urgent care centre (UCC) with care provided by emergency nurse practitioners (ENPs) 24 hours a day seven days a week. The centre was staffed with GPs from 9am to midnight. The UCC provided assessment and treatment for non-life threatening, illnesses and injuries.

The ED at NMUH is a trauma unit within the North East London and Essex Trauma Network (NELETN). The service provides trauma care to patients, by means of a full trauma team 24 hours a day and works in partnership with the networks Major Trauma Centre (MTC) at a nearby hospital.

The main ED for adults was refurbished and was opened in December 2018. The refurbished ED had a new facility (Horizon) unit for patients in ED who need mental health support.

We last carried out a comprehensive inspection of the service in May 2019. The service was rated requires improvement for safe. Effective, caring, responsive and well-led were rated good. The service was judged to be good overall.

Our inspection team

Our inspection team included a CQC inspector and two specialist advisor's who both had a background working as consultants in an urgent and emergency care setting.

The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection for Midlands region.

How we carried out this inspection

This was a focused unannounced inspection of the emergency department at North Middlesex University Hospital on 20 January 2020.

We did not inspect the whole core service therefore we have not reported against or rated the effective domain. We did not inspect any other core service or wards at this hospital.

Summary of this inspection

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and therefore have not rated the service on this occasion.

Urgent and emergency services

Safe

Responsive

Well-led

Are urgent and emergency services safe?

Environment and equipment

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

- We have previously reported the size of the children's emergency department was too small to effectively manage the high number of attendances annually. During times of surge, limited departmental capacity meant patients were managed in areas with limited line of sight. The local leadership team were conscious of the need to develop a larger children's emergency department which required extensive capital investment. The local team and the executive described the strategies and departmental redesigns necessary to future proof the children's service and to ensure it met national standards. The trust reported aims to seek such capital investment by bidding for sustainability and transformation partnership funding in the new financial year to help the redevelopment of the environment.
- Extensive building works had been completed at the time of our previous inspection and this has been detailed in the associated inspection report of May 2019. The clinical area was clean and well maintained. Equipment was stored appropriately and issues such as expired consumable clinical equipment identified at the previous inspection had been resolved. We randomly checked equipment throughout the equipment and found it to be in date and ready for use.
- There was appropriate emergency equipment in the clinic areas such as resuscitation equipment. Checklists confirmed emergency equipment was checked daily. We checked a range of consumable items from the resuscitation equipment and noted all items were sterile and in-date.
- There was sufficient equipment such as adult, infant and paediatric physical observation devices and monitors. Cubicles were sufficiently equipped with

oxygen and suction. Air outlet points had been covered with clearly labelled plugs; this prevented staff from inadvertently supplying medical air to patients instead of oxygen.

- The service controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- There were systems to ensure clinical waste, such as sharps, was appropriately disposed of. Clinical waste was correctly segregated, stored, labelled and disposed of regularly. We checked a sample of sharps bins and found all to be assembled correctly, dated, signed and were not over full. Sharps containers were stored at an appropriate height to help prevent children from placing their hands near to, or in the container itself.

Assessing and responding to patient risk

Risks to patients were assessed and their safety monitored and managed do they were supported to stay safe.

- The department had a safe and working triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours. During the inspection we noted an increase in the time taken for patients to be triaged by the nursing team. We noted patients were seen in time order from arrival as compared to the nurses considering the patients high-level presenting complaint given to the reception staff at the time of registering. We observed one patient who presented with a severe headache and another with a head injury wait approximately 47 minutes before being seen. This meant there was a risk acutely unwell patients may not have been seen quickly. To mitigate against delays in patients being triaged, especially during times or surge

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activity, the nurse in charge worked with the emergency physician in charge to redeploy appropriately trained staff to the triage area to effectively resolve the backlog. We observed this happen during the inspection.

