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ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE JOINT OVERVIEW AND SCRUTINY COMMITTEE ON HEALTH

A meeting of the Joint Overview and Scrutiny Committee on Health will be held in Committee Rooms 1 & 2, Haringey Civic Centre, High Road, Wood Green, London, N22 8LE on, **19 September 2014 at 10.00 am.**

John Lynch
Head of Democratic Services

Islington Council nominee is **Councillor Martin Klute**

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NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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Friday 19 September 2014 10:00 a.m.
Committee Rooms 1 & 2, Haringey Civic Centre, High Road, Wood Green, London N22 8LE

Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Peter Brayshaw and Alison Kelly (L.B.Camden), Alev Cazimoglu and Anne Marie Pearce (L.B.Enfield), Gideon Bull (Chair) and Pippa Connor (L.B.Haringey), Jean Kaseki and Martin Klute (L.B.Islington),

Support Officers: Anita Vukomanovic, Andy Ellis, Robert Mack and Harley Collins

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members of the Committee are invited to identify any disclosable pecuniary or prejudicial interests relevant to items on the agenda. A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting at which the matter is considered:

a) must disclose the interest at the start of the meeting or when the interest becomes apparent; and
b) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in their borough's Register of Members' Interests or the subject of a pending disclosure must notify their Monitoring Officer of the interest within 28 days of the disclosure.

3. URGENT BUSINESS

4. MINUTES (PAGES 1 - 8)

To approve the minutes of the meeting of 27 June 2014.

5. WHITTINGTON HEALTH NHS TRUST: FIVE YEAR PLAN/DEVELOPMENT OF INTEGRATED CARE

To report on the five year plan for Whittington Health and its development of integrated care.

6. LONDON AMBULANCE SERVICE (LAS) - UPDATE

To receive a report from the LAS on current issues, including:

- Deployment of ambulances at local ambulance stations
- Handover times
- Work with urgent care centres
- Recruitment and retention
- Intelligent conveyancing and
- Use of private ambulances.

7. WINTER A&E PRESSURES AT BARNET HOSPITAL - ADMISSIONS FROM CARE HOMES

To receive an update on work undertaken at Barnet Hospital to address the issue of A&E admissions from care homes.

8. NORTH MIDDLESEX UNIVERSITY HOSPITAL - CARE QUALITY COMMISSION INSPECTION (PAGES 9 - 104)

To consider the outcome of a recent inspection by the Care Quality Commission on the quality of care at the North Middlesex University Hospital. A copy of the inspection report is attached.

9. DISTRICT NURSING

To consider the position in each borough in relation to the commissioning of District Nursing services.

10. WORK PLAN AND DATES FOR FUTURE MEETINGS (PAGES 105 - 106)

11 September 2014

Agenda Item 4

North Central London Sector Joint Health Overview and Scrutiny Committee

27 June 2014

Minutes of the meeting of the North Central London Joint Health Overview and Scrutiny Committee held at Islington Town Hall on 27 June 2014

Present

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
Danny Beales	LB Camden
Peter Brayshaw	LB Camden
Alev Cazimoglu (Vice Chair)	LB Enfield
Anne-Marie Pearce	LB Enfield
Pippa Conner	LB Haringey
Martin Klute	LB Islington
Jean-Roger Kaseki	LB Islington

Also in attendance:

Councillor Alison Cornelius	LB Barnet

1. ELECTION OF CHAIR AND VICE CHAIR

RESOLVED:

That Councillor Gideon Bull be appointed Chair and Councillor Alev Cazimoglu be appointed Vice Chair for the 2014-15 Municipal Year.

2. WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Kelly (Councillor Beales deputising).

Councillor Cornelius reported that Barnet were not yet able to confirm their representation on the Committee. She had nevertheless been appointed as Chair of the Health Overview and Scrutiny Committee.

The Chair expressed his thanks to ex-Councillors John Bryant and David Winskill for their contribution to the work of the Committee.

3. DECLARATIONS OF INTEREST

The following personal interests were declared:

- Councillor Bull declared that he was an employee of Moorfields Eye Hospital;
- Councillor Brayshaw declared that he was a governor of University College London Hospitals (UCLH);
- Councillor Cornelius declared that she was an Assistant Chaplain at Barnet Hospital; and

- Councillor Beales declared that he was an employee of Bliss, a neonatal charitable organisation and a governor of UCLH.

4. URGENT BUSINESS

None.

5. MINUTES

The Committee noted that an update on progress with outstanding actions arising from previous meetings had been circulated to Committee Members beforehand. The two outstanding issues relating to the Barnet, Enfield and Haringey Clinical Strategy, which concerned the review of its implementation and lessons learnt from the reconfiguration process, had been raised with the relevant organisations and a response was expected shortly.

In respect of item 10 of the minutes of 28 March, the Chair reported that he had received a copy of the summary of the Mental Health Strategies report. However, he nevertheless still wished to access the full report and requested that this be conveyed to relevant commissioners.

RESOLVED:

1. That the minutes of the meeting of 28 March be approved; and

2. That mental health commissioners for Barnet, Enfield and Haringey be requested to make available the full Mental Health Strategies financial review report to relevant members of the Committee.

6. ACQUISITION OF BARNET AND CHASE FARM HOSPITALS BY THE ROYAL FREE

Caroline Clarke and Deborah Sanders from the Royal Free attended the meeting. They reported that the process for the acquisition by the Royal Free of Barnet and Chase Farm hospitals had so far taken two years and been very onerous in nature. It appeared highly likely that the implementation date would be 1 July. A lot of this time had been spent ensuring services would be secure for patients. The enlarged trust would be a mix of a specialist, teaching and local hospital.

Plans for the development of the Chase Farm site were at an early stage and it was possible that the Committee would want the trust to come back when more details were available. Around £100 million was likely to be invested in the site. Money raised through the sale of parts of the site would be re-invested. It was not possible to give exact valuations on the land that would be sold as this was dependent on a range of issues, including how the land would be packaged up. The amount raised from land sales alone was unlikely to be sufficient to fund the necessary work and additional funding would come from the Department of Health and from the trust's own resources. The overall project was likely to be very large and the land sales would be a comparatively small part. Work was

also being undertaken to the interior of the Royal Free in Hampstead but this would not be affected by the plans to redevelop Chase Farm.

An engagement meeting was planned to take place in July. A wide range of stakeholders would be invited to this, including local MPs and Healthwatch. Planning and development issues would also be subject to local consultation, including a pre-planning exercise involving local residents.

Committee Members commented that good relationships needed to be developed and maintained with local residents and their representatives. Disappointment was expressed that more detail was not available at this stage. The promise to invest in the site and engage with local residents was nevertheless welcome.

Ms Clarke reported that she recognised that there were operational issues relating to Chase Farm hospital at the moment and the Trust was keen to address these. They understood fully the need to work with the local Council and community. There were currently several different options that were being considered for the development of the site but the necessary detail had not yet been developed.

The Chase Farm site was currently losing up to £20 million per year whilst Barnet and Chase Farm Hospitals had an overall projected deficit of £35 million for the year. There were many possibilities for how the site could be adapted. Primary and urgent care would be part of whatever scheme was adopted. A school was another possibility. The valuation of the site would depend on the footprint. She would be happy to come back when plans had been formulated.

The trust would be investing some of its own money in the redevelopment of the site. The breakdown of the relative amounts that were to be invested in the potential redevelopment of the site was as follows:

- Department of Health: Between £35 – 40 million;
- Land sales: £30 – 50 million;
- Royal Free: £20 – 30 million (the remaining amount required).

In terms of the future of directors and non executive directors of BCF, some would be joining the Royal Free whilst others would be leaving. It was important that their knowledge and expertise were not lost to the organisation.

Ms Sanders reported that there had been a lot of engagement with staff. They had initially been cynical about the acquisition but they were now more sympathetic. In particular, the changes would allow them greater scope for career progression. Savings would be made in support services but the level of redundancies was likely to be very low as there were a lot of vacancies. The Committee noted that there was some uncertainty regarding the future of a number of administrative staff. Ms Clarke stated acknowledged that this matter needed to be resolved.

Ms Sanders reported that there were no plans for changes to clinical staff although more nurses might be needed. Some wards that had been earmarked

for closure had remained open longer than anticipated and this had required additional temporary staff to be employed.

In answer to a question, Ms Clarke reported that £263 would be reinvested over the next 5 years, with most funding coming from the Department of Health. However, the Royal Free would have to take over the work that had previously been undertaken by Barnet and Chase Farm. None of this money would be diverted for investment on the Hampstead site.

Ms Clarke reported that Barnet and Chase Farm Hospitals had been making losses of around £35 million per year and this may have influenced the Department of Health's decisions in relation to the capital funding that had now been made available as they were more willing to allocate money when expenditure was non recurrent. In addition, the trust had been fortunate in its timing as the Department of Health had underspent its budget last year.

In answer to a question from Councillor Cornelius regarding ambulances queuing at Barnet Hospital, Ms Clarke stated that the Royal Free was aware of the issues relating to this. Consideration was being given to whether further investment was needed, including the provision of additional capacity.

The Committee noted that risk levels for the next five years had been assessed. In terms of the refurbishment of Chase Farm, the trust was aiming to be ambitious and complete the work within four years. Assessments of the acquisition plans had been made by the Trust Development Agency and Monitor. These were in the public domain but the Trust would be happy to pass them onto Committee Members if they were unable to access them.

7. NHS 111/OUT OF HOURS COMMISSIONING

Alison Blair, Chief Officer of Islington CCG and Samit Shah, Clinical Lead for NHS 111 in North Central London, reported on the process for recommissioning the Out of Hours and NHS 111 Services. A national report on the future of out-of-hours care was expected in the autumn. One function that was being considered was the possibility of enabling services to directly book appointments with GPs.

It was acknowledged that the current system was difficult to navigate and sometimes confusing. People often went to A&E by default as they did not know where else to go but it was often not the best option. The NHS 111 Service was a pilot project and would be subject to evaluation. Consideration was currently being given to extending the out-of-hours contracts for Camden and Islington. Around 45% of calls to the out-of-hours service were dealt with purely on the phone. In the longer term, a proposal was being worked up to commission one system for all five north central London boroughs for NHS111 and out-of-hours services, with local and cross borough elements.

The NHS 111 Service was data rich and nationally received over a million calls per month. The use of 111 was fairly even across the five boroughs but there could nevertheless be benefits in raising awareness of the service in some areas. National work was being undertaken to consolidate the learning and understand

the benefits of NHS111. A series of pilot projects were taking place which would look at specific elements of the system. The sharing of learning and development would enable local areas to make informed decisions as to their preferred choices regarding the future procurement and development of 111 within their strategic vision.

Included within the pilot was a project involving the Whittington Hospital that involved encouraging patients - in an urgent but not life-threatening situation - to call NHS 111 before going to A&E. Another scheme involved placing two GPs in call centres in order to facilitate earlier GP intervention. All of the evidence would be gathered and assessed and used to guide the commissioning process, including the setting of standards. The evidence would allow better informed decisions to be taken on future arrangements.

Ms Blair stated that it was recognised that there was a problem with access to GP appointments in many places and a pilot project whereby out-of-hours services could book appointments with GPs was aimed at making this easier. The overall issue of access to GPs might warrant a longer discussion. The Committee noted that NHS England were undertaking work that was aimed at transforming primary care and this issue would be addressed as part of this process.

The Committee noted that Harmoni/Care UK, who were the provider of out-of-hours services for Camden and Islington, had previously been the subject of concerns relating to staffing levels. Ms Blair commented that Harmoni/Care had recently been inspected by the CQC and received a positive report. LCW, who provided the NHS 111 Service for the five boroughs and were also involved in out-of-hours care, had a close relationship with local GPs. There could nevertheless be a tension between broadening the service and fulfilling staffing needs. It was important to have a good mix of staff, including experienced GPs and it was not always possible to recruit these from the local area.

It was noted that each CCG was likely to want its own base for out-of-hours services. The specification would therefore need to encompass both borough and cross borough issues.

The Committee noted that the Whittington project would be evaluated and fed into the learning. Dr Shah reported that the demographics for those using the NHS 111 Service were fairly reflective of the area as a whole. Commissioners were examining the possibility of providing digital access to GP appointments so patients could be booked directly in by NHS 111. The Committee were of the view that the statistics suggested that there was a lower level of awareness of the service in Camden than elsewhere and it was agreed that this issue would be explored further by NHS partners.

It was noted that the current NHS 111 contract ran until 2016 and it was intended to recommission on a five year basis. The Committee commented that if the service were in a position to offer priority booking for GPs, people would be more inclined to contact them as it would provide a new means of access.

RESOLVED:

1. That NHS commissioners be requested to consider comparative rates of use between boroughs and, in particular, whether there might be a need to raise awareness of the service in Camden; and

2. That the Committee consider further the issue of access to GP services as part of ongoing consideration of the Transforming Primary Care in London process that is being led by NHS England.

8. COMMISSIONING SUPPORT UNIT - FURTHER DEVELOPMENT

Ros Gray, from NEL Commissioning Support Unit (NELCSU), reported on how the organisation had developed since its creation. Their only income came from contracts with NHS organisations. They currently had 17 CCG customers as well as around 50 others, including national and London wide pieces of work. They had recently been successful in obtaining contracts from Norfolk CCGs. The unit had nearly 1000 staff and provided a range of services including IT, Finance, Business Intelligence, Human Resources and Procurement. There were also a small number of clinical services including medicines management.

The unit had been set up to create economies of scale for commissioners. Some CCGs were very small and did not have the necessary experience in many areas that were covered by the unit. The unit was very much driven by NHS values.

In answer to a question, Ms Gray stated that commissioning support units (CSUs) were different organisations from primary care trusts as they were driven by the clinical commissioning groups (CCGs) and decision making was local. Although they acted on behalf of commissioners, they also had strong relationships with providers. They were bound by NHS governance. They were fully audited and had a rigorous assurance policy.

The Committee noted that private sector organisation were to be actively encouraged to bid for work from 2016. CSUs would nevertheless be open to apply for work but CCGs were able to choose who they obtained services from. CSUs would be expected to become autonomous from 2016 and NELCSU were currently considering possible organisational forms. Full privatisation had been ruled out but other options were being explored, such as social enterprise. However, they could no longer be part of NHS England.

RESOLVED:

1. That the Commissioning Support Unit be requested to circulate statistics on the percentage of CCG funding spent on commissioning support; and

2. That further reports on progress be submitted to the Committee in due course.

9. SPECIALIST CANCER AND CARDIOVASCULAR SERVICES - UPDATE

Neil Kennett-Brown from NELCSU provided an update on the further development of proposals to reconfigure specialist cancer and cardiovascular services. He reported that 1,200 lives per year could be saved if performance in London in the services in question merely matched the England average. The proposals for the reconfiguration had originally been part of Lord Darzi's Healthcare for London 2007 report.

Another period of engagement was currently in progress, following agreement on the commissioners' (CCGs and NHS England) preferred options. These preferred options had very few changes from the original proposals, with the only ones of significance being to oesophageal cancer where two specialist surgery centres were now recommended.

The Committee noted that the Royal Free would be a net recipient of services (renal cancer) and additional car parking plus improved patient transport had now been factored into the proposals. Final decisions would be taken at the end of July following consideration of the engagement feedback by CCGs and NHS England. If approved, the proposals would be implemented over the next three years. All of the joint health overview and scrutiny committees covering the area had indicated their support for the proposals.

Mr Kennett-Brown reiterated that, in terms of cancer, it was only the most specialised surgical procedures that would be centralised and that this would only impact on a small minority of patients. One of the principal aims was that specialised centres would become system leaders. He also emphasised the importance of early diagnosis.

The Committee commented that it was important that providers were scrutinised rigorously on their delivery of the changes and that appropriate processes were in place to ensure that this happened.

The Committee commented that the reconfiguration was a very good example of good engagement and transparency by the NHS.

The Committee noted that NELSCU could undertake such transformation work for a variety of NHS organisations, including acute providers. The rate of change and transformation within the NHS was accelerating and the CSU was working with commissioners and providers to help deliver this. CCGs have the responsibility for local strategic direction. The CCGs covering north central London were collaborating to produce a single five year plan for the whole area which would articulate the sort of changes that needed to happen in the forthcoming years.

10. MEETING OF BARNET, ENFIELD AND HARINGEY MEMBERS - MINUTES

RESOLVED:

That the minutes of the meeting of Barnet, Enfield and Haringey Members of the JHOSC on 24 March 2014 be approved.

11. WORK PLAN AND DATES FOR FUTURE MEETINGS

RESOLVED:

1. That meetings of the Committee be arranged on the following dates:

    - 19 September (Haringey);
    - 21 November (Barnet);
    - 16 January (Enfield); and
    - 20 March (Camden)

2. That the following items be added to the work plan:
    - Royal Free acquisition of Barnet and Chase Farm – Ongoing progress;
    - District nursing
    - Access to GPs/Primary Care Case for Change
    - Ambulance services.

Gideon Bull
Chair

North Middlesex University Hospital NHS Trust

North Middlesex University Hospital

Quality Report

Sterling Way,
London,
N18 1QX
Tel: 020 8887 2000
Website: www.northmid.nhs.uk

Date of inspection visit: 4-6 June 2014 & 23 June 2014
Date of publication: 21 August 2014

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

Ratings

Overall rating for this hospital	Requires improvement
Accident and emergency	Requires improvement
Medical care	Requires improvement
Surgery	Good
Critical care	Good
Maternity and family planning	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

North Middlesex University Hospital is the main acute hospital for the North Middlesex University Hospital NHS Trust, which provides acute medical and surgical services to a population of 350,000 people across the London boroughs of Haringey, Barnet, and Enfield, and surrounding areas.

We carried out this comprehensive inspection because the trust is an aspirant foundation trust, prioritised by Monitor.

We inspected all the main departments of the hospital: accident and emergency, including the urgent care centre; medical wards, including care of the elderly; surgical wards and theatres; critical care; maternity and family planning; services for children and young people; end of life care and outpatient departments.