- The rapid assessment area was overseen by a consultant. We observed the area being used effectively during the inspection. Patients arriving by ambulance were received quickly and both nursing and medical staff undertook rapid assessments of patients. Where necessary, interventions such as analgesia, administration of urgent antibiotics, electrocardiograms (ECG) or blood tests were carried out. Once stable, patients were then relocated to the most appropriate clinical area such as a cubicle in major's, or if the presenting complaint of the patient was of a low acuity, ambulance crews were directed to support the patient to access the urgent care service co-located in the emergency department.
- Two hourly safety huddles involving the consultant in charge, nurse in charge and operations staff were observed to take place during the inspection. All patients were quickly considered to ensure there was an appropriate plan of care. Patients requiring additional intervention or urgent reviews were escalated to the relevant specialty following the safety huddle. Deployment of both medical and nursing staff was considered as part of the safety huddle. We noted that at the 17:00 safety huddle, the majors pathway was well controlled with capacity for the team to accept additional patients. The consultant in charge noted a two hour delay for patients referred to the urgent care pathway and so they took action to deploy medical staff to the UCC to help reduce the waiting time. Additional resource was also directed to the triage team to help reduce the time taken for patients to be triaged. These actions supported the notion the team were considering the whole of the emergency care pathway and were effective at managing overall safety of the emergency department.
- Where patients were recognised as being extremely sick, arrangements were made to move patients to the resuscitation area. When the resuscitation area was at full capacity, the emergency physician in charge worked with nursing staff to identify the most suitable patient to "Step-down" to an appropriate cubicle in the major's area, or to an inpatient area in the hospital.
- As part of their induction all reception staff had received training on 'red flag' presenting complaints and the

deteriorating patient. Red flags are signs and symptoms that indicate the possible or probable presence of serious medical conditions that can cause irreversible disability or untimely death unless managed promptly.

Median time from arrival to initial assessment

- National data-sets report the median time from arrival to initial assessment ranged between 10 minutes in May 2019 to 16 minutes in 2019. The median time through the year remained marginally higher when compared to the national average. However, with the exception of December 2019, the median time remained in line with the Royal College of Emergency Medicine which recommends 95% of patients are assessed within 15 minutes of arrival.
- In September 2018, 8.2% of patients arriving by ambulance waited more than 60 minutes before they were handed over to trust staff. This had improved to 6.4% in September 2019. Between 2 December 2019 and 19 January 2020 a total of 5,800 ambulances arrived at North Middlesex Hospital. Of those, 3% of ambulances were delayed by more 60 minutes. Of note, on 14 January 2020, 30% of ambulances were delayed by more than 60 minutes.
- We had noted the number of ambulances being delayed from handing over their patients had increased on certain days during December and January which contributed to our reasons for inspecting the service. This was because there are risks associated with patients being delayed in that patients may not be clinically assessed by trust staff and therefore there is an inherent risk a sick patient may be delayed from receiving timely care and treatment. In response to challenges associated with ambulance handover delays, the trust had reconfigured the department and had developed a purpose built area to receive patients arriving by ambulances, and to manage patients who were fit to sit, as compared to being managed on a trolley. Although we did not observe any delays in patients being handed over during the inspection, both nursing and medical staff could describe the actions they took during times of surge. This included the consultant in charge undertaking a rapid assessment of any ambulance queue to ensure patients were prioritised where necessary. A nurse was also allocated to oversee the ambulance queue so the personal needs of patients could be met whilst a cubicle was made available.

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- Patients received a comprehensive assessment in line with clinical pathways and protocols. Patients were assessed using a range of national evidence based tools. This included sections for clinical observations (national early warning score), Glasgow coma scale and details of past medical history, complaint history and a section for treatment plans. These were completed by the nurse and doctors attending the patient and clearly described the assessment process, treatment given and planned, and the outcome of any investigations.
- The national early warning score (NEWS2) and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). We looked at 12 NEWS/PEWS logs and saw that they were completed correctly and regularly. NEWS2 is a point system implemented to standardise the approach to detecting deterioration in patients' clinical condition. On the charts reviewed, clinical observations were repeated in line with the previous score and escalated when scores were elevated.
- Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection. We saw the records of five patients in the department who had the sepsis pathway implemented. All charts we reviewed showed diagnostic and initial treatment was completed within one hour of identification of sepsis. This was in line with the NICE guideline (NG51) Sepsis: recognition, diagnosis and early management.

Nurse staffing

Although there was a relatively high vacancy rate within specific bands, there were enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.

- The emergency department used a combination of the baseline emergency staffing tool and the National Institute of Health and Care Excellence (NICE) emergency department staffing recommendations, to ensure the department was staffed appropriately. In addition to this, the trust had engaged with Health Education England (HEE) who were, at the time of the inspection, undertaking a systematic review of the staffing establishment in the emergency department.

The results of this review was not yet available at the time of the inspection. However, the trust reported they had worked with both HEE and the national Emergency Care Intensive Support Team (ECIST) to transform the workforce across the emergency department. This included looking at how different health professionals could be used more effectively to improve outcomes for patients. Regular safety huddles occurred during which deployment of staff was considered to ensure the department remained safe. Staff looked at the acuity of patients and how many were in the department at certain times of the day. As a result, the department changed staff allocations to provide a safe amount of staff at the busiest times of the day to the right clinical area.

- At all times throughout our inspection, we found the skill mix of staff to be suitable for the needs of the emergency department, with actual staffing levels meeting the planned levels. Senior staff had oversight of the staffing within the department and moved staff around to ensure all areas were safe and they were able to manage surges in demand.
- The department had a budgeted nursing establishment of 142.7 whole time equivalent (WTE) posts. At the time of the inspection, there were 34 wte vacancies, equating to a vacancy rate of 24%. The majority of vacancies were associated with band 2 healthcare support worker roles. The trust used bank and agency staff to back-fill vacant gaps. Temporary staff were orientated and inducted to the clinical area.

Medical staffing

There were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.

- There was a consultant present in the department for 16 hours a day, seven days a week, with a specialist trainee doctor (ST4 or above) available 24 hours a day.
- As the department saw over 16,000 children a year there was three consultants with sub specialist training in paediatric emergency medicine or who were designated paediatricians.
- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when

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shifts changed. Handovers between different teams of doctors was well-structured and detailed. We observed early senior involvement in the treatment of patients throughout our inspection.

- Junior doctors spoke positively about working in the emergency department. They told us that the consultants were supportive and always accessible.

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

Access and flow

Patients could access the service when they needed to.

- Front line staff reported they were on operational pressure escalation level (OPEL) two at the time of the inspection. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care.
- There were systems in place to manage the flow of patients through the ED to discharge or admission to the hospital. There was an emergency department streaming flow chart which was used to assess and navigate patients through the various assessment and treatment pathway. Based on staff assessment at streaming and triage, patients could be directed to different areas such as the fit zone, sit2treat and the UCC.
- The ED used a nurse-led approach to streaming and triaging patients. After registering at the reception, a senior nurse would assess patients within 15 minutes of arrival. Where there was challenges in delivering against the 15 minute standard, additional resource was directed to the triage area to help address backlogs. This was observed to happen during the inspection.
- Following the booking of patients by the reception, patients were seen by a streaming nurse and can be directed to specific areas in the department which were

majors area, sit to treat chairs or the urgent care centre. Patients could also be directed to resuscitation area if needed and mental health patients could be directed straight to the horizon unit. Again, this was observed to happen during the inspection. This included a patient who presented with chest pain; the nurse prioritised the patient and once having completed an ECG, took the patient direct to the resuscitation area for on-going care and treatment.

- The trust had established a winter pressures operations control room which was led executively by the Chief Operating Officer. Patients who were assessed as being medically fit for discharge from an acute hospital but who required supplementary care support in a setting such as a care home or nursing home, was a contributory factor to the high level of hospital bed occupancy. Due to the heightened level of escalation, the trust had been required to "Board" patients across medical and surgical wards within the hospital. Boarding is a term used when patients who may be fit for discharge but are waiting for discharge procedures to be completed (such as paperwork being finalised or medicines being prepared by the pharmacy); or a newly admitted patient who has been admitted to a ward, but is managed in a non-clinical area on a ward until a bed space becomes available. The concept of boarding is included in the trusts escalation protocol and was used as a last resort when acutely unwell patients required admission to an appropriate hospital bed. There was evidence the executive team continually reviewed the practice of boarding and dynamically de-escalated and escalated the protocol throughout the inspection to ensure sufficient flow was afforded to the emergency department.
- NHS Trusts are required to monitor and report nationally the percentage of patients who attend ED and get seen, discharged or admitted within four hours of arrival. This is known as the Emergency Access Standard (EAS). The NHS standard requires 95% of patients to spend less than four hours in ED. Although the trust did not meet the national standard of 95%, trust performance between January 2019 and December 2019 was consistently similar to the national average.