Overall, this hospital requires improvement.

We rated it good overall in the following departments: surgery, critical care, maternity and family planning, and services for children and young people. However, we rated accident and emergency, medical wards, end of life care and outpatients as requiring improvement.

While we rated the hospital good overall in caring and providing effective care, it requires improvement overall in providing safe care, being responsive to patients' needs and being well-led.

Our key findings were as follows:

- Most patient, carer and patient relative feedback was positive in relation to the care being provided by the hospital.
- The hospital had fully embraced the increased workload brought about by the reconfiguration of hospital services under the Barnet, Enfield and Haringey strategy and the closure of Chase Farm Hospital accident and emergency department.
- While the hospital had achieved much in absorbing increased numbers of patients, its infrastructure of staffing levels, training provision, complaints handling and governance had been stretched, and there had been an underestimate of the resources needed to maintain services at the current level.
- The improved environment with the extensive rebuilding programme had undoubtedly enhanced patient experience.
- We saw examples of good practice in most areas and of dedicated care in the maternity department (despite overstretched resources), ambulatory care unit and hospital mortuary.
- We saw many examples in every area of the hospital of staff giving treatment in a caring and compassionate way.
- In surgery, the clinical teams coped well with the pressures of high demand by working with commitment and flexibility while maintaining a calm and professional atmosphere.
- We saw examples of good multidisciplinary working contributing to areas of good practice (for example, the use of the 'five steps to safer surgery' procedure and enhanced treatment and recovery pathways).

We saw several areas of outstanding practice including:

- The trust had developed partnership working with local primary care providers to address the poor use of primary care services by the local population. This included regular teleconferences with local authorities and other services to tackle frequent inappropriate visits to the trust by the same patients, and delayed transfers of care.
- The trust had recently launched a health bus to inform the local community about the availability of, and access to, primary care services, and to offer basic health checks to people in its catchment area.
- The trust had developed an in-house database to improve the quality of care to patients with HIV; it was marketing this database to other providers.
- The department had an innovative pathway for patients with sickle cell conditions. Staff displayed a high level of knowledge in diagnosing and treating this specialism.

Summary of findings

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

Importantly, the trust must:

- Take action to ensure that the outpatients department is responsive to the needs of patients, in that appointments are made in a timely manner, those with urgent care needs are seen within the target times, cancellations are minimised and complaints are responded to.
- Take action to improve its training – both mandatory and non-mandatory – and its recording and administration of training records and training renewal requirements.
- Ensure that the provision of ambulatory care maintains people's privacy and dignity.

In addition the trust should:

- Review the needs of people living with dementia across the hospital to ensure that they are being met.
- Review the use of the decontamination room in A&E, which poses a contamination risk to the rest of the hospital. This was closed during our inspection following highlighting our concerns.
- Ensure that medicines are stored safely in A&E and that systems for recording take home medication are consistent throughout the hospital.
- Ensure that A&E staff undertake risk assessments for those patients at risk of falls or pressure sores.
- Review the risk assessments for the ligature points noted in the psychiatric assessment room in A&E.
- Ensure that there is adequate provision of food and drink for patients in A&E who are waiting for long periods, including at night.
- Improve patient discharge arrangements at weekends.
- Improve investigation and response times to complaints, particularly in A&E and outpatients.
- Ensure that the lines of responsibility between A&E and children's' services over the responsibility for the paediatric A&E are clear to staff during a period of change.
- Review arrangements for the consistent capture of learning from incidents and audits and ensure that learning and audit data is always conveyed to staff.
- Improve medical recording to remove anomalies and inconsistencies in records, paying particular attention to elderly care wards and take steps to improve the security of records in surgery.
- Review the provision of specialist pain nurse support across the whole hospital.
- Ensure consistent ownership and knowledge of the risk register across all nursing and medical staff.
- Review decisions made at a senior non-clinical level being unchallenged and having a potential clinical impact on patient welfare.
- Review development and promotional prospects and progress for staff, such as healthcare assistants.
- Review and implement a system for updating national guidelines in maternity and palliative care.
- Improve documentation around assessment of mental capacity in end of life care.
- Improve consistency of use of early warning scores for deteriorating patients.
- Improve documented guidance for staff around referral of patients to palliative care.
- Increase mortuary capacity beyond current temporary arrangements.
- Appoint a non-executive director with responsibility for end of life care.
- Review clinic cancellation processes to avoid clinic appointments being cancelled at short notice.
- Review appointment arrangements to ensure that appointments are not booked at unsuitable times or clinics overbooked in error.
- Review the waiting areas in outpatient clinics, particularly the eye, fracture and urology clinics at busy times to prevent people having to stand while waiting.
- Review follow-up outpatient appointment arrangements to increase capacity to organise follow-up appointments in some of the outpatient clinics. This includes dietician, nephrology, paediatric urology and hepatology clinics where no appointments were available within 5 weeks.

Summary of findings

- Improve communication with outpatient staff and their involvement in the development of the service to ensure service vision and values are understood and fully supported by staff. Allow staff increased opportunity to express their concerns related to developments within the trust and how this affects their day-to-day work.
- Accelerate plans to move to 7-day working across all core services. The support for patients recovering from surgery is limited at weekends with no access to occupational therapists, physiotherapists or clinical nurse specialists.
- Improve the recording of care on the labour ward.
- Improve access to records for community midwives.
- Review the impact of the Barnet, Enfield and Haringey strategy, its impact on staff and its potential impact on quality of care.
- Review the heavy reliance on agency staff due to a 20% shortage of paediatric nurses in the neonatal unit.
- Review inconsistency around documentation of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms.
- Improve training for junior doctors on palliative care.
- Improve the privacy and dignity of patients during the reception process and waiting times to see a clinician within the Urgent Care Centre during the reception process.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Requires improvement 	The trust told us there was an over-reliance on accident and emergency (A&E) services from the people living in the local community. This had an impact on the numbers of people attending and the pressure on the department. Patients at risk of deteriorating were not always identified early, which may lead to poorer outcomes. Medicines, not including controlled drugs, were not being stored safely within the department and could be accessed by children, patients or members of the public. During our inspection, we observed good care being given to patients in a friendly and considerate manner. All the patients and relatives we spoke to were positive about the care they had received and said things had improved in recent years. However, the privacy and dignity of patients attending the urgent care centre (UCC) were not respected during the reception process. There was no robust auditing process for validating breaches of this target. Patients may have prolonged waits to be seen by a clinician in the UCC. We found that the needs of people living with dementia were not being met. Staff had not received training in caring for people living with dementia and showed a limited understanding of the condition. The paediatric A&E was providing a service that was responsive to the needs of both children and their carers and parents. The managers of the department did not always consult or inform staff about key changes.
Medical care	Requires improvement 	The medical service requires improvement across the safe, effective, responsive and well led domains, however caring was found to be good. The hospital failed to capture learning from some incidents and, when it did, that learning was not always conveyed to staff. There were numerous anomalies and inconsistencies in records across medical wards, which raised considerable concern on the wards for older people. Senior nursing staff told us that they had no difficulty in obtaining permission to recruit staff. Patients' nutrition and hydration needs were being

Summary of findings

met. There was comprehensive multidisciplinary team working in patient care, on ward rounds and in ward meetings. Patients reported being treated with dignity and respect. We observed staff being polite to patients and involving them in their care.
The trust stated that it had implemented its plans to deliver the BEH clinical strategy. We found the older persons' assessment unit (OPAU) and ambulatory care unit operating in the same cramped space with medical day patients and a diabetes outpatients clinic. This impacted upon the responsiveness of the service to patients in this area. While we found that local leadership on many wards was good, some staff members felt unsupported in their role or in being able to progress within the trust. Less than 50 per cent of nursing staff were compliant with full mandatory training requirements.

Surgery

Good

Demand for surgery (in particular, emergency surgery) was higher than had been anticipated and this put pressure on the surgical assessment unit, theatres, recovery areas and wards. Good team work and staff commitment had limited the impact of this, but patients often experienced delays. Surgical patients were protected from the risks of surgery by the effective use of the 'five steps to safer surgery' procedure. There was good awareness of patient safety and the importance of reporting incidents. We saw evidence of action taken in response to patient safety incidents.
Surgical services were delivered in line with best practice, for example in the use of enhanced care pathways across all specialties. The trust had appointed emergency surgeons and a theatre was available at all times for emergencies. Nursing staff were caring and responsive. There was a high level of awareness of the importance of taking into account patients' cultural and religious needs. The patients we spoke with were very positive about the hospital and its staff. They said they had received good explanations about their treatment. Patient records were not always well organised and some were incomplete. We also found discharge summaries were often incomplete.
There was effective multi-disciplinary working with allied health professionals at pre-assessment and on

Summary of findings

the ward to enhance patient recovery and facilitate discharge. There was good teamwork in the areas we visited and nursing, medical and surgical staff communicated effectively.

Critical care

Good

We found the critical care complex to be good overall. Patients' needs were met by the service, and patients were cared for in a supportive way. There were criteria for admission to the unit run by intensive care staff. Patients were treated according to national guidelines and evidence-based practices. They and their families told us they felt the unit was safe and the care they received was "very good". Staff used clinical governance methodologies, such as audits, to monitor the quality of treatment and the clinical outcomes for their patients. However, some staff were not fully aware of this governance and quality monitoring. They reported incidents so they could improve on the quality of care patients received. There were processes to ensure patients received care and treatment that was as risk free as possible, and other processes to prevent the spread of infection and monitor risk.
There were enough staff to care for and treat patients effectively. Staff were aware of the department's values and vision, and felt supported by the senior clinicians and nurses to report incidents without the fear of being blamed. There was enough equipment for staff to perform their duties appropriately, and the unit was clean and hygienic. Staff training was supported by competent practitioners based in the unit.

Maternity and family planning

Good

The maternity unit was spacious, modern and clean. Women and their partners said that the staff were caring and friendly. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in planning and decision making. The ratio of births to midwives was higher than the national average, but a review against Birthrate Plus was planned. Additional staff may be needed given the complexity of cases on the labour ward. The postnatal/antenatal ward was waiting to move to new premises and was cramped by comparison with the other areas, but women were reasonably happy with the care there. We were

Summary of findings

conscious of shifts being understaffed and of midwives being under pressure. Staff did not seem to be distributed to provide optimum care for mothers.
Midwives we spoke to had a good awareness of safeguarding and there were clear multidisciplinary procedures for safeguarding and child protection concerns.
There was good multidisciplinary team working throughout the service. Staff development and continuing professional development had been somewhat neglected in the move to the new building and staff and system change. The management was in transition and a number of changes had recently been introduced. It was too soon to assess their impact. Although the service appeared to be running well, the trust needs to conduct more audits to assess performance against local and national standards. Risks arising from incidents were promptly and appropriately managed but some issues, such as some unfilled shifts or the unavailability of records, were not identified as risks.

Services for children and young people

Good

Parents and children were complimentary about the care and treatment provided. Parents felt that staff of all disciplines were compassionate, understanding and caring. Staff in paediatrics considered they worked in supportive teams and responded to children's needs effectively.
Children's services had reported no Never Events from January 2013 to the time of the inspection. From January 2013 to March 2014, there had been no serious incidents in the children's services. On 2 June 2014, there was a medication error, which had been reported through the Datix system and an investigation was in progress.
The hospital had recently recruited seven nurses (grade B5) for the children's ward. However, the neonatal unit (NNU) had a 20% shortage of nurses, which was not on the risk register. We were told that recruitment for the NNU was in progress and that regular agency nurses were being deployed to make up staff numbers The rest of the children's services were adequately staffed. The hospital employed 16 consultant paediatricians who also specialised in various medical fields, such as sickle cell anaemia,

Summary of findings

diabetes, asthma and allergies. A consultant-led seven-day service was provided, supported by a team of registrars and junior doctors, who were on site out of hours.

End of life care — **Requires improvement** 

We found that many of the services that supported end of life care to patients were working under considerable pressure, due to workload. Staff working on the wards felt able to contact the palliative care team for advice but this service only operated during weekdays within office hours. This meant that, most of the time, advice was not available, and patients received a different level of service outside normal office hours.

Staff were using an end of life care bundle, adapted from the Liverpool Care Pathway (LCP) that had been phased out across the trust. The relatives we spoke to felt that all staff were caring and the palliative care team was supportive and had involved them in decisions about their relatives' care. They also said they had been allowed to spend time with their loved one outside of normal visiting hours.

The palliative care team was aware of which patients were under their care. We saw records that showed they had reviewed and amended medication, and had prescribed additional anticipatory medication if needed. We also saw evidence, however, that staff were concerned about giving this medication because of possible side effects and in some cases did not administer it. This meant that patients did not always receive the medication they could have had to ease their symptoms.

There were inconsistencies in the completion and review of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, and people who lacked capacity were not routinely having their capacity properly assessed and documented.

The mortuary staff and bereavement team showed a strong sense of ownership and went out of their way to ensure the deceased were treated with respect and dignity and that families and friends received compassionate care. On the day of our inspection, some of the deceased were being housed in

Summary of findings

temporary fridges that had been in use since December 2013. We saw data that showed there had been times when the mortuary was close to being unable to house any more people.

Outpatients **Requires improvement** 

The service provided by the outpatient department required improvement in terms of protecting people from avoidable harm. There were systems for reporting and investigating incidents; however, not all staff were aware of the actions that had been taken in response. Other aspects of safety were suitably monitored. Records of staff training showed that some staff were not up to date with their mandatory training. The hospital did not ensure that outpatient clinics were adequately staffed at all times.

The hospital ensured that suitable clinical guidelines were followed for different patient pathways. Some patients had limited access to follow-up appointments. Staff were competent and knowledgeable; however, not all of them had been appraised. We found good examples of multidisciplinary working.

Outpatient services were caring. We observed patients being treated with compassion, dignity and respect. Many of the patients we spoke to felt they were offered a kind and caring service. We were told that staff were helpful and polite most of the time. The hospital was able to provide emotional support to patients who had received bad news.

The hospital was not responsive to the needs of patients. Some of the clinic appointments were cancelled at short notice. Clinics were busy and some appointments were booked at unsuitable times and some clinics were overbooked in error. The trust did not respond to patients' complaints in a timely manner.

Although we observed strong local leadership and examples of good team work, the senior management of the hospital was not visible in the outpatient departments. Some of the staff said they had not been listened to regarding key service changes affecting their day-to-day work. Staff were not aware of how they had performed in relation to referral to treatment targets. They were also unaware of the key performance indicators set for their clinics.

Requires improvement

North Middlesex University Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to North Middlesex University Hospital

North Middlesex University Hospital was selected for inspection, under CQC's revised inspection approach, because it is an aspirant foundation trust, prioritised by Monitor. CQC's latest intelligent monitoring tool placed the trust in Band 5 (Band 1 is the highest priority for inspection and Band 6 the lowest priority). We selected a number of trusts in lower bands to ensure that our assessment of risk was robust.

The hospital serves the London boroughs of Enfield, Haringey, Barnet and surrounding areas with a local population of more than 350,000. Haringey is the 13th most deprived local authority area and Enfield the 64th most deprived out of a total of 326.

Our inspection team

Our inspection team was led by:

Chair: Professor Ted Baker, Deputy Chief Inspector for Hospitals, Care Quality Commission

Deputy Chair: Elaine Jeffers, Specialist Clinical Advisor

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

Inspection Manager: Robert Throw, Care Quality Commission

The team included CQC inspectors and a variety of specialists including: two previous board level managers, a consultant nephrologist and divisional director of medicine, a subspecialist urogynaecologist, a consultant in accident and emergency medicine, the clinical director for surgery and critical care, two clinical fellows, a consultant nurse for older people, a theatre manager, a trauma nurse co-ordinator, a modern matron, a former head of midwifery, a patient safety and clinical governance manager, a senior lecturer in children's health, a student nurse and two experts by experience.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the trust and asked other organisations to share what they knew about the hospital. This included local clinical commissioning groups, the NHS Trust Development Agency and local Healthwatch groups. We held a listening event on 3 June 2014 to hear people's views about care and treatment received at the hospital and carried out announced inspections to the hospital and wards on 4, 5 and 6 June. We also carried out an unannounced inspection on 23 June of the day surgery unit, ambulatory care unit and maternity department.

As well as observing care on the wards, we spoke to patients, their relatives and carers, and members of staff. We held focus groups of consultants, senior and junior doctors, senior and junior nurses, healthcare assistants and allied health professionals, and non-executive directors. We conducted formal interviews of senior staff including the chief executive, chair and director of nursing. We also held two drop-in sessions for individuals who wanted to talk to us, and we reviewed information from comment cards that people had completed. We also inspected the hospital early in the morning and in the late evening to observe care.

Facts and data about North Middlesex University Hospital

Context

- The trust is not a foundation trust but aims to have foundation trust authorisation in April 2015.
- 417 inpatient beds

Detailed findings

- Serves more than 350,000 people
- Employs 2,985 whole time equivalent staff
- Annual turnover: around £216 million
- Deficit: £1.85 million in 2012/13

Activity (2012/13)

- Inpatient admissions 49,723
- Outpatient attendances 266,855
- Accident and emergency (A&E) attendances 150,132
- Deliveries 4,050 between October 2012 and November 2013
- Births 4,355 between October 2012 and November 2013 (includes multiple births)
- Home births: according to the data pack, page 109, "Home births are excluded, as the level of information recorded in HES for these births is not detailed enough to be used in our analysis."

Intelligent Monitoring

- Safe: Items = 8, Risks = 1, Elevated = 0, Score = 1
- Effective: Items = 31, Risks = 1, Elevated = 1, Score = 3
- Caring: Items = 5, Risks = 1, Elevated = 0, Score = 1
- Responsive: Items = 10, Risks = 0, Elevated = 0, Score = 0

Total: Items = 54, Risks = 3, Elevated = 1, Score = 5

Safety

- No Never Events since January 2013
- Strategic Executive Information System (STEIS) 105 serious incidents (April 2013–March 2014)
- National Reporting and Learning System (NRLS) (April 2013–March 2014)

Death: 6

Severe: 4

Moderate: 86

NHS Safety Thermometer (March 2013–February 2014)

- New pressure ulcers better than the national average for all months except July 2013
- Venous thromboembolism above national average except for March 2013 and November 2013
- Catheter-related urinary tract infections below national average for most of the period (except for 4 months)
- Falls with harm below national average for the whole period except for 2 months

Infections (April 2013–March 2014)

- C. difficile 20 cases. Statistical analysis of C. difficile infection data over the period December 2012–November 2013 shows that the number of infections reported by the trust was within a statistically acceptable range.
- MRSA 6 cases. The number of MRSA bacteraemia infections attributable to the trust is higher than the expected range relative to the trust's size and this has been flagged as a 'Risk' in Hospital Intelligent Monitoring.

Effective

- Hospital Standardised Mortality Ratio (HSMR) – No risk
- Summary Hospital-level Mortality Indicator (SHMI) – No risk

Caring

CQC inpatient survey (10 areas): worse than other trusts for two areas of questioning and about the same as other trusts for the remaining eight areas.

Cancer patient experience survey: worse than other trusts for 39 out of 69 questions; the same as other trusts in 29 questions and better than other trusts for the remaining question.

Responsive

Bed occupancy 97.4% between October 2013 and December 2013

A&E 4-hour target: the trust's performance varied widely over the period, being both above and below the England average. Since December 2013, the trust breached the 4-hour target in 7 weeks out of 21.

Cancelled operations: similar to expected

Delayed discharges: similar to expected

Referral to treatment times under 18 weeks: admitted pathway: no evidence of risk

Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test (April 2013): no evidence of risk

Well-led

NHS Staff Survey 2013 (28 questions):

Better than expected or tending towards better than expected for five questions

Detailed findings

Within expectations for seven questions

Worse than or tending towards worse than expected in 16 of the 28 key findings

Sickness rate 3.6% below the national average between April 2011 and September 2013.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Accident and emergency

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The accident and emergency department (A&E) at the North Middlesex University Hospital is one of the busiest in London, seeing about 189,000 patients this financial year compared with 150,000 in 2013. The unit was modernised in 2010 at a cost of £123 million. In December 2013, the A&E department at nearby Chase Farm Hospital closed, leading to a large increase in patients attending North Middlesex University Hospital

We inspected all the areas within the department: resuscitation (Resus), area 1 (Minors and Majors overflow), area 2 (Majors, more seriously ill patients), the paediatric area, the observation ward and the urgent care centre (UCC). During our inspection, we spoke with 17 members of staff and 21 patients. We examined 54 sets of medical notes for patients who had been treated in the department.

Summary of findings

The trust told us there was an over-reliance on accident and emergency (A&E) services from the people living in the local community. This had an impact on the numbers of people attending and the pressure on the department. Patients at risk of deteriorating were not always identified early, which may lead to poorer outcomes. Medicines, not including controlled drugs, were not being stored safely within the department and could be accessed by children, patients or members of the public.

During our inspection, we observed good care being given to patients in a friendly and considerate manner. All the patients and relatives we spoke to were positive about the care they had received and said things had improved in recent years. However, the privacy and dignity of patients attending the urgent care centre (UCC) were not respected during the reception process. The trust's performance on waiting times for treatment was inconsistent but often met the 4-hour target. There was no robust auditing process for validating breaches of this target. Patients may have prolonged waits to be seen by a clinician in the UCC.

We found that the needs of people living with dementia were not being met. Staff had not received training in caring for people living with dementia and showed a limited understanding of the condition. The paediatric

Accident and emergency

A&E was providing a service that was responsive to the needs of both children and their carers and parents. The managers of the department did not always consult or inform staff about key changes.

Are accident and emergency services safe?

Requires improvement

The A&E department requires improvement to ensure that services protect patients from avoidable harm. Medicines, apart from controlled drugs, were not stored safely. We found the paediatric A&E cupboards used to store them were not locked and the door of the treatment room containing medicines was unlocked and left open.

Patients in the 'Majors' and 'Minors' areas of the department who were at risk of deteriorating were not always identified early enough. There was no evidence of good practice in identifying patients who might deteriorate. Patients have prolonged waits to be seen by a clinician in the UCC.

The decontamination room did not have a closed ventilation system. This posed the risk that any airborne substance from a patient could enter the main department and the rest of the hospital. There were enough trained and qualified doctors and nurses for the department to be safe, except on rare occasions of exceptional demand.

Incidents

- All staff we spoke with said they were encouraged to report incidents and received direct feedback from their line manager, clinical leads and in teaching sessions. A department newsletter was available to highlight incidents that had occurred. Doctors had a weekly 3-hour learning session, which was well attended. Nurses also had a weekly learning session but this was not protected time away from the ward.
- Staff were able to tell us of practice that had changed as a result of incident reporting. For example, the department had a high incidence of pressure sores and nurses we spoke with were aware of this and the reasons for it. They were able to describe the actions they took to prevent pressure sores developing in patients at risk.
- Between April 2013 and March 2014, the trust reported and investigated two unexpected deaths that had occurred in the department. The senior managers we spoke to were fully aware of the incidents and had been involved in making changes that had been identified as

Accident and emergency

necessary to prevent future risks to patients. Some of the key changes that had been identified, such as to introduce a 'medical navigator' to the UCC, were still in the planning stage.

Cleanliness, infection control and hygiene

- All areas of the A&E were clean and tidy. We examined seven trolleys and trolley mattresses in different parts of the department. They were all clean and well maintained. The side bars that can be pulled up to stop patients from falling were all working correctly.
- The department had a range of equipment that was seen to be clean, and there was a system of labels to indicate that an item had been cleaned and was ready for use.
- Staff used protective clothing appropriately, regularly washing their hands and using hand gel both between patients and when moving from one clinical area to another. They complied with the 'bare below the elbow' guidance. All the hand gel dispensers were well stocked.

Environment and equipment

- There is a dedicated x-ray unit and convenient access to computerised tomography (CT) scanning and other diagnostic equipment.
- The children's A&E cared for both children being treated in the UCC and more seriously ill children.
- The resuscitation trolleys were correctly stocked and maintained. They were fully checked at each shift change, with records kept to corroborate this.
- There was a risk of patient harm in the psychiatric assessment room where two of the alarm strips had sharp edges and there were potential ligature points around the ceiling vent and door handle. Staff were informed of our observations.
- The decontamination room did not have a closed ventilation system. This posed the risk that any airborne substance from a patient could enter the main department and the rest of the hospital. We immediately raised this concern with the trust and the room was taken out of service.

Medicines

- Medicines, apart from controlled drugs, were not stored safely. We found the paediatric A&E cupboards used to store them were not locked and the door of the treatment room containing medicines was unlocked and left open.
- All drug boxes were accessible to staff and fit for use.

Records

- Medical and nursing records were kept together in single sets of patient notes that were kept safely in filling trays behind the nursing stations. We examined 54 sets of patient notes during our inspection and found that although initial clinical observations, such as pulse and blood pressure were always recorded when patients arrived, only the notes in the resuscitation area had additional observations recorded.
- Medical staff maintained appropriate records, but on every occasion failed to time their entries. None of the paper records indicated the patient's condition at the time of discharge. Nurses did not consistently record when patients received food and drink, and they never recorded if these had been offered but declined.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us consent was mainly verbal for procedures such as receiving medicines and suturing. We did not see examples of patients who did not have capacity to consent to their procedure, but we were able to speak with staff who showed that they understood the requirements of the Mental Capacity Act 2005.

Safeguarding

- Staff we spoke with had a good understanding of safeguarding concerns for adults and children. Access to information on how to report a concern was available and displayed on boards in the department.
- The department had a positive focus on child protection. All children who attended were immediately checked to identify if they were 'at risk' within their home environment. The paediatric department had access to social workers and a health inspection team that was located within the hospital.
- The paediatric unit had effective working relationships with other professionals in the hospital and in wider community.
- Staff in the paediatric department had up-to-date training and exhibited a good level of knowledge about child protection.
- We reviewed 10 sets of patient records and found that on each occasion the notes had been marked to indicate that a check had been made to identify whether the children were on the 'at risk' register and what the result was.

Accident and emergency

Mandatory training

- Staff told us there was good support when they needed to attend external courses as part of their skill development.
- Several nursing staff undertook advanced training in emergency care, particularly the ENPs who undertook extended practices (to enable them to carry out further tests etc.), and worked alongside the consultants during their training and practice skills assessments.
- All the junior doctors we spoke to confirmed that they had an allocated educational supervisor. They described how three different cases would be discussed at the weekly training sessions, which were compulsory.
- Staff had relevant, up-to-date training in life support, advanced life support and paediatric life support.

Assessing and responding to patient risk

- The department had a system of rapid assessment and treatment (RAT) for the immediate review of patients arriving by ambulance. From 10am to 6pm, a senior doctor oversaw the process. Outside these hours it was a senior nurse. This system ensured that patients received a clinical handover from the ambulance service, an early clinical diagnosis and early treatment.
- Walk-in patients were seen by a receptionist, who decided if they were suitable for the UCC or more serious and needing to go to the main A&E. If the receptionist decided on the UCC, they enter the patient's personal details onto the computer with a few words describing their condition. A triage nurse then used this information to decide if the patient should see the triage nurse, a GP or an ENP.
- We found that, during April and May 2014, patients who were waiting to see the triage nurse waited on average between 14 and 25 minutes. Patients who were waiting to see an ENP or GP during the same period waited on average between 58 and 78 minutes.
- Good practice states that patients should be seen by a clinical practitioner within 15 minutes of arriving in an A&E department. We found that patients have prolonged waits in the UCC and this increased the probability of their having poorer outcomes from their treatment.
- Staff did not undertake risk assessments for patients at risk of falls or pressure sores. This meant there was no process to ensure that the risks of those events occurring were reduced.
- We found that the department used the recognised modified early warning score (MEWS) to clinically assess patients and identify if their condition was deteriorating. Staff we spoke to in the resuscitation area were aware of this process and used a specific form to make regular records of patients' vital signs. We examined 8 sets of notes in the resuscitation area and found that all of them contained properly completed MEWS monitoring forms.
- When we examined 34 sets of patient notes from other parts of the department, we found that none of them contained MEWS forms. Five nurses we spoke to told us that the forms were only used in the resuscitation area, two others told us they had never seen the forms before. Patients whose condition might deteriorate in Majors and Minors were therefore at risk of not being identified early enough due to the use of different observation charts.
- In the 34 sets of notes we looked at, we also found that patient observations were not being recorded after the initial set of observations had been done on arrival. Nurses we spoke to were able to describe correctly how they monitored patients and when it would be appropriate to seek assistance from a clinical colleague.
- Nursing handovers occurred three times a day and consisted of information on a patient's presenting condition, treatment given, tests undertaken or awaited, recent hospital admissions and relevant social circumstances. Staffing for the shift was discussed, as well as any high-risk patients or potential issues. We observed two nursing handovers during our inspection and found them to be effective and well organised.
- Medical handovers occurred three times a day in the morning, late afternoon and night. We observed one handover. We found that doctors were not clear which areas they had been allocated to. The handover was focused on general staffing issues and individual patient care was not discussed. The handover was unstructured and there was a risk that important medical information might be omitted.

Nursing staffing

- There were enough nurses in the department to maintain safety; however, the increase in the number of patients since the closure of Chase Farms Hospital's A&E meant that nurses often had to work under increased pressure.

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- The department had an establishment of 17 registered nurses during the day and 15 at night. Managers told us that there were often two or three nurses short on a shift. Those numbers were sometimes made up by using agency staff, but that did not always happen.
- In addition to nursing staff, there were usually between two and four healthcare support workers, who would undertake activities such as taking blood samples, doing electrocardiograms (ECGs), and making sure patients had food and drink and were able to go to the toilet.
- Staff told us that, when the department was short of nursing or support staff, they would work very hard to make sure that patient care did not suffer, but sometimes activities like checking on food and drink would get missed.
- Nurses told us that they felt the number of nursing staff had not increased sufficiently to meet the additional number of patients attending following the closure of Chase Farm Hospitals A and E department. There was to be an independent review of nursing levels in mid-June 2014
- During the day, the paediatric A&E was expected to have three paediatric nurses and one healthcare assistant at all times. At night, it was two paediatric nurses, one general nurse and one healthcare assistant. Staff told us that they generally achieved this level but, when staff went sick at short notice, replacement paediatric nurses were very difficult to find. They said the number of paediatric nurses had not increased to take account of the higher number of patients attending as a result of the closure of Chase Farm Hospital's A&E.
- Staff told us that there was good medical cover in the paediatric department and paediatricians would attend from the main paediatric ward whenever they were needed. We observed paediatricians working in the department. Staff told us there was a very good working relationship between the paediatric A&E and the main paediatric ward.

Medical staffing

- There was sufficient medical cover in the department for it to be safe. The College of Emergency Medicine (CEM) recommends that an A&E department should have enough consultants to provide cover 16 hours a day, 7 days a week. The trust currently met this recommendation with a consultant always on duty between 8am and midnight.
- There were 9.4 permanent consultants in post from a target establishment of 11. Another consultant was due to start shortly.
- There were two middle grade trainees and 10 middle grade doctors employed by the trust. There were always two registrars on duty at any time.
- We saw that the medical team worked well together, with consultants being available for junior doctors to discuss patients and receive advice.
- The department had low levels of sickness absence for nursing staff and very low levels of for medical staff.

Major incident awareness and training

- Staff we spoke with told us that the hospital staff practise for major incidents regularly, and that the hospital could be secured in the event of a major incident. The practice development nurse had knowledge and experience of attending emergency table-top exercises, which included a chemical, biological, radiological or nuclear incident (CBRN).
- While staff received 'in-house' training for major incidents and decontamination events, no staff had had any external major emergency management training. The emergency planning officer described appropriate high-level major incident planning (such as interagency), but there was no evidence that nursing staff in the department knew about this.
- Security staff were based in the unit at all times. They were able to provide additional support for nursing staff when patients required one-to-one observation because of actual or potential violence or aggression. They were trained and readily available when needed.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Staff in the A&E department showed good clinical practice following accepted national and local guidelines. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs.

Patients were at risk of not getting appropriate nutrition, particularly at night, weekends and during periods of high

Accident and emergency

demand. The department was good at undertaking clinical audits and incorporating the learning into improved care for patients. Specific examples were 'Fever in children' and 'Renal colic'.

Evidence-based care and treatment

- The A&E department used a combination of National Institute for Health and Care Excellence (NICE) and CEM guidelines to determine the treatment they provided. Local policies were written in line with this, and updated regularly.
- There were specific pathways for certain conditions (for example, sepsis, acute cardiac syndrome, renal colic and head injury).
- We looked at the way the department dealt with patients who had sepsis. Staff displayed good knowledge of treatment options.
- The department had an innovative pathway for patients with sickle cell conditions. Staff displayed a high level of knowledge in diagnosing and treating this specialism.
- The department had good access to radiology services at all times. It had a dedicated x-ray area and preferential access to one of the two trust CT scanners that was located close by.

Pain relief

- The department had undertaken a pain relief audit. This indicated a number of areas in need of improvement.
- Two of the patients we spoke to had been in pain during their attendance. They both told us they had been given pain relief soon after arriving at the hospital. Staff we spoke to were aware of the appropriate guidance on providing pain relief to patients.

Nutrition and hydration

- A housekeeper was responsible for ensuring that patients are offered hot or cold drinks and sandwiches. However, we were advised that there was only one housekeeper and they did not work weekends**.** This meant that, most of the time, nurses were responsible for ensuring that patients received food and drink. The nurses we spoke to were all aware of this responsibility but most said they often did not have the time to get food and drink for patients.
- Most of the patients we spoke to in the department told us that they had not been offered food or drink while they had been there. There was a risk that patients would not receive appropriate nutrition while in the department.

Patient outcomes

- The mortality rates for the trust did not raise any cause for concern during the national monitoring process.
- The trust as a whole participated in 47 of the 51 national clinical audits for which it was eligible. In addition, the department participated in two clinical audits managed by the CEM. These audits were of fever in children and renal colic.
- The department managers were all aware of these audits and had made improvements in practice as a result of them. We noted that for both audits the department had significantly improved performance.
- Unplanned re-attendances for the department in the past year were between 8% and 9%, which was worse than the target of 5% set by the CEM.

Competent staff

- We observed that clinical practice by both doctors and nurses was within accepted guidelines. Staff were competent and exhibited a good level of knowledge. They were aware of NICE and CEM guidance.
- All the nurses in the paediatric A&E were qualified in both paediatrics and emergency care.
- All staff we spoke to had undergone an annual appraisal within the past 12 months. Most told us they enjoyed working in the department and all said everyone got on well with each other.

Multidisciplinary working

- We observed three handovers from the ambulance service to the A&E staff. They were well structured and ensured that all the relevant clinical information about the patients was properly conveyed.
- We spoke to five members of the London Ambulance Service during the inspection. They all told us that this was one of the better hospitals for handing over patients. They tended to wait for less time and staff listened to what they said. One person told us, "Yes, it's the best one I come to. The nurses here are very professional."
- We spoke to two members of the admission avoidance team. They told us that some patients were being discharged too quickly, before there was time to put community support in place.
- Staff told us that GPs usually referred patients to the department with the correct paperwork and only if they really needed to be there. There were also good examples of A&E staff working well with social workers

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in the community to ensure prompt and effective discharge. These good working relationships meant that patients were referred to the right areas of the hospital for their medical needs.

Are accident and emergency services caring?

Good

The department had scored poorly in the NHS Friends and Family tests over the past year but this had improved recently and it was now meeting the London average.

During our inspection, we observed good care being given to patients in a friendly and considerate manner. All the patients and relatives we spoke to were positive about the care they had received and said things had improved in recent years.

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

Compassionate care

- The A&E Friends and Family Test highlighted that the trust was performing below the England average from January to March 2014 when they scored 47. In the past 2 months, performance had improved and the score of 58 in April and May puts the department close to the London average.
- We spoke to 21 patients and they all told us they were happy with their care. One said, “It’s fine here; I have no complaints.” Another said, “I have been coming here for years and it’s so much better than it used to be.” We found examples of patients who had been in the department for some time but had not been fed. One, who had been there for 3 hours, said, “No, I haven’t been offered a drink or anything.”
- It is good practice for an A&E department to undertake ‘comfort rounds’ at regular intervals to ask people if they need something to eat or drink, or help to go to the toilet. We raised this with a senior manager, who told us that such rounds should have been undertaken.
- All the children and their parents or carers we spoke to were positive about the care they had received in the children’s area of the A&E. We found that staff were caring and able to meet the needs of their patients. There were always specially trained nurses on duty.
- During our inspection, we observed good care being given to patients in a friendly and considerate manner. We also noted that people’s privacy was respected by curtains being drawn when personal care was given. Staff lowered their voices to prevent personal information being overheard by other patients.

Patient understanding and involvement

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care. One person said, “Yes, they have told me what is going on; the doctor has been to see me three times to keep me updated.” Another said, “I know exactly what is going on. I am just waiting for my blood test to come back and then I can go home.” Patients had a good understanding of their conditions and had been given treatment options by clinicians.
- Parents accompanying their children in the children's A&E were positive about the treatment their children had received. They said that the nurses and doctors had been understanding and supportive. One parent told us, “I think they’re great. They listen to us and try to do their best.”

Emotional support

- The A&E staff had a protocol on how to deal with relatives who experienced bereavement. They displayed compassion when talking about this area.

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

Requires improvement

The department had a good understanding of patient flow and managed the system well to ensure most patients accessed the appropriate care pathway for their needs. The trust’s performance with regards to waiting times was inconsistent but often met the 4-hour target. There was no robust auditing process for validating breaches of that target.

We found that the needs of people living with dementia were not being met. Staff had not received training in caring for people living with dementia and showed a limited understanding of the condition. The paediatric A&E was providing a service that was responsive to the needs of

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both children and their carers and parents. There were effective paediatric pathways, and staff were responding appropriately to the needs of the children in the department.

Complaints were not always dealt with in a timely manner and interpretation services were not used consistently.

Service planning and delivery to meet the needs of local people

- Trusts in England are given a target by the government of admitting, transferring or discharging 95% of patients within 4 hours of their arrival in the A&E department. The trust's performance with regards to waiting times was on average around 95%.
- The UCC had a large waiting room and a number of consulting rooms where patients were seen either by a GP, an emergency nurse practitioner (ENP) or a triage nurse.
- The environment was child-friendly, with murals on the walls, a play area and a seating area, but there was no provision via recording equipment for patients to watch children's TV programmes outside normal broadcasting hours.
- The trust invested £123 million in a substantial development of the A&E in 2010. The premises are modern, with the capacity to deal with the number of patients who attend.

Access and flow

- Most of the time, the flow of patients from the department into other parts of the hospital was good. It was facilitated by the large number of pathways the trust had put in place to ensure that patients spent as little time as possible in the department or bypassed it altogether.
- Staff within the A&E had good working relationships with local partners such as social services and GPs. Senior staff told us that the department had worked with local GPs to agree the best procedures for referring patients to the hospital. For example, the hospital had both surgical and acute assessment units and patients could be referred directly to one of those without needing to go to A&E.
- Women who attended the department between 10am and midnight with early pregnancy or gynaecological concerns had a specific pathway to the maternity department.
- The department had a dedicated pathway for patients with sickle cell conditions. Previously diagnosed patients would have been issued with a 'patient passport'. If their condition was stable, they would immediately be referred to the sickle cell day centre, which was open 7 days a week from 8am to 8pm.
- Any children identified as suitable, and all those under 6 months' old, were sent to the paediatric assessment unit. All other children went straight into the paediatric waiting room, which served the main paediatric A&E and the paediatric UCC. All children saw the triage nurse. Staff told us they aimed to see all children within 5 minutes, but they did not always achieve that target.
- It was clear that the nurse in charge of patient flow had a good understanding of the process and the current status of every patient. They told us that the trust was proactive in making sure beds were available for patients who needed to be admitted.
- There were a number of reasons why patients breached the 4-hour target. These included lack of a bed on a ward; a delay in A&E review; a delayed specialty review, such as to a surgical team; a delay in transport; or a clinical issue leading requiring the patient to remain in the department longer.
- Patients who arrived by ambulance went to the rapid assessment and treatment (RAT) area of the department, except for those who needed to go immediately to the resuscitation area. From Monday to Friday, the RAT process was led by a consultant or middle grade doctor between 10am and 6pm. At other times, the process was led by a senior nurse. It ensured that patients received an early diagnosis from a senior clinician.
- The UCC was open from 8am to 2am 7 days a week. There was always a triage nurse and an ENP on duty as well as two GPs from 11am to midnight. An A&E doctor provided cover from midnight to 2am. About 40% of patients attending the A&E department were referred to the UCC pathway.
- The trust had an escalation plan that set out clear pathways and processes that needed to be followed if the demand for beds in A&E increased. This covered the normal steady state (Green) and escalated to the declaring of an internal incident (Black).
- The department also had a small observation ward with seven beds where patients could stay for up to 24 hours.

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- Discharge could be more difficult at the weekend when there was less medical cover to assess patients as well enough to go home. Staff told us they often had difficulties finding a porter to take patients to the discharge lounge.

Meeting people's individual needs

- The trust provided a dedicated 24/7 children's emergency service and children were triaged in A&E. All children were cared for by children's nurses. Approximately 100–120 children a day were seen in the department.
- Patients who attended the department spoke many languages. Most went to the hospital with a family member who acted as an interpreter. This is recognised as not good practice. However, we found examples in the main department of reception staff calling on interpreting services for patients. Reception staff in the UCC, however, said they rarely used these services and instead would ask if there was someone else in the waiting room who spoke the patient's language. This practice does not respect people's confidentiality or dignity.
- We found that the needs of people living with dementia were not being met. Staff had not received training in caring for people living with dementia and showed a limited understanding of the condition. Managers told us that the practice development nurse had just completed her dementia training and was due to train other staff.
- The paediatric A&E would often see children with long-term and complex needs. They were issued with a 'passport' setting out details of their condition and care needs, so that staff could provide prompt and appropriate care and treatment in an emergency.
- We found that the paediatric department had a protocol and checklist to be used in the event of a child's death. This ensured that the families' specific cultural needs were likely to be taken into account.
- However, people who attended the UCC had to book in with the receptionist who sat behind a glass screen. Patients were required to give details of their symptoms. This area was part of the main waiting room and people could easily be overheard. Staff told us there was no facility for people to talk privately.
- We looked at the relatives' room where people waited while their seriously ill relatives were being cared for, or where people were informed that a relative had passed away. We found it to be in good condition with clean furniture and tea and coffee making facilities. It was adjacent to a viewing area where people could see their deceased relative.

Learning from complaints and concerns

- The department had a system in place for identifying, receiving, handling and responding to complaints and comments made by patients and those acting on their behalf. Complaints were managed by the governance manager. Patients were made aware of the complaints system. Publicity about complaints, in the form of leaflets and posters, was visible in the department. Most patients told us they would raise any concerns with a nurse.
- The department was slow at investigating complaints; we were told this was because clinicians did not respond quickly when they were asked to provide information. The department was not meeting its target of responding to a complainant within 25 days.

Are accident and emergency services well-led?

Requires improvement

The managers of the department did not always consult and inform staff about key changes. We found there was a significant lack of clarity among staff as to whether the paediatric department or the A&E department was responsible for the paediatric unit in the A&E.

Staff within the department spoke positively about the care they provided for patients. Quality and patient experience were seen as priorities and everyone's responsibility.

A number of staff told us they felt management within the department and the trust was oppressive and overbearing. They said some managers were too focused on performance targets and that, at times, this took priority over patients' care. Managers told us they had an open and approachable style, and did not consider there to be any staff issues. Senior managers were aware that some members of the A&E team are perceived as overly focused on performance targets and this is being addressed.

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Vision and strategy for this service

- Whilst the trust does not have a vision for specific services the staff were unable to articulate the corporate strategic objectives outlined in the business plan. The nursing leadership within the department was disparate and staff were not clear who to go to with issues.
- The main recent strategic change to the A&E had been the closure of the A&E department at Chase Farm Hospital a few miles away. The trust had predicted an increase in patients to the department but, although it increased the number of doctors, many nursing staff feel that it failed to increase the number of nurses. Nursing levels are due to be independently reviewed in June.
- Nursing staff in all parts of the department told us that their workloads had increased significantly since December 2013.

Governance, risk management and quality measurement

- The department held a monthly performance review meeting that covered key issues, such as clinical governance, performance, infection control and staffing.
- The clinical manager was responsible for auditing breaches to targets. Each day, the manager reviewed all breaches and the department's overall performance. When appropriate, he amended records when a breach had been shown on the computer system but in fact had not occurred (for example, when a member of staff had forgotten to update a person's discharge time on the computer system). He then sent an email to the clinical director and operation director.
- Although managers had acknowledged that shortages of staff and delays in UCC triaging were risks, they were not recorded in the department's risk register.

Leadership of service

- The department was led by a clinical director, a clinical manager and a matron. The nurses and doctors we spoke to were all clear as to their lines of supervision.
- The leadership team did not share the same vision for the department. They had different views on what the risks and priorities should be. The matron chaired nursing staff meetings, which were not attended by the other two managers. This created an additional risk of the management team not delivering a consistent message despite a regular email bulletin highlighting key management messages which was sent to all staff.
- We found there was a significant lack of clarity among staff as to whether the paediatric department or the A&E department was responsible for the paediatric unit in the A&E. One manager told us that the department was still being managed by paediatrics but there was a plan for this to change to A&E. Two of the staff in the paediatric unit thought the change had already happened. We could find no evidence that staff had been consulted about the plan.
- Patients in the UCC were receiving a less responsive service than patients in other parts of the hospital. We visited at 10pm and found the main department to be relatively quiet compared with the UCC, which was very busy. The management of the department had not considered the possibility of moving clinical resources from the main department into the UCC so that supply better matched demand.

Culture within the service

- Staff within the department spoke positively about the care they provided for patients. Quality and patient experience were seen as priorities and everyone's responsibility.
- There was positive feedback from trainee doctors who had been on placement in the department. They said they had been made to feel part of the team and staff ensured that they were fully involved in all aspects of patient care and treatment.
- A number of staff told us they felt management within the department and the trust was oppressive and overbearing. They said some managers were too focused on performance targets and that, at times, this took priority over patients' care. Managers told us they had an open and approachable style, and did not consider there to be any staff issues. Senior managers were aware that some members of the A&E team are perceived as overly focused on performance targets and this is being addressed.

Public and staff engagement

- The department traditionally had a poor response rate for the Friends and Family Test but had recently managed to increase this significantly to almost 40% from 10%. Senior managers accepted that they needed to do much more to increase patient involvement and feedback. They were developing a plan to achieve this based on good practice from other trusts.
- The Trust recently commissioned KPMG to review its governance systems. The report findings identified that

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although commissioner engagement is strong staff engagement is an area for further development. Many staff told us that they did not feel informed or consulted about major decisions that were made by management.

Innovation, improvement and sustainability

- The department had undertaken research on the configuration of the UCC. They had developed a plan to improve patient care and responsiveness. The management was unclear, however, about the timescales for implementing these improvements.
- The paediatric department was providing a good level of service to children. However to maintain this the trust need to consider engaging staff with planned changes.

Medical care (including older people's care)

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

Information about the service

The medical care provision at North Middlesex University Hospital includes a short stay medical ward (acute medical unit [AMU]), an acute assessment unit (AAU), an older persons' assessment unit (OPAU),an acute stroke unit, oncology, five general medical wards (one having older people's care as a second specialty), three wards for the care of older people and the Alexander Pringle Centre for patients with HIV infection They are spread between the Pymmes building and the Tower with a programme of refurbishment in progress and due for completion in phases. The ambulatory care unit, which was part of the medical directorate, is currently housed in the outpatient department while the unit is being refurbished.

We spoke with patients, their carers and relatives, members of staff including doctors and nurses, ward managers and senior staff. We reviewed patient and medication records and observed care being delivered on the wards.

Summary of findings

The medical service requires improvement across the safe, responsive and well led domains, however effectiveness and caring was found to be good. The hospital failed to capture learning from some incidents and, when it did, that learning was not always conveyed to staff. There were numerous anomalies and inconsistencies in records across medical wards, which raised considerable concern on the wards for older people.

Senior nursing staff told us that they had no difficulty in obtaining permission to recruit staff. However some staff appeared unaware that a safer staffing tool had been used as an evidence base for staffing numbers. Patients' nutrition and hydration needs were being met. There was comprehensive multidisciplinary team working in patient care, on ward rounds and in ward meetings. However, there were low numbers of clinical nurse specialists to support the delivery of care and patients' emotional needs. Patients reported being treated with dignity and respect. We observed staff being polite to patients and involving them in their care.

The trust stated that it had implemented its plans to deliver the BEH clinical strategy. We found the older person's assessment unit (OPAU) and the ambulatory care unit operating in the same cramped space with medical day patients and a diabetes outpatients clinic with inadequate toilet facilities. Not only did the cramped space increase the risk to patient safety including patients not located but the lack of adequate

Medical care (including older people's care)

toilet facilities posed a risk to infection control. While the trust had sent a copy of its trust dementia strategy there was no clear operational strategy for patients living with dementia on the medical wards. While we found that local leadership on many wards was good, some staff members felt unsupported in their role or in being able to progress within the trust. Less than 50 per cent of nursing staff were compliant with full mandatory training requirements.

Are medical care services safe?

Requires improvement

While the trust stated it had processes to feedback learning from incidents to staff we found that the hospital failed to capture learning from some incidents and, when it did, that learning was not always conveyed to staff. We found that clinical areas were kept clean and tidy. However some side rooms and waiting areas were not always clean and tidy. Hand hygiene was an integral part of care.

Staff told us they had good access to equipment except for adjustable beds. The hospital recognised the need to redecorate some of the wards for older people. The layout of some wards in the Tower and the stroke unit posed a challenge to patient observation. Medicines management and recording were good. However, there were anomalies and inconsistencies in records across medical wards, which raised considerable concern on the wards for older people. Despite this, documentation of the management of deteriorating patients was good.

Safeguarding and safeguarding training appeared under-resourced and staff displayed inconsistent knowledge of the application of the Mental Capacity Act 2005. Less than 50% of nursing staff were compliant with full mandatory training requirements. Senior nursing staff told us that they had no difficulty in obtaining permission to recruit staff. However, the department could not be assured that staffing levels were adequate because we were told that no acuity or nurse staffing tool had been used as an evidence base for the staffing numbers.

Incidents

- Since January 2013, the trust had not reported any Never Events. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. We identified a serious incident in January 2014 when a patient died while waiting in a corridor for a bed on the AMU. We looked at the investigation that was carried out into this incident and the subsequent findings.

Medical care (including older people's care)

- We spoke with nursing staff on medical wards who confirmed that they were aware of that incident, and they told us that neither the outcome of the investigation nor any learning from it had been shared with them.
- We were told that, up until the week before our inspection, the practice of moving patients from the accident and emergency (A&E) department to corridors while they were waiting for beds on wards continued to occur.
- The chief executive told us that this had been raised with the Director of Nursing and escalated to her. She confirmed that she had made sure that it was clear this was not acceptable and the Director of Nursing had issued a written communication to that effect.
- We identified two similar serious incidents that had occurred when patients with tracheostomies needed to be urgently transferred in lifts from medical wards to critical care. One incident happened on 26 March 2014 and the other on 27 April 2014.
- We looked at the investigations into each incident; these stated that a risk assessment of the lifts would be carried out; however, the only lesson recorded as learned from the first incident was simply that the patient had not been harmed. The division had failed to capture proper learning from its investigation.
- It did capture learning in more detail from the investigation report into the second incident and the risk assessment carried out in May 2014. However, this learning was not shared with ward staff.
- In March 2013, a serious incident was reported of a potential transfusion of incorrect blood to a patient.
- The trust had a policy that only one nurse was required to check the blood match with the patient before transfusion.
- Recommendations were made in an incident investigation report in June 2013. We saw evidence that the trust was reviewing these recommendations (which included consideration as to whether to reinstate the check by two nurses) but, 12 months on, the recommendations were still being considered and were listed in an April 2014 divisional action plan.
- However, the trust was auditing the quality and safety of its blood transfusion practice throughout the period, and the issues were known and discussed by the hospital transfusion committee.

Safety thermometer

- The NHS Safety Thermometer we saw displayed on the medical wards did not appear to include data on new venous thromboembolisms.

Cleanliness, infection control and hygiene

- Clinical areas were clean.
- However, we found several patient areas such as waiting areas, rooms in wards and a quiet room on one ward for older people that were not visibly clean.
- Patients in side rooms were nursed appropriately.
- During our visit, we saw that staff throughout the division observed good practice in mitigating the risks of the spread of infection.
- We noted that hand hygiene practice was appropriate.
- Nursing staff we spoke with demonstrated awareness of the symptoms of infection and steps they would take to prevent its spread.
- Trust hand hygiene audits showed that staff and wards in the division were regularly achieving above 95% compliance.
- The trust's infection rates for C. difficile were within a statistically acceptable range for the size of the trust.
- The trust's infection rates for MRSA infections were outside the statistically acceptable range for the size of the trust in that they had 6 cases this previous year.
- During the 12 months from April 2013 to March 2014, the trust reported six cases of MRSA infection.

Environment and equipment

- Staff told us that they had good access to equipment and facilities for repairs and maintenance on all wards.
- The only exception to this was that there was limited access to height adjustable beds across the division.
- There were only three height adjustable beds available to the 29-bed acute stroke/general medical ward and we were told there were no others available in the hospital.
- The layout of the Tower wards and the acute stroke unit made it challenging for staff to observe patients when not at their bedsides, because their view was obstructed by the design of the building. Staff in the acute stroke unit had recognised this risk and escalated it in their risk register.
- At the time of our announced visit, the ambulatory care unit had around 35 people in attendance. The large chairs provided for comfort made the area cramped and

Medical care (including older people's care)

we heard that a patient had fallen the previous day. The environment was hot and it was difficult for staff to attend to patients. We saw sufficient equipment available.

Medicines

- The trust used a comprehensive medication administration record for patients, which facilitated the safe administration of medicines.
- The record included a separate section for thromboprophylaxis and antibiotic medication.
- Medicines reconciliation by a pharmacist was recorded in the medicines management section.
- We looked at the medicine administration records for 34 people on four wards. We found appropriate arrangements for recording the administration of medicines.
- Records were clear and fully completed. They showed people were getting their medicines when they needed them, there were no gaps and any reasons for not giving people their medicines were recorded.
- If people were allergic to any medicines, this was recorded on their medication administration record chart.

Records

- There were numerous anomalies and inconsistencies in records across medical wards, which raised considerable concern on the wards for older people.
- When assessments triggered the need for care plans, such as falls' care plans or pressure area care plans, these were missing for some patients on the medical wards.
- On some wards for older people, we found that patients did not have care plans and there was little evidence of patient-centred care.
- Documentation used to support people living with dementia was inconsistently used across the division.
- One patient was admitted with delirium and their records stated that they had appeared confused.
- The assessment for the use of bed rails for this patient said that the patient was "alert and orientated".
- Assessment of cognitive and sensory function was not consistently recorded.
- Skin care charts, often kept in a separate folder, were not always completed for patients when necessary.
- Many of the risk assessments we looked at were incomplete.
- Personal care records were not always completed appropriately.
- There was regular recording of multidisciplinary team involvement for older people.
- Risk assessments and supporting documentation in the AAU and AMU were completed appropriately.
- On Ward T4, we noted that there were several sets of temporary notes still in use for inpatients.

Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with the safeguarding lead who delivered all the level 1 safeguarding training for staff.
- They had access to one local authority's social work team, who were based at the trust and liaised with other authorities when safeguarding alerts were raised.
- The safeguarding lead told us that they also led on Mental Capacity Act training and Deprivation of Liberty Safeguards (DoLS) guidance.
- There had been a recent change in the law that governs DoLS and they told us how they had worked with the trust's solicitors to devise training and guidance for staff on this change.
- The safeguarding lead told us that they were the only resource at the trust for accessing and providing training and guidance on the Mental Capacity Act.
- During our inspection, we identified that staff did not show sufficient awareness of the Act and therefore its application was inconsistent.
- Assessment of mental capacity was not consistently recorded within the hospital and it was unclear from records as to whether assessments had been carried out.

Mandatory training

- As of June 2014, the trust was reporting low compliance with compulsory training.
- For acute and general medicine, the trust reported that only 46% of staff were compliant with mandatory training requirements. However the trust highlighted that the training system was not capturing all training. We could not be assured that staff had been trained.
- The lowest staff compliance rate across medicine and older people's care was on Michael Bates Ward, an elderly care ward, with only 25% compliance with mandatory training.

Medical care (including older people's care)

Management of deteriorating patients

- Despite concerns about record keeping, documentation to support the management of deteriorating patients was completed appropriately.
- The national early warning score (NEWS) was used by the trust and we found that documentation was completed appropriately across the division.
- There was adequate patient observation and timely escalation, and patients received specialist input when needed.

Nursing staffing

- Senior nurses and matrons told us that they had been able to over-recruit after a recent recruitment campaign.
- They were given authorisation to make offers for over-establishment to nurses whom they felt were of high calibre.
- Nurse staffing levels had increased to meet the change in demand that the trust had experienced.
- The AAU matron had been supported in a proposal to increase staffing levels to meet patient demand, and this had been ratified promptly.
- We were told that staffing levels were safe across the division. However, we were told by several members of staff that no acuity or nurse staffing tool had been used as an evidence base for the staffing numbers. This was despite the trust having stated that a safer staffing stocktake had been undertaken. The matron in AMU had presented their own evidence base to the trust in pressing for the increase in staffing, and this had been accepted and funded.
- There were nine escalation beds in the acute stroke unit that had become established.
- Extra staffing had not been made available to account for the increase in dependency on the stroke ward that had an impact on nurse to patient ratios for stroke patient care.
- Nurses in both one-to-one interviews and focus groups expressed concerns about the skill mix on medical wards in that a large number of newly qualified staff and overseas staff, who required some support, could be present on any given shift.
- However, we did not identify patient safety concerns due to the skill mix during our inspection.
- Nursing staff who had been employed from overseas told us that they felt integrated, supported by colleagues and well inducted into their role by senior colleagues.
- They told us that they had sufficient time on the wards in a supernumerary capacity when they first took up post.
- Newly qualified staff told us that they had access to mentors who were supportive.
- Nursing staff spoke positively about the access to and coordination of one-to-one care when needed for patients.
- We observed nursing handovers happened daily and were comprehensive.

Medical staffing

- The AAU had 7-day consultant cover with a recent increase in geriatrician and stroke physician support to meet the higher patient numbers.
- A geriatrician was on call to the AMU at night.
- Feedback from staff on the wards was that they had on-call access to doctors at all times out of hours.
- We observed a medical handover that we were told had no set structure.
- The list of patients being discussed was compiled from several pieces of paper, and there was no conformity in the lists so that participants to be reviewed together.
- There was confusion as to who had consultant responsibility for patients who had recently been transferred. Some transferring departments felt they had responsibility until handover while receiving wards felt they had responsibility from the beginning of transfer.
- We also observed reluctance by one consultant to receive patients. There was therefore a potential grey area around responsibility that could compromise patient safety.

Are medical care services effective?

Good

Patients' nutrition and hydration needs were being met. There was comprehensive multidisciplinary team working in patient care, on ward rounds and in ward meetings. However, there were low numbers of clinical nurse specialists to support the delivery of care and patients' emotional needs. The hospital participated in national audits and scored well in the stroke audit but not so well in the diabetes audit.

Medical care (including older people's care)

Evidence-based care and treatment

- In the AAU a gap analysis audit against the National Institute for Health and Care Excellence (NICE) Guideline 50:" Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital", had been carried out, and a plan had been drafted and shared with the AMU. An action plan was in place.

Pain relief

- We were told by staff that there was one specialist pain nurse who supported the whole hospital.
- Nursing staff told us they often relied on advice from each other on pain management.
- On Charles Coward Ward, staff were able to talk us through what medicines were being given to patients for pain relief, but no pain scale or assessment was being used to manage patients' pain.

Nutrition and hydration

- We found that malnutrition universal screening tool (MUST) assessments were routinely completed, and patients' nutritional needs were being met.
- Food and fluid intake charts were accurate and up to date, and people's needs were monitored appropriately.
- As well as monitoring charts, daily notes gave details that helped staff to deliver appropriate care.
- Patients told us that the food was generally of good quality and that diverse needs were catered for.
- We saw menus that catered for cultural preferences.
- Refreshments were provided throughout the day in the ambulatory care unit.
- Meals were available but had to be heated up in the microwave in the kitchen shared with the office staff. Patients were assisted with eating and drinking when necessary.

Patient outcomes

- In 2012/13, the trust participated in 47 of the 51 national clinical audits it was eligible for.
- We reviewed the Sentinel Stroke National Audit Programme (SSNAP) clinical audit data from October to December 2013.
- The trust scored one of the highest two grades of either A or B for 15 of the 26 indicators used to assess performance.
- The trust's SSNAP level score was rated as C. Only two other trusts in the London region scored higher than C for performance over the same period.
- In comparison, the trust performed poorly for the number of medication errors reported in the National Diabetes Inpatient Audit published in September 2013.
- Sixty-eight per cent of patients with diabetes experienced a medication error, compared with 37% across England as a whole.

Competent staff

- There were clinical nurse specialists within the trust to support the delivery of care.
- In one of our focus groups, consultants from across the division told us that doctor revalidation was taking place.
- Less than 78% of staff in the division had been appraised (85% of registered nurses). However, appraisals for allied healthcare professionals aligned to medicine had a completion rate of below 70%.

Multidisciplinary working

- We saw evidence in patient records of appropriate timely input from the multidisciplinary team.
- We also observed ward rounds and saw that allied health professionals were involved to ensure that the delivery of care was appropriate and effective.
- Nurses who led on handovers showed an awareness of multidisciplinary input being both requested and received, and they shared this input with their teams at handover.
- We received positive patient feedback about partnership working; one patient told us that there was effective communication with external specialists (for example, their heart specialist at another trust).
- Another patient told us that they had received input from in-house specialists and felt this aspect of their care was well coordinated.
- Wards had 24-hour access to occupational therapists and physiotherapists.
- Discharge leads were present at daily ward rounds.

Seven-day services

- The AAU and AMU had 7-day consultant cover and out-of-hours access to a geriatrician.
- Medical wards including ward T4, which had patients from a mix of specialties, had consultants present on the wards at weekend for 8 hours a day and out-of-hours access to consultants.

Medical care (including older people's care)

- Daily ward rounds took place across the division, involving physiotherapists, occupational therapists and other allied healthcare professionals. Dieticians were also available to ward staff.
- Speech and language therapists (SALTs) were not as available as other therapists, but nursing staff on the acute stroke unit had been trained to support patients with swallowing difficulties.
- The ambulatory care unit operated 6 out of 7 days.

Are medical care services caring?

Good

Patients reported a significant improvement in the compassionate way staff cared for them. They reported being treated with dignity and respect. We observed staff being polite to patients and involving them in their care.

Compassionate care

- Several patients we spoke with regularly visited the trust as inpatients and told us that they felt there had been noticeable improvements over time. One person said there had been improvements in the care given and that they felt staff were compassionate.
- We asked several patients about the care they received at night, and their responses showed that they thought well of the night staff.
- Patients were treated with dignity and respect on the wards.
- We saw this both in interactions between staff and patients but also in the use of curtains at bedsides and signs on side room doors.
- We noted on several occasions and during one handover that many of the nurses and healthcare assistants were not using people's preferred names.
- Also, patient information on white boards on the wards had patient names written in full and visible to all visitors.
- Five of the 14 medical wards surveyed on the NHS Friends and Family Test in the scored below the trust average in their results. Two of these were geriatric as a first specialty and one was geriatric as a second specialty.

Patient understanding and involvement

- Most patients we spoke with felt involved in decisions about their care and treatment.
- One patient told us they were a carer, and that hospital staff were supporting them to make sure that the relative they cared for was being looked after while they were in hospital.
- In the interactions we witnessed, staff were polite and involved patients in their care.
- One patient's relative told us that the care and treatment they had received in the AMU were exemplary and they felt that care was delivered to a high standard both in terms of clinical input and in being person centred.
- Staff were attentive to the patients in the older persons' assessment unit (OPAU), and we saw them speaking reassuringly to those attending the unit, and to their carers.

Emotional support

- We found little evidence, apart from on the acute stroke unit, that patients' mood and emotional wellbeing had been assessed and provided for.
- We were often unable to understand patients' non-physical needs from their records.

Are medical care services responsive?

Requires improvement

The trust was currently planning its service provision to meet increased patient demand. The facilities for the older persons' assessment unit (OPAU) and ambulatory care unit were very poor. These services were operating in the same cramped space with medical day patients and a diabetes outpatients clinic. The services lacked privacy and dignity. The trust accepts that the facilities are cramped and compromise the patient experience.

Families of patients told us that they were involved in their relative's care.

Assessment of cognitive and sensory impairment was inconsistent across the division and there was a lack of specialist support for dementia care on the wards.

Use of beds was not always appropriate. For example, we found nine beds on the stroke unit occupied by general medicine patients.

Medical care (including older people's care)

Service planning and delivery to meet the needs of local people

- The trust had developed partnership working with local primary care providers to address the poor use of primary care services by the local population.
- This included regular teleconferences with local authorities and other services to tackle frequent inappropriate visits to the hospital by the same patients, and delayed transfers of care.
- The hospital had recently launched a 'health bus', which informed people in the local community about the availability of, and access to, primary care services. It also offered basic health checks to people in its catchment area.
- Two people at our listening event described attending presentations by the trust, and workshops about general health, dementia and diabetes that were provided for specific ethnic groups from the local population.
- The trust was currently adapting its provision to meet the increased patient demand due to recent changes in acute provision locally.
- Consultants in our focus group said they thought there had been inaccurate modelling when planning for the patient mix and the demand that would place on the hospital.
- They said that the trust had planned for a 50/50 mix of non-elective to elective patients and, instead, 75% of the patients they had seen had presented without appointment.
- The hospital provided ambulatory care and the unit was located with the OPAU in a space at the back of the outpatient department. However, they shared that space with medical day cases and a diabetes outpatient clinic.
- We were told by staff that the ambulatory care unit had moved around the hospital on several occasions and, each time it had moved, its footprint had got smaller.
- The area was not large enough for all the services located there. Ambulatory care patients were often left standing while waiting to be seen, while day case patients sat directly next to or opposite other patients, in small rooms, who were receiving treatment.
- We observed blood tests and blood pressure tests being conducted in waiting areas.
- There was only one toilet available in the area for a wide range of patients. This was a breach in same sex facilities.
- Because of the limited space available, we were told that one of the exclusion criteria for patients attending the unit was lack of mobility, but we saw patients in the waiting area who were using wheelchairs. There was no privacy for patients in this area.
- During one short observation, we witnessed a conversation in which a patient who was supposed to be discharged could not be found by staff, and another patient's wheelchair could not be found.
- The OPAU could only see a small number of the patients who were eligible to attend as a result of the space restrictions.
- The ambulatory care pathways that the service could offer were reduced as the footprint became smaller.
- We were told that the unit was sometimes put under unnecessary pressure by patients being referred to it for discharge when they were not ready to be discharged.
- The ambulatory care unit had recently begun offering a service on a Saturday for Doppler scanning to check for deep vein thrombosis.
- After our announced inspection but before our unannounced inspection, some members of the ambulatory care team visited a nearby hospital with a similarly sized ambulatory care unit in order to bench mark best practice.
- However, during our visit we saw that four people were receiving blood transfusions in a small room within the ambulatory care unit. There was only one curtained area available in this room.
- Some wards for older people were in need of redecoration. This had been recognised by the trust and the trust had made financial provision to address this.

Access and flow

- The older patients pathway at the AAU had been redesigned to ensure an appropriate level of geriatrician support and to meet best practice guidelines.
- GP referrals are received via a dedicated phone line so that patients could be triaged appropriately before arriving at the hospital.
- Between October 2013 and December 2013, the trust's bed occupancy was 97.4% compared with the England average of 85.9%.
- In January to May 2014, 6.8% of inpatients experienced three or more bed moves.
- All patients were booked in through A&E, before being referred to the AAU or AMU.

Medical care (including older people's care)

- We saw that the flow was appropriately facilitated by the acute assessment teams in the hospital.
- The trust had a newly designed and purpose-built discharge lounge, which we visited. Staff told us they discharged 3–10 inpatients a day through the lounge, and that it was predominantly used by outpatients.
- Excluding outpatients, only 560 of 15,823 patients who were discharged from the hospital between December 2013 and May 2014 were discharged through this lounge. This figure represented just over 3.5% of inpatients who had been discharged through the lounge during this period.
- The trust's policy was that all inpatients, except for certain unsuitable ones, such as those who were confused, should be discharged through the discharge lounge.

Meeting people's individual needs

- We spoke with the families of two regular inpatients with learning disabilities on Wards T5 and T7. We were told by the T7 ward manager that T7 had been identified as the ward where medical patients with a learning disability would be cared for, whenever possible.
- Families of both patients told us that they were involved in their relative's care, and that staff welcomed parental guidance on meeting their son's or daughter's complex needs.
- Relatives told us they felt staff had grown in confidence in engaging with these patients because of their regular interaction with them and their parents.
- A geriatrician saw all over-75 patients who presented to the AMU at the hospital.

However, assessment for cognitive and sensory impairment was inconsistent across the division.

- There was a lack of specialist support for dementia on the wards.
- The trust's dementia lead told us that patients living with dementia stayed 4–7 days longer on wards than other patients.
- The acute stroke unit was a newly refurbished space with good facilities, and it was well run. However, there were nine beds on the ward used for general medicine, and staff felt these could be used more effectively to respond to the needs of stroke patients.
- Staff told us that having those nine beds, which would give the unit a total of 29, would help them to meet repatriation targets from the local hyper-acute stroke unit, and possibly to provide some rehabilitation.
- Nurses on the acute stroke unit had been trained to assess if patients' had difficulty swallowing.

Learning from complaints and concerns

- Patients had little awareness of the complaints process, and certain staff grades knew little about how to handle a complaint on the medical wards. This did not reflect a division in which complaints were promoted and encouraged.
- Several nursing staff told us they would defer to a senior colleague rather than feeling empowered themselves to respond to a complaint.
- Staff in the AAU and AMU told us that learning from complaints was discussed at staff meetings.

Are medical care services well-led?

Requires improvement

While the trust had sent a copy of its trust dementia strategy, there was no clear operational strategy for patients living with dementia on the medical wards and staff were unaware of the strategy. While we found that local leadership on many wards was good, we also found that band 7 staff often had no ownership of their local risk registers and were not involved in governance meetings. The department did not appear to be taking action against the issues that they were aware of such as the medical records audit, issues with capturing mandatory training and the ambulatory care unit.

While the Chief Executive and Chair were visible, some staff members felt unsupported in their role or in being able to progress within the trust. Some staff were concerned that decisions made which had a potential clinical impact on patient welfare did not appear to be open to challenge and gave the example of requests to 'board' patients from A&E on wards when no beds were available.

Vision and strategy for this service

- The trust dementia strategy had not been embedded across the division.

Medical care (including older people's care)

- There was a lead consultant for dementia, but they and an occupational therapist had sole responsibility for raising awareness and delivering training to the trust's staff.
- Staff on the wards told us they had not received dementia training and it was not a mandatory training module.
- There were dementia champions in the hospital but no forum provided for them.
- The trust strategy for its ambulatory care provision had been reactive, resulting in care becoming less responsive to patient needs.
- There was currently no apparent vision or solution to resolve this issue.
- Healthcare assistants in one of our focus groups told us that they couldn't progress to the next grade within their department unless they applied for a position elsewhere. This was despite the trust providing opportunities for Healthcare assistants.

Governance, risk management and quality measurement

- While local leadership on many wards was good, we also found that band 7 staff often had no ownership of their local risk registers and were not involved in governance meetings.
- However, the trust held a daily Datix meeting when it discussed all incidents, and local teams told us they received feedback from these meetings.
- Feedback from investigations of incidents was not given in a timely and responsive manner. Staff appeared unaware of the feedback system which the trust stated was available on Datix.
- There was also evidence that the implementation of learning from serious incidents was slow.

Leadership of service

- We were told that the trust's chair regularly visited the stroke and oncology wards.
- The lead consultant for dementia was passionate about their role, but they were not supported by the trust to deliver the operational strategy. Their only support was an occupational therapist.
- There was minimal input from nurses on the dementia steering group and no lead dementia nurse to help promote the work of the group.
- We saw strong leadership at ward level and staff who felt supported by that leadership.
- However, ward managers did not feel engaged in the quality and safety agenda and were not accountable for local risks.
- Many ward managers raised concerns about their involvement in bed management meetings and how these had an impact on their time on the wards.
- We were told that ward managers were asked to complete a bed status report at 8am each day, and they also had to attend bed management meetings at 10am and 3pm every day.
- Staff on the stroke unit showed strong team spirit, took pride in their work and spoke positively about the hospital's stroke pathway.

Culture within the service

- Staff in the AAU and AMU and other staff on wards felt that they were able to challenge colleagues' practice and that they were encouraged to do so.
- They felt there was good team work in the division and that all grades and roles worked as a team.
- Staff often praised their local leadership and we received positive feedback from staff and patients about ward managers.
- New staff were integrated effectively onto their wards.
- Several staff expressed concern that actions that might put patient safety at risk may have been taken without challenge at executive level.
- We raised these concerns with the chief executive. She was aware of some detailed concerns raised by individual members of staff and was able to describe action taken to challenge practice that was not acceptable after concerns were raised by staff.
- National policy allowed for the trust to agree an individual timescale for a response to a complainant; however, 35 working days was the current recognised response time target that the trust should aim to meet.
- Twenty of 52 complaints logged as medical (including surgical) in 2014 were not responded to within 35 working days.

Innovation, improvement and sustainability

- The Alexander Pringle Centre was one of the largest specialist services for patients with HIV infection in the UK.
- We attended a risk outreach meeting in which a multidisciplinary and holistic person-centred approach to care was evident.

Medical care (including older people's care)

- The meeting was to discuss patients who were potentially at risk because they were not engaging with the service.
- There was a discussion around patients' physical and medical needs, psychological support and social needs; and what steps had been taken, and could be taken, to enable them to receive appropriate support.
- This approach was well-led, well-coordinated and demonstrated that the trust and its partners understood the needs of this patient group and responded to the needs of each person individually.
- The trust had developed an in-house database to help facilitate improvements in care quality for this patient group, and they were marketing this to other providers.
- The trust provided care and treatment to patients with sickle cell anaemia and related conditions in a specialist day unit.
- Patients told us that the unit was responsive to their needs and that they had access to care and treatment and, in particular, pain management when they needed it.
- Staff showed a good understanding of the needs of this patient group, and nurses told us they felt there was a positive working relationship between nurses, consultants, patients and families.
- Nurses received specialist training to be able to meet the needs of this patient group, and a weekly training day was available to nurses on the unit.
- Feedback from staff was encouraged to inform the development of the service.

Surgery

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

Information about the service

North Middlesex University Hospital provides a range of surgical services including trauma and orthopaedic, general, urology, eye and breast surgery. The hospital also provides pelvic floor and endoscopic treatments. There are seven operating theatres currently in use. There are three surgical wards, a surgical assessment unit and pre-assessment clinic.

A high percentage of surgical patients are day patients and elective patients admitted on the day of surgery. They wait in a common admissions area before going to theatre. There is a stage one recovery area and a stage two recovery area, from which day patients are discharged.

There is a surgical assessment unit, which is part of the acute assessment unit, with nine beds for surgical patients referred by their GPs or coming though A&E. There are emergency surgeons, a 24-hour emergency theatre and a dedicated daily trauma list.

We inspected the surgical assessment unit, the pre-assessment clinic, the admissions area, theatres and recovery areas. We also inspected the three surgical wards and the urology and endoscopy units.

We talked with 29 patients and received comments from people who contacted us to tell us about their experiences. We talked with over 50 members of staff including managers, theatre nurses, operation department practitioners, anaesthetists, surgeons, junior doctors, senior and junior ward nursing staff, physiotherapists, occupational therapists and clinical nurse specialists. We observed the use of the World Health Organization (WHO) surgical safety checklist in theatre and looked at care records. We reviewed information about the performance of the hospital before the inspection and requested further information during our inspection.

Surgery

Summary of findings

Demand for surgery (in particular, emergency surgery) was higher than had been anticipated and this put pressure on the surgical assessment unit, theatres, recovery areas and wards. Good team work and staff commitment had limited the impact of this, but patients often experienced delays. Surgical patients were protected from the risks of surgery by the effective use of the 'five steps to safer surgery' procedure. There was good awareness of patient safety and the importance of reporting incidents. We saw evidence of action taken in response to patient safety incidents.

Surgical services were delivered in line with best practice, for example in the use of enhanced care pathways across all specialties. The trust had appointed emergency surgeons and a theatre was available at all times for emergencies. Nursing staff were caring and responsive. There was a high level of awareness of the importance of taking into account patients' cultural and religious needs. The patients we spoke with were very positive about the hospital and its staff. They said they had received good explanations about their treatment. Patient records were not always well organised and some were incomplete. We also found discharge summaries were often incomplete.

There was effective multi-disciplinary working with allied health professionals at pre-assessment and on the ward to enhance patient recovery and facilitate discharge. There was good teamwork in the areas we visited and nursing, medical and surgical staff communicated effectively.

Are surgery services safe?

Good

Patients were protected from the risks of avoidable harm by the effective use of the 'five steps to safer surgery' procedure. There was pressure on staff in the theatres and recovery areas and we did not see evidence of any process to assess safe staffing levels in these areas. However, we observed that good team working mitigated the effects of the pressure on staff. An escalation plan for when capacity did not meet demand had been implemented shortly before our inspection, resulting in some elective operations being cancelled or rescheduled.

Patients were observed appropriately postoperatively. Medical and surgical staff were available to nursing staff when needed. Staff from all clinical backgrounds had a good understanding of the importance of safe practice. They used the Datix system to report safety incidents and told us that these were investigated and action taken to address the issues raised. Incidents with the potential to result in serious harm were placed on the risk register and we saw that prompt and effective action had been taken to prevent recurrence.

However, action had not been taken promptly to address other items on the risk register, such as the need for replacement equipment. Some risks were not identified on the risk register, such as pressure on staff in the recovery areas.

Incidents

- Staff in all areas we inspected said there was an expectation that incidents affecting the safety of patients should be reported, and they themselves had used the incident reporting system. For example, theatre staff were encouraged to report any 'near miss' incident that was prevented by use of the WHO surgical safety checklist. Nursing staff on the surgical wards said they received feedback and were able to give examples of action taken in response to incident reports. On one of the wards we inspected, we saw reported incidents displayed on the board to promote staff learning. Nursing staff in other areas said they did not always receive feedback in response to reports.

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- There was an incident meeting every morning when potentially serious incidents were allocated for review within 48 hours to decide whether they were a serious incident (SI). SIs were allocated to a member of staff trained in root cause analysis for investigation.
- No Never Events had been reported in the past year. In a previous year, there had been a Never Event of a retained swab following gynaecology surgery, and an additional safeguard was introduced to ensure the subsequent removal of intentionally retained swabs (these are swabs which are intentionally left in a patient in order to absorb excess blood and fluid).
- Incidents were discussed at multidisciplinary meetings every 2 months.
- Consultant surgeons told us there were well-attended monthly mortality and morbidity meetings. As well as discussions about unexpected deaths, expected deaths were reviewed to assess adherence to the end of life pathway.

Safety thermometer

- NHS Safety Thermometer information was clearly displayed at the entrance to the wards. This included information about falls and new pressure ulcers in the area.
- As a trust the safety thermometer showed that the trust in all areas measured apart from new venous thromboembolisms.
- Risk assessments were completed at pre-assessment and on admission to the wards or the surgical assessment unit. Patients on the wards had risk assessment forms at the end of their bed in which relevant risks were identified (for example, moving and handling, falls, pressure care and whether bedrails were needed). We found that not all risks had been assessed and recorded in two of the eight forms we reviewed. Venous Thrombo Embolism (VTE) risk assessments were sometimes not completed by medical staff. Nurses confirmed this, but told us that all surgical patients wore compression stockings. We saw that there was routine use of compression stockings when patients were being prepared for theatre.

Cleanliness, infection control and hygiene

- Surgical site infection rates were within expected limits.
- There was a traceability system for the sterilisation of theatre equipment in the event of a patient developing a postoperative infection.
- MRSA/C. difficile rates were within the expected range.
- Each ward had enough single rooms for patients who were an infection risk. The ward manager assessed each new patient to decide on the most appropriate bed to keep them safe and limit the risk of infection. Patients were isolated in accordance with infection control policies and we observed staff following good practice guidance and informing visitors of the guidance. We met an infection control nurse visiting the wards to review patients and advise the ward manager about infections, such as E. Coli.
- There was good compliance with the trust hand hygiene policy. Wards and pre-admission, admission and recovery areas appeared clean and there were easily accessible hand-washing facilities and hand sanitiser dispensers. However, there was no hand sanitiser dispenser in the theatre suite corridor adjacent to the theatres. The '5 moments of hand hygiene' WHO guidance stated that staff must clean their hands before entering a patient area, including theatre. The 'bare below the elbow' policy was adhered to. However, we saw that some theatre staff wore necklaces.

Environment and equipment

- The recent building and refurbishment work at the trust had resulted in a spacious and uncluttered environment on the wards and in the theatre and recovery areas.
- We saw that equipment in theatre and recovery, such as anaesthetic machines, was appropriately checked. There were systems to collect, repair and sterilise equipment used in theatres. The theatre manager held a weekly meeting to ensure availability of equipment.
- We saw labels on items of equipment in theatres, the recovery area and the wards confirming that they had been tested.
- We looked at resuscitation trolleys in the surgical assessment unit, theatres, recovery areas and wards, and found that there were daily checks with appropriate action, such as replacing out-of-date medication.
- Staff on the wards told us they were able to obtain the supplies they needed from the stores on the ward and housekeepers would go to the central store, if necessary, to 'borrow' equipment from other surgical wards. There had been some difficulties because of a recent change in suppliers. A ward manager told us there had been a change in the intravenous equipment, but that staff had not been trained to use it. The housekeepers were asked to find the previous

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equipment until staff were trained. This mitigated the risk of using equipment that staff were not trained to use. Ward managers told us faulty equipment was usually repaired promptly.

- When there were shortages or a need to replace expensive equipment or instruments, a case for capital funding was made. We noted there were items on the risk register relating to equipment (for example, no back-up diathermy machine in theatre and ophthalmology instruments needing replacing. These items had been on the risk register for a year or longer. There was no date of when risks were added to the register on the copy provided and there appeared to be no control measures, except for an arrangement to borrow ophthalmology instruments from other hospitals.
- The trust had undertaken to review and update procedures for restocking stores and supplies, as a result of NHS England's annual assurance audit of the trust's emergency preparedness, resilience and response compliance in October 2013.

Medicines

- The trust used a comprehensive medication administration record (MAR) chart for patients that facilitated the safe administration of medicines. Medicines reconciliation by a pharmacist was recorded in the medicines management section of the form. A pharmacist was allocated to each surgical ward and inspected every weekday to undertake these reconciliations.
- There was a pharmacist on the acute admissions unit 7 days a week who reviewed the medication of new surgical admissions.
- We observed a nurse on the ward wearing a red tabard to discourage interruption while she was administering medication. She told us this was respected by other staff, unless a patient was in urgent need.

Records

- The daily notes made by nursing staff in the records on the wards and in the surgical assessment unit were well completed and informative. Allied health professionals contributed to the records. However, records were sometimes badly organised and risk assessments not always complete.
- In theatre we saw that sticky labels were put in the theatre register (for example, lot numbers of a prosthesis that had been implanted). There was a risk that these would be lost.
- Records in the admissions area were left unsupervised on a trolley at times.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told that patients were screened for dementia when this was indicated. There was a consent policy, including guidance for medical and surgical staff on best interest decision making when patients lacked capacity. At the time of our inspection, there were no patients on the surgical wards who had been assessed as not having the capacity to consent to decisions about their treatment.

Safeguarding

- Training in safeguarding was not up to date in some areas. Staff on the wards were aware of safeguarding and the importance of reporting concerns about possible abuse or neglect. Managers gave examples of the process they had followed when these types of concerns had been raised.

Mandatory training

- Mandatory training for theatre staff was not up to date. However due to issues with the training records it was unclear as to what the percentage of staff who had received training was.
- Training for nursing staff on the surgical wards had fallen behind. This was now being addressed and we saw current gaps in the training of staff displayed on the staff room wall. Staff were now able to access e-learning modules from their home computers and this was expected to help address shortfalls in mandatory training.
- Staff told us they did not have protected time to complete e-learning and many staff, particularly in the theatres and recovery areas, were working overtime, which further limited their opportunities to do the training.

Assessing and responding to patient risk

- Theatre staff had enhanced the safety of surgical patients by implementing the effective use of the 'five steps to safer surgery' procedure (briefing, the three stages of the WHO surgical safety checklist and debriefing). Audits of the paperwork recording the use of

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the surgical safety checklist in the past 6 months found 100% compliance in 4 months and 99.5% compliance in 2 months. The trust's safety and quality committee had requested further work to assess the quality of the use of the 'five steps' (in particular, the contribution of consultants to its use) and this audit was currently under way. Theatre staff reported positively on the use of the 'five steps' and said they had been encouraged to speak out if they were unhappy with any aspect of its use. We were told pre-list briefings had become embedded in practice and enhanced the smooth running of theatre lists. The morning list for a theatre did not start until all members of the team were present, and action was taken against staff who were late. We saw that an afternoon list did not start with a brief and were told by staff that this was unusual. In common with other hospitals in England, theatre staff found debriefs at the end of a list difficult to implement because operations were often running late or staff had to take patients to the recovery area. We observed the use of one or more of the 'five steps' on seven occasions in six operating theatres, including one team brief before a list starting and seven 'time outs'. We observed that all staff present followed the patient and procedural checks and were engaged in the process.

- We were told that anaesthetists trained in human factors and simulation had provided training to other theatre staff. The simulation suite had been used for training on the use of the WHO surgical safety checklist and obstetric emergencies. However, the suite was not currently in use as the room is being used for other purposes. We were informed that a decision was being made about the location of the suite.
- The post of clinical governance coordinator for surgery had been vacant for a year before a recent appointment. The new person in post was ensuring that all reported incidents were reviewed and trends analysed. He was also tracking actions allocated to address risks identified on the risk register, and meeting regularly with the general manager to review these. We noted that many red-rated items had remained on the risk register for some time, but we were unable to find out for how long because there were no dates on the copy provided to show when an item had been added to the register.
- After an incident of delayed diagnosis of cancer, the risk had been identified of delays in urology patients receiving their histology results and starting treatment. This had been placed on the risk register and urgent action was underway.
- The trust had responded to the 2010 National Patient Safety Agency (NPSA) rapid response alert, 'Reducing harm from omitted and delayed doses', by regularly auditing how many doses were omitted or delayed. Missed doses were recorded on the incident reporting system.
- Patients in recovery were observed appropriately post-operatively, and staff had access to anaesthetists and the critical care outreach team if they had concerns about a patient. There was an anaesthetic machine with capnography ready for use in the recovery areas, although only a small number of patients needed ventilation.
- NEWS observation charts had been implemented on the surgical wards and we saw evidence that these were completed and appropriate steps taken when there was evidence of deterioration. Nursing staff told us junior doctors came to the ward when requested; junior doctors said they had access to middle grade doctors and consultants when needed.

Nursing staffing

- Surgical ward managers said they had the staffing establishment they needed to provide care for their patients. Staffing was increased to address increased need (for example, if a patient who was living with dementia and needed close supervision was admitted to the ward). Nursing staff worked flexibly across the wards to ensure adequate cover. An additional post of a night-time healthcare assistant at night had recently been approved to share between two adjoining wards.
- A ward manager who had a team with a high proportion of recent appointments said she rotated healthcare assistants to undertake specific tasks to make sure learning occurred.
- The staffing establishment and actual numbers were displayed on every ward every day and during our inspection there were no discrepancies. We saw that the Director of Nursing had undertaken a recent review of the staffing establishment in line with the Royal College

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of Nursing guidance for safe staffing levels. We were told that the audit found that all areas of the hospital were compliant, with the exception of the A&E department, which was amber rated.

- However, nursing staff in the surgical assessment unit told us that at busy times there were insufficient numbers of staff to care for patients in a responsive way. Also, staff told us they felt they were inadequately trained to care for some patients admitted to the unit (for example, patients needing neurological observation or those with spinal injuries). When we inspected the unit, there was a patient with a fracture of the T12 vertebrae (lower back). Staff had previously submitted an incident report about a similar situation because they considered it a patient safety issue. Training had yet to occur on nursing patients with spinal injuries.

Surgical and medical staffing

- The trust had identified a shortage of anaesthetists, and made additional appointments. There was also a shortage of theatre nurses and operation department practitioners and because of difficulties in recruiting there had been an increased use of agency staff in theatres.
- We saw no evidence of a systematic analysis of activity to plan for an appropriate number and skill mix of nursing and operation department practitioner staff in pre-assessment, admissions, theatres and recovery. A new theatre management IT system was about to be introduced, which it was hoped would result in a more effective collection of activity data to aid planning.
- The urology service was in the process of making a case for employing a specialist cancer nurse and more middle grade doctors in order to improve patient treatment and care.
- The surgical assessment unit had access to a registrar and specialty doctor without theatre commitments, and this facilitated a prompt response to requests for advice and treatment.
- The trust had appointed three emergency consultant surgeons, and was in the process of appointing another, to meet the London emergency standard requirements.

Handover

- Junior doctors told us there was consultant presence at handover. All patients were entered onto a spreadsheet with a note of any outstanding tasks related to their care. These were checked off by junior doctors as they are completed. The surgical team had implemented improved weekend handover with an easily visible green form to record key items of information and outstanding tasks to be kept in the patient's file.
- We observed that handover between nurses included written and verbal information about individual patients passed from the named nurse to the next one on duty.

Major incident awareness and training

- The escalation plan for when capacity did not meet demand had been implemented shortly before our inspection and the status 'Black' declared because of a surge in demand. In surgery, this had resulted in cancellation of elective operations.
- NHS England's 2013 annual assurance of the trust's emergency preparedness, resilience and response compliance had found that the performance of North Middlesex University Hospital NHS Trust compared favourably with their peers. i

Are surgery services effective?

Good

Surgical services were delivered in line with national good practice and guidelines. There was 100% adherence to the target length of time for fractured neck of femur repair. There was a pathway for emergency patients through the surgical assessment unit with access to middle grade doctors and a pharmacist 7 days a week. Emergency surgical surgeons had been appointed. However, some services, such as radiology, were not available 7 days a week and this meant that some patients' treatment was delayed. Plain film x-ray and CT scans were available at any time. Staff told us that it was sometimes difficult to access ultrasound scans for emergency cases at weekends.

There was effective multidisciplinary working with allied health professionals at pre-assessment and on the ward to enhance patient recovery and facilitate discharge. There were well-established enhanced recovery pathways across all surgical specialties resulting in improved outcomes for patients, including shorter lengths of stay. However, we found patients were not always adequately hydrated before surgery.

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We saw evidence of improvements in pain management and all the patients we spoke with said their pain was well controlled.

Evidence-based care and treatment

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) recommendations. A theatre was available at all times for emergencies, and surgery was carried out after 11pm when necessary.
- The trust had arrangements for referrals and transfers of patients to other London hospitals for specialist surgery (for example, for urology and gynaecology), in accordance with the National Institute for Health and Care Excellence (NICE) Improving Outcomes guidance.
- The trust had a new pelvic floor centre with consultant surgeons specialising in colorectal and urogynaecological pelvic floor dysfunction supported by a clinical nurse specialist and an assistant nurse practitioner with specialist training. We inspected the centre and staff explained the innovative treatment provided.
- A process was introduced in 2013 for cascading new guidelines from NICE and professional associations to the relevant division for a nominated clinician to lead on their implementation. The matron informed us that she had recently reviewed the guidelines on the surgical wards to make sure they were up to date.
- We were informed of a number of local audits during our inspection (for example, consent audits and audits of the pain relief given to surgical patients).

Pain relief

- Patients we spoke with had been given information about pain at their pre-operative assessment and those on the ward said someone regularly checked them to make sure they had the pain relief they needed.
- A nurse on the trauma and orthopaedic ward had been trained in pain management and helped other staff assess pain to make sure that all patients had the most effective analgesia.
- Post-operative patients in the recovery area had access to patient-controlled analgesia after surgery. Its use was recorded.

Nutrition and hydration

- Surgical patients told us they were given information at their pre-operative assessment about when they should stop eating and drinking.
- A patient in the admissions area told us they had been 'nil by mouth' since 9pm the previous evening. He had arrived at 8am and we saw that he was called for his operation at 11.45am. According to national guidelines, patients should be able to drink up to 2 hours before their operation. We did not observe patients in the admissions area being offered water while we were there, although we were aware that there had been delays to operations.
- Admissions staff said there was good communication with theatre staff about lists and the expected times for people to go to theatre, but they acknowledged that this could improve. A member of theatre staff suggested that the task of communicating the order of the list to admissions staff should be allocated at the pre-list brief. This would enable admissions staff to offer a drink to patients whose operation was delayed.
- A nurse on a surgical ward we inspected was trying to find out whether a patient, whose operation had been delayed, would go to theatre that day because she had been nil by mouth (but receiving intravenous fluids) since the previous day. The nurse was not clear about whom to contact. We found no evidence of a protocol for theatre staff to follow to inform wards of delays to operations.
- Patients' notes on surgical wards included information about eating and drinking (for example, what food texture a patient required).

Patient outcomes

- There were enhanced recovery pathways in all surgical specialties, which had resulted in improved length of stay and reported patient experience. A physiotherapist described the collaboration with occupational therapists and the pain team to care for elective knee and hip surgery patients, as part of the enhanced care pathway. This included running a 'joint school' to prepare patients pre-operatively. An enhanced recovery database was completed by all members of the team and there was a dedicated audit clerk.
- In 2013, North Middlesex University Hospital was in the top 10 of the 180 hospitals contributing to the national hip fracture database for length of time to repair for fractured neck of femur. The latest figures provided by the trust indicated that 100% of fractured neck of femurs were repaired within 48 hours. We found that

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there was a pathway that provided appropriate treatment and care, including orthogeriatrician review. However, there was no defined, fast-track pathway for this patient group through A&E.

- Patient Reported Outcome Measures (PROM) scores for groin hernia surgery, varicose vein surgery and hip replacement were within the expected range. The PROM score for knee replacement for 2012/13 was lower than expected. The pain nurse on the trauma and orthopaedic ward told us that they had improved the pain service and were confident that in future scores would improve. Pain is one of the measurements including in PROMS.
- There were no mortality outliers for relevant surgical specialties. This indicated that there had been no more deaths than expected for patients undergoing surgery at North Middlesex University Hospital.
- The surgical division participated in all the national audits for which it was eligible, with the exception of the National Emergency Laparotomy Audit.

Competent staff

- A practice educator had been appointed in theatre and was reviewing training needs. However, because theatre staff were busy and often worked late, it was difficult for them to keep up with their training and half the nursing and operation practitioner staff had not had appraisals. The practice educator also had to cover in theatre when there were staff shortages.
- We saw that induction training forms had been completed for agency staff in theatres.
- Staff training in the use of equipment in theatres was not up to date. There were competencies for the use of items of equipment and staff self-certified that they were confident in using them. However, these were not sufficiently detailed for managers to be sure that staff were competent in testing, using, maintaining and cleaning each piece of equipment.
- There had been a training needs analysis of nursing staff on surgical wards and the practice educator was looking at the training programme to cover training needs identified in appraisals as well as mandatory training. Nursing staff said they had access to training and were now able to complete e-learning modules on their home computers. However, some nurses told us they had fallen behind on training over the past 6 months.
- Nursing staff on the general surgery wards were receiving additional training from a physiotherapist to ensure that they were competent to care for trauma and orthopaedic patients who were placed on their wards.
- We spoke with one of the recently appointed nurses from overseas who was working on a surgical ward. They said they had a month's induction and the trust paid for English language classes.
- Some of the senior nurses on the surgical wards were enrolled on diploma in health and social care management modules and leadership training.
- Student nurses and newly qualified staff told us they had mentors, and we observed student nurses being supported by qualified staff in the recovery areas and on the wards. There was a programme of mentorship training. However, senior nursing staff acknowledged it was difficult to provide sufficient numbers of trained mentors for the number of new staff.
- Training for nurses caring for urology patients was being addressed.
- Junior doctors working in the surgery division reported that the appointment of additional surgeons, registrars and specialty doctors meant they were now well supported. Information provided by the trust indicated that most consultants had completed teacher training courses. However, some junior doctors were critical of the quality of teaching. There had been criticism of the formal training and support given to junior doctors in anaesthesia by the Deanery. There was an action plan to provide protected time for teaching and training, but anaesthetists recognised the challenges in implementing this because of the high workload.

Multidisciplinary working

- Nursing staff on the surgical assessment unit and the surgical wards said they had good access to tissue viability nurses and other allied health professionals.
- We attended the 9 a.m. multidisciplinary team meeting on one of the wards, attended by the ward manager, the discharge nurse specialist, an occupational therapist, physiotherapists and junior doctors. We were told the orthogeriatrician attended the meeting once a week. There was a comprehensive discussion about patients, the assessments they needed and the plan for their discharge. Nursing and allied professional staff described close working with consultants and their teams.

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- We observed that good team work in theatres and the recovery areas promoted effective working in the face of considerable pressures.

Seven-day services

- Computerised tomography (CT) scans were available 7 days a week, but radiology ran a 5- or 6-day service. Staff on the surgical assessment unit said they sometimes had difficulty getting ultrasound scans.
- The trust's self-assessment process had identified that it was not meeting the expectation that hospitals admitting medical and surgical emergencies should have access to interventional radiology 24 hours a day.
- The endoscopy service ran 7 days a week (mornings only, Saturday and Sunday), but it did not meet the standard of a comprehensive endoscopy service with a formal consultant rota 24 hours a day, 7 days a week.
- There was a pharmacy service 7 days a week (limited hours, Saturday and Sunday).
- Junior doctors told us there was good availability of registrar and specialty doctors out of hours and consultants were contactable.
- There was now a physiotherapy service available at weekends. Only one physiotherapist was on duty so she had to ask for assistance from nursing staff to mobilise patients.

Are surgery services caring?

Good

The patients we spoke told us nursing staff were caring and attentive. They said they had received good explanations about their treatment. Patients on enhanced recovery pathways were well informed and their involvement in their care was promoted to speed recovery.

Compassionate care

- We observed nursing, physiotherapy and occupational therapy staff treating patients with dignity and respect.
- The patients we spoke with were positive about the care they had received. A patient in the surgical assessment unit said, "They are good on the unit. They're friendly. … They check how you're doing. They explain what's happening." This patient had been an inpatient several times before and he commented that nurses had become more caring. All the patients and their relatives whom we spoke with on the wards were complimentary. One of them said staff were "marvellous". Another patient said that night staff were attentive and made sure she had her call bell within reach. We observed that the wards were calm and quiet and one of the patients commented on the lack of noise.
- The three wards scored highly in the patient survey on questions about being well cared for and treated with dignity and respect.
- In response to comments from patients, there had been work with nurses and healthcare assistants on the surgical wards to make sure people were treated with respect. Staff were expected to ask patients "Is there anything else you want?" after providing assistance. Ward managers gave us examples of action they had taken to address poor attitude when this was reported to them.
- A student nurse told us there was a high level of awareness of the importance of treating all patients fairly, and taking into account the cultural and religious background of patients (for example, that some patients preferred to have a nurse of the same sex).
- On the surgical wards, lights were turned out at 10pm and posters were put up at night to remind staff to be quiet.
- The trust had scored below the England average on the Friends and Family test in previous months; however, the scores displayed on the surgical wards during our inspection were high, although the response rates remained low. Friends and Family questionnaires were collected in the recovery area but there were no results displayed there and staff were unaware of the results.

Patient understanding and involvement

- The trust performed lower than average in the Adult Inpatient Survey, CQC, 2013, on questions relating to information giving by nurses and involvement in decision making. The results of the more recent trust survey indicated that performance had improved over the past year and the surgical wards were now achieving positive results. We were told of action to improve communication, including by staff training.
- The patients we spoke with said they had received the information they needed about their treatment at the outpatient clinic. One of them said they had been given "lots of information" and the surgeon had explained the risks. Two relatives we spoke with on the surgical wards were concerned that they had been unable to speak to the doctor or surgeon about their relative's treatment.

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Nursing staff had told them that, if their relative had difficulty understanding the information given, they could come to the ward outside normal visiting hours in order to speak to the surgeon.

- An enhanced recovery nurse described the information given to patients on enhanced care pathways, individually or in groups pre-operatively, in order to promote their involvement in their care and speed recovery.
- There was a named nurse for patients on the surgical wards. Pictures of ward staff were displayed on a board on the ward.

Emotional support

- Clinical nurse specialists provided support for breast and colorectal cancer patients. One patient told us, "The cancer nurses were fantastic. They asked all the right questions. They phoned me at the weekend to check how I was. I felt I could ask them anything." Patients on enhanced recovery pathways were asked to complete a questionnaire and the results were collated and discussed.

Are surgery services responsive?

Good

Staff were focused on their patients and we found examples of initiatives to improve the responsiveness of services to patients.

There were large numbers of day cases, but the high bed occupancy rates left surgical services with little room to manoeuvre if these patients required a bed. Some surgical patients experienced delays because of the high demand for emergency and elective operations. We saw that theatre staff worked flexibly to minimise delays and avoid cancellations, but there was a risk that changes to list order might undermine the processes in place to maximise safety and be responsive to the needs of patients.

Service planning and delivery to meet the needs of local people

- The average for bed occupancy between January and April 2014 was 96.4% and in the previous three quarters it was over 96%, which might have put pressure on patient care. These figures were much higher than the England average of 86%. The pressure on the acute admissions unit, theatres, recovery areas and wards was acknowledged by the trust.
- The reported percentage of patients referred who were treated within 18 weeks was 90% of admitted patients and 95% of non-admitted patients, which met the national target for referral to treatment times.
- There had been increasing delays for ophthalmology patients because of cancellation of clinics.

Access and flow

- Elective patients attended pre-assessment appointments where nurses assessed them and referred them to an anaesthetist if required. A decision about whether patients should be treated as day cases was made at this point.
- The elective surgical day case rate was over 85% for the year to date, meeting the trust's target. The percentage of elective admissions on the day of surgery was 96% and exceeding the trust's target.
- Day patients and inpatients being admitted on the day of surgery go to the same admissions area early in the morning or in the afternoon and are then called to the nearby theatre suite.
- Staff told us there were six consulting rooms in the admissions area, insufficient for seven theatres, and this hindered patient flow because there were delays in patients being seen by the anaesthetist and consultant surgeon before surgery.
- There was a pathway to surgery through the surgical assessment unit, which was part of the acute assessment unit, for patients attending A&E or referred by GPs. The unit had priority access to investigations and dedicated porters. The emergency pathway practitioner facilitated the flow of patients (for example, by accessing beds on surgical wards). Ambulatory patients sometimes went home and returned for investigations before a decision was made about surgery. However, the shortage of beds and staff impeded the effective working of the unit at busy times.
- Surgical patients experienced delays because of the high demand for emergency and elective operations. We saw that theatre staff worked flexibly to minimise delays and avoid cancellations. This sometimes resulted

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in patients not being told of likely delays because the timings of operations remained flexible. There was also a risk that the effectiveness of the pre-list brief would be undermined if the list order changed.

- Cancellation rates for operations had been similar to those expected for a hospital of its size over the past year. All patients had been rebooked for surgery within 28 days of the cancellation. The number of cancellations had increased over the week of our inspection as part of the plan put in place to deal with the unprecedented demand and shortage of beds. Three of the seven patients we spoke with in the admissions area and several patients on the wards had previously had their operation cancelled at the last minute or rearranged. In some cases, they were contacted and asked to be prepared to come the following day, and then that arrangement was also changed.
- Theatre utilization is 70%, lower than the trust target of 77%.
- The two-stage recovery facilities enhanced patient flow. However, patients often had an extended stay in recovery because of a shortage of high-dependency beds in the critical care complex, or because a bed was not yet available on a ward.
- Staff in the recovery area routinely worked late beyond the 11pm closure time. Theatre staff also regularly worked late in order to complete lists.
- We looked at discharge summaries in the recovery area and found that many of these were incomplete. The low percentage of discharge summaries completed (45%) had been red-rated on the division's dashboard.
- There was effective multidisciplinary working on the wards to discuss and plan discharge for all patients on the ward in collaboration with a discharge coordinator.
- There was one surgical 'outlier' patient on a medical ward on the day we inspected the wards and we were told this was unusual. Trauma and orthopaedic patients were often admitted to the general surgical wards. We were told that many nursing staff were trained across specialties so that they were competent to care for patients.
- The matron for surgery and a senior nurse had initiated the setting up of the nurse-run emergency gynaecology unit (EGU) so that women (for example, pregnant women with abdominal pains) were referred directly by their GP or A&E and did not have to wait in A&E before being seen. The nurse liaised with gynaecologists and arranged scans. We spoke to a woman on the unit who was full of praise for the responsiveness of the service and the quality of care at the hospital generally. She said, "I tell everyone to come to this hospital."

Meeting people's individual needs

- Ward managers told us an interpreter service was booked if needed, including for patients who communicated in British Sign Language when the medical or surgical staff or clinical nurse specialists wanted, to explain treatment. There was an in-house Turkish interpreter.
- Staff in areas that were under pressure, such as the surgical admissions unit and the recovery areas, told us they sometimes found it difficult to provide responsive care. We saw patients in both areas who were seated, but who had conditions that indicated a need for a bed. The surgical assessment unit was very busy when we inspected and nurses told us this meant they were unable to respond to requests for assistance, monitor pain relief effectively or keep people informed. A patient told us staff had not responded to her call bell in a timely manner and this had resulted in her urinating in her bed and, inevitably, a loss of dignity.
- We spoke with a patient on the surgical assessment unit who had been given a choice to be admitted or to go home and return for investigations. She had gone home and returned for investigations and the results before the consultant made a decision about treatment. She said this had enabled her to arrange child care.
- Patients were screened for dementia when this was indicated. Support services were available for patients with dementia or learning disabilities.
- A consultant psychiatrist and registrar were available to assess patients with mental health needs.
- The discharge nurse specialist described the regular contact between the discharge team, local authority social workers and community health services to facilitate care of patients after discharge. There were twice-weekly meetings with the clinical commissioning group to discuss access to step down beds and other facilities for patients medically fit for discharge.
- Patients were given written information and a telephone number to call if they wanted more explanation.

Learning from complaints and concerns

- Senior nursing staff on the wards gave us examples of action taken in response to patient surveys and

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complaints. In response to the complaints about pain not being managed, a senior nurse on the trauma and orthopaedic ward had been trained in pain management.

- In 2013, North Middlesex University Hospital had a poor response time to complaints compared with other trusts and we were told this was because of vacancies in clinical governance posts. However, managers in the surgery division had been dealing with complaints until the recent appointment of the clinical governance coordinator and most complaints had been dealt with promptly.

Are surgery services well-led?

Good

There was a strong safety culture in theatres and nurses on wards and in the units we inspected told us there was an expectation that unsafe or poor practice should be reported.

Patients and staff told us there had been improvements in the way surgical services were delivered. Many staff from all professions and grades told us they were committed to further improvements.

Vision and strategy for this service

- Many staff in the areas we inspected talked about the improvements that had been made to services and the contribution they hoped to make to further improvements.

Governance, risk management and quality measurement

- Theatres were closed for an afternoon every 2 months so that theatre staff could attend a multidisciplinary clinical governance meeting. There were presentations and discussion of audits, such as those on pain and consent. However, theatre staff told us that many members of staff were unable to attend these meetings because of overruns in theatre.

Leadership of service

- Senior trust and divisional managers, clinicians and theatre staff had implemented the effective use of the 'five steps to safer surgery' procedure.
- Nursing staff on the surgical wards told us they felt well supported and that the matron and ward managers were approachable. Managers told us of regular management meetings, where risks and pressures on the service were discussed. There were opportunities to propose solutions and to make the case for testing these.

Culture within the service

- Staff from all professional backgrounds and grades demonstrated a keen focus on the patient and the desire to promote their well-being.
- We found a strong safety culture in the theatres and there were plans to develop training to further improve understanding of the factors that affect patient safety. We also found that patient safety was promoted in theatres by anaesthetists, nursing and operation department practitioners, and junior doctors.
- Nurses on wards and units told us there was an expectation that unsafe or poor practice should be reported to their line manager, or more senior staff if the manager was implicated. We were given examples of action managers had taken to address poor practice.
- Throughout our inspection in all the areas we inspected, staff told us they "pulled together" to deal with demand and to ensure patients were receiving appropriate care and treatment. There was an atmosphere of calm even at the busiest times.

Public and staff engagement

- Matrons attended patient representation meetings and listened to patients' stories.
- There were regular meetings of middle and senior grade nurses, but there were no team meetings held for pre-assessment, theatre, recovery or ward staff. Junior nursing staff were not always clear whether issues they had raised had been taken further. There were plans to reintroduce team meetings on the wards.

Innovation, improvement and sustainability

- Senior nurses and allied professionals told us they were encouraged to think about ways of doing things differently and to take the initiative. We were told that senior management was open to new ideas. We were given examples of initiatives to improve patient care, such as the setting up of the nurse-run emergency gynaecology unit.

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- There had been a strong commitment by staff to meet the challenges of the reconfiguration of the service. However, there was a risk to the safety and effectiveness of the service if the pressure on staff and resources continued.

Critical care

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

Information about the service

The critical care complex at North Middlesex University Hospital NHS Trust consists of two clinical areas and an outreach team. Twenty-one beds are available across the unit –10 intensive care unit (ICU) beds with level 2 and 3 patients, and 11 beds in the progressive care unit (PCU) that treats level 1 and 2 patients. The critical care outreach team assists in the management of critically ill patients throughout the hospital.

The ICU consists of six isolation rooms and two double rooms. The PCU has a male and a female bay as well as isolation rooms. The unit is open 24 hours a day, every day of the year.

Staff provide care for critically ill patients with life-threatening illnesses and after surgery. Patients are received from theatres, A&E and wards throughout the hospital. There were 889 admissions to the ICU in 2013.

During our inspection, we spoke with three patients, three relatives, and 15 staff members, including consultants, doctors and nurses. We observed care and treatment and reviewed medical records and care documentation.

Summary of findings

We found the critical care complex to be good overall. Patients' needs were met by the service, and patients were cared for in a supportive way. There were criteria for admission to the unit run by intensive care staff. Patients were treated according to national guidelines and evidence-based practices. They and their families told us they felt the unit was safe and the care they received was "very good".

Staff used clinical governance methodologies, such as audits, to monitor the quality of treatment and the clinical outcomes for their patients. However, some staff were not fully aware of this governance and quality monitoring. They reported incidents so they could improve on the quality of care patients received. There were processes to ensure patients received care and treatment that was as risk free as possible, and other processes to prevent the spread of infection and monitor risk.

There were enough staff to care for and treat patients effectively. Staff were aware of the department's values and vision, and felt supported by the senior clinicians and nurses to report incidents without the fear of being blamed. There was enough equipment for staff to perform their duties appropriately, and the unit was clean and hygienic. Staff training was supported by competent practitioners based in the unit.

Critical care

Are critical care services safe?

Good

Risk assessments were carried out to ensure the safety of patients while in critical care. Observation monitoring was effective and recorded adequately. During our inspection, we observed an emergency situation that was handled quickly and effectively. Early escalation of treatment for deteriorating patients was used. Infection control standards were good.

There were policies and guidelines in place for staff to follow. Incident reporting was encouraged and some learning from feedback was evident. Audits were carried out to ensure that treatments received by patients were of a good standard.

Incidents

- We were informed of the process for incident reporting, which was linked to the trust governance system, and how learning from incidents supported staff learning. For example, one incident's root cause analysis led to the unit changing all patient mattresses after a patient developed a pressure sore. We saw these new mattresses in use.
- Mortality rates averaged between 10% and 15%. Staff attended a regular mortality and morbidity meeting. Plans from this meeting were acted on, such as medical staff needing 'Epr' (electronic patient records) training. Doctors told us that they had been trained in Epr.
- Staff used incident reporting to improve patient outcomes, and they described how they used risk assessments developed from feedback from incidents to implement 'skin care bundles'. These are a pathway of care designed for staff to follow when patients are at risk of developing pressure sores, which we saw in use.
- There had been no Never Events reported in the critical care unit.

Safety thermometer

- NHS Safety Thermometer information was clearly displayed opposite the nurses' station.
- We were told that there had been no patient falls in critical care since January 2014. We saw that falls in February 2014 across the trust had reduced.
- Reports of pressure ulcers were recorded and sent through the governance system; the ICU now reported grade 2 pressure sores as a precautionary measure after an incident of a patient developing a pressure sore.
- The number of new venous thromboembolisms (VTEs) was above the national average, but critical care were proactive in aiming to prevent these (that is, they gave preventative medication, and applied preventative leg stockings).

Cleanliness, infection control and hygiene

- The unit appeared clean and hygienic, and the patient areas we saw were free of clutter.
- There were no cases of MRSA infection reported between January and May 2014. Patients were actively screened on admission in accordance with hospital policy.
- There were 11 cases of C. difficile between January 2013 and April 2014. Not all cases were attributable to the unit. This was below the national average for a unit of this size. Staff told us that they worked closely with the infection control and microbiology teams to reduce the spread of infection.
- Hand hygiene audits were carried out weekly and we saw compliance scores of 100%. Inspectors to the unit were encouraged to clean their hands before proceeding to the patients' areas.
- All staff we observed wore appropriate personal protective equipment when caring for patients.
- There was one reported MRSA case reported in 2013. This was below the number expected for similar critical care units. We were told there had been no cases since January 2014.

Environment and equipment

- Staff told us that they had enough equipment to perform their daily duties. They had been trained on how to use the equipment, and during our inspection an equipment representative was training staff on how to use some specialist equipment.
- We saw that equipment was clean and appropriately labelled.
- We were informed that the unit was inspected daily by a technician who checked and replaced any equipment identified as faulty. Ventilators and infusion pumps that were in use had been serviced regularly.
- Resuscitation equipment was checked daily; we saw that trolleys were well stocked and equipment on them was within its sterilisation date.

Critical care

Medicines

- We checked the treatment room areas and found locked medicine cabinets.
- The controlled drug cupboard was locked and the keys held by an appropriate member of staff.
- A record was kept of all controlled drugs. We checked this and it matched the supplies within the cupboard. It was departmental policy for all controlled drugs to be signed by two members of staff and we observed this was taking place.
- The main medicine cupboards were kept locked with keys held by an appropriate member of staff. We checked a sample of these medications and all were in date.
- Medical errors were reported as incidents or near misses, and feedback was given to staff through the trust email and meetings such as the multidisciplinary team meeting. Staff told us they were encouraged to report errors openly so that learning could take place.
- There were a few reported medication errors but we saw from records that these had been managed well. Incidents were reported back at various meetings and the learning from such incidents was descended down to staff. Staff had been trained in how to administer medications safely.

Records

- Patient records were kept safely at each patient bedside and behind the nurses' station; staff were aware of confidentiality and data protection procedures.
- We reviewed patient records and saw that they were completed fully by members of the multidisciplinary team.
- Risk assessments were completed in the patient records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff informed us that they followed 'best interest' practices when patients were sedated in the ICU. Staff in the PCU told us that they always approached patients for their consent when needed. .
- Patients' families were involved in decisions on patient care and a consultant informed us that they were available to speak to families.

Safeguarding

- Most staff had been trained in safeguarding to level 2 and 3 and those we spoke with explained how to escalate and report safeguarding concerns if they had any. One example was given of an incident involving a safeguarding issue. Staff told us about the investigation and how feedback had led to service improvements. More vigorous risk assessments had been undertaken and safeguarding documentation had been implemented.
- On the PCU we saw a 'patient chaperone' sign, which informed patients and relatives that a chaperone could be provided if required

Mandatory training

- Staff were asked to complete mandatory training through methods such as e-learning and attending study days. Staff were supported by a practice development nurse. However, it was noted that in the critical care department not all staff were up to date in completing their mandatory training. We found this was an issue for departments across the trust.

Assessing and responding to patient risk

- Staff undertook risk assessments such as pressure sores (Waterlow scoring), falls and nutritional assessments.
- Continuous monitoring of all patients took place in the ICU and this was recorded. On the PCU, observation of patients varied according to their needs. Abnormal observations were reported to medical staff.
- We observed how staff managed deteriorating patients with increased observations and escalation to medical staff. During our inspection, we saw an emergency situation that was handled quickly and effectively by staff who were present. A recent audit of the national early warning score (NEWS) showed 87% effectiveness and medical staff informed us that they were working to improve this.

Nursing staffing

- There were enough trained nursing staff on duty during our inspection. We saw an adequate staff skill mix to enable patients to remain safe. We looked at previous rotas showing that these staffing levels were sustained over time.
- Staffing levels in the critical care service were in line with relevant national guidelines.
- Bank and agency nurses were used when there was a nursing shortage, and they undertook a unit induction to ensure they were competent to care for patients.

Critical care

Medical staffing

- Most of the medical staff we spoke to were positive about their work on the unit. They reported a "good working environment" where they could voice opinions about patient care.
- There was a good skill mix of medical staff on the unit and the clinical lead was an intensivist, which is recommended by the Faculty of Intensive Care Medicine (FICM).
- There was adequate cover out of hours and at weekends by both medical and nursing staff. Consultant ward rounds were conducted in the morning and evening.

Major incident awareness and training

- There was a major incident policy on the unit, but when we spoke to staff they were not fully aware of what it entailed. We were told that there was a fire evacuation procedure and staff appeared more knowledgeable about this process.

Are critical care services effective?

Good

The critical care unit was effective. Policies and guidelines were based on the core standards for intensive care. Evidenced-based practices were being used and audited. There were guidelines for staff to follow such as management of patents with sepsis. Some policies and guidelines had not been updated at regular intervals, but staff told us that this was gradually happening. There were competent staff and clinical supervision was in place.

Evidence-based care and treatment

- Guidelines and policies used in the unit were in line with the National Institute for Health and Care Excellence (NICE) and FICM guidelines.
- The General Medical Council had also attended the unit and their feedback was being acted upon during our inspection. Continued concerns related to clinical supervision and overall satisfaction rates.
- The unit had qualified intensivists who used evidence-based practices.
- We were told that the use of proning patients (patients are laid on their stomach to assist with lung disease) in the ICU was being introduced and a guideline was being established for this. Staff said that they had not been able to do it before because there was a shortage of staff to ensure patient safety. They had delayed the practice until staff numbers were adequate.
- Staff followed local trust policies such as on MRSA screening and medications management, but they had also written their own guidelines on sepsis management that was specific to ICU and PCU patients.
- Most staff we spoke with were aware of the audits and data collection that took place on the unit.

Pain relief

- Patients we spoke with said their pain had been managed well. Staff spoke of the importance of pain management.
- There were adequate protocols on pain management and intravenous infusions for pain management.

Nutrition and hydration

- We checked records and observations charts of patients that showed that nutritional risk assessments had been done. The unit used the dietetics service to assist them. Records we saw showed adequate nutrition and hydration for patients. We also saw the fluid balance charts of patients were completed appropriately.

Patient outcomes

- The ICU participated in the Intensive Care National Audit and Research Programme (ICNARC). The programme results enabled staff to identify actual and potential risks to their patients. The critical care unit treated patients with varying conditions. Mortality rates were comparable to other hospitals of this size and demographic.
- Unplanned readmission was within the national average.

Competent staff

- Staff reported that they had regular appraisals and clinical supervision.
- Most nurses had completed the ICU course, and new nurses were being guided by the practice development nurse.

Multidisciplinary working

- All staff told us that multidisciplinary working was effective and the multidisciplinary team meeting took place during our inspection.

Critical care

- The critical care outreach team assisted with the early detection and admission of patients to the unit. Doctors from different hospital departments reported that the team was effective.

Seven-day services

- Because of the high-level needs of patients, services throughout the hospital, such as radiology, pathology and physiotherapy, were available to the unit out of hours and at weekends.
- The critical care outreach nursing team responded to deteriorating patients on the hospital wards, using the modified early warning score (MEWS) system. Staff we spoke to said the team was very effective.

Are critical care services caring?

Good

We observed staff who were caring, respectful and professional. People who inspected the service were spoken to with dignity and respect. Privacy and dignity for patients were maintained. The PCU had separate male and female bay areas. We observed a family member being consoled by nursing staff at a time of distress.

Compassionate care

- During our inspection, we observed patients being treated with dignity and respect. Staff spoke to people politely. Relatives said, “They are very caring” and “The staff are wonderful.”
- A satisfaction survey of inpatient care reported that relatives scored the care as good to excellent.
- The most recent Friends and Family Tests also showed that people thought the service was good to excellent.
- Visiting hours were from 1pm to 8pm. Relatives of patients who were deteriorating were able to visit outside these set hours.

Patient understanding and involvement

- Because of the nature of patients’ condition in critical care, relatives were involved in making decisions about treatment options. Any care discussed was documented. We looked at patient records and saw that documentation showing the input of patients’ families had been included.

Emotional support

- We were told that relatives of patients admitted to the ITU were spoken to as soon as possible. Relatives could also have regular updates on their family members’ care.
- We witnessed a distressed relative being comforted by staff. We also observed relatives being spoken to by doctors.
- There was a private room for relatives to have private discussions with doctors and nursing staff.
- Patients and relatives had access to support from the palliative care team and chaplaincy department.
- There was a specialist nurse for organ donation (SNOD) who supported patients in the unit who were awaiting organ donation.

Are critical care services responsive?

Good

The critical care unit was responsive to people’s needs. The clinical lead informed us that, when an issue was identified by staff, it would be discussed at the staff meetings to find a solution to ensure that the service met people’s needs. We saw staff acting quickly on information from observation monitoring. Nursing staff told us doctors were always available in the event of emergencies.

Most complaints were dealt with at local level, and there was a complaints procedure that patients and their relatives could follow. Leaflets were available in both the ICU and PCU.

Service planning and delivery to meet the needs of local people

- The consultant lead had introduced an IT system called Acubase that documented mortality, morbidity and other patient factors. This enabled staff to see the demographics, morbidities and types of illnesses people came to the unit with. The system was accessible and used to assist staff in their planning of services to meet people’s needs. Although it was not being used to its full capacity, the consultant told us that it would be disseminated further and used in conjunction with ICNARC to meet the needs of patients.
- During our inspection, there was an increase in patients needing admission. This was handled well in the unit

Critical care

and extra qualified staff were accessed quickly. The increase in bed numbers did not appear to have an impact on the quality of care, treatment or support being provided.

Access and flow

- There were 311 admissions between January and March 2014; 19 of these were readmissions according to ICNARC**.** Patient flow in and out of the unit was good.
- From December 2013 to March 2014, the service had an average bed occupancy rate of 93.3%, which was above the national average of 85.7%. One reason for this increase was the decline in services from a nearby hospital and a merger of three trusts. The impact on bed occupancy was being dealt with by the trust board.
- Patients were admitted from accident and emergency (A&E), the PCU and theatres after surgery.
- There were admission delays of between 4 and 7 hours between December 2013 and March 2014.
- Delayed discharges were reported at 2%, which was similar to expected.

Meeting people's individual needs

- The critical care service had access to the trust's interpreter service. Staff told us that they used this to inform family and patients about care and treatment.
- Some staff were aware of how to care for patients living with different types of dementia.
- A chaperone service was available if patients requested it.

Learning from complaints and concerns

- Complaints were handled in line with trust policy and staff we spoke to knew how to handle complaints. One complaint we were told of was dealt with at ward level and staff said it did not escalate further. There was a complaints procedure leaflet available on the wards how detailed how to complain and to whom.

Are critical care services well-led?

Good

The service was well-led and staff we spoke with said the clinical lead was "excellent" and "had a clear vision" for the unit. Although there were some issues