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Number of patients waiting more than 12 hours from the decision to admit until being admitted

- Over the 12 months from January 2019 to December 2019, eight patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in July 2019 (three patients), June 2019 (two patients) and September 2019 (two patients).

Median total time in A&E per patient (all patients)

- From January 2019 to December 2019 the trust's monthly median total time in A&E for all patients was higher than the England average.
- We were told that there were often periods of overcrowding, when ambulance crews could not offload the patient into the rapid assessment area. During these periods, the corridor was used as extra capacity. The trust allocated a nurse to oversee this area. During the inspection, there was good flow through the majors pathway. There was sufficient capacity to ensure patients were offloaded quickly. Although there were 18 patients waiting for inpatient beds, the Emergency Physician in charge and nurse in charge worked to ensure major's cubicles were available for new patients to be assessed and treated. The operations team worked to source inpatient beds for patients who had decisions to be admitted. We spoke with ambulance staff during our inspection and they told us that this ED was very swift and responsive in offloading their patient's as soon as possible. We saw evidence of this during the inspection.
- Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. (AMSAT).
- As had previously been reported, there were systems in place to help staff to identify patients in need of additional support or specialist intervention. At 'risk' or complex patients including those living with dementia and learning disabled patients were 'fast tracked' from the time they booked into reception. The streaming nurses were made aware of their presence by the receptionists and also through flags on the patient information system.

Are urgent and emergency services well-led?

Leadership

The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.

- The emergency department was part of the medicine and emergency division. The management structure included a clinical director, operational manager and head of nursing for ED. The clinical director reported to the divisional director while the operational manager reported to the divisional director of operations. The head of nursing covered the ED, acute medical unit (AMU) and acute assessment unit (AAU). Staff reported the leadership were approachable and visible. Senior leaders were well sighted on departmental risks and could describe actions being taken to resolve on-going challenges.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

- Staff we spoke to were aware of the trust vision, values and objectives. Staff could also describe the strategy for the emergency department. Based on nationally aligned values, the vision for the emergency department was orientated around delivering safer, faster and better care for patients. Staff working in the children's emergency department was focused on providing evidence based care from a setting which was fit for purpose. As we have previously reported, the existing children's department was too small to manage the increasing number of attendances each year. The trust had a strategy to resolve this and had been encouraged to bid for additional capital expenditure funds in the new financial year (April 2020).

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Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.

- All staff we spoke to had a strong commitment to their job and were proud of their role, team working and the positive impact they had on patient care and experience. Staff felt there was a positive working culture and reported collaborative and effective team working to provide safe care and provision. For example, the emergency physician in charge routinely considered activity throughout the department and deployed medical resource to support colleagues where it was appropriate.
- We had previously reported staff had experienced violence, aggression, verbal threats and abuse from patients and public. This had previously caused low morale among some staff. Managers were aware of staff experiences and had increased the numbers of security staff in the department and displayed posters on zero tolerance of abuse, violence and aggression towards staff in the department. Staff told us the increase in security staff reduced the incidents of violence and aggression in the department. However, we noted two separate occasions when patients and/or their relatives were verbally abusive towards staff. We spoke with those staff members who reported that due to the low level nature of the abuse, they would not routinely report the altercation as an incident. The executive

team recognised violence and aggression was an ongoing area of concern and was also mindful that staff had likely normalised low-level acts of verbal abuse, resulting in staff not reporting the incidents. This was something the executive team was keen to resolve and reported actions being taken to encourage staff to report all episodes in order the trust had a better understanding of the scale of the issue.

Governance

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

- The emergency service sought reassurance through various governance meetings such as the ED governance meetings, mortality and morbidity meetings, patient safety and outcomes committee and the clinical audit and effectiveness committee which reported to the trust board.
- The ED governance meeting was held monthly and attended by the leadership team and MDT staff. We reviewed the most recent minutes from both the ED governance meeting and also considered the annual mortality review report. The ED governance meeting was well attended by a range of health professionals. Consideration was given to incidents, serious incidents, complaints, patient experience, patient safety alerts and departmental and strategic risks.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

Ensure staff report all episodes of verbal or physical violence.

In regards to the triage process, the trust should ensure staff consider the presenting complaint of patients as well as the time of arrival to ensure high risk patients are prioritised, especially during times of surge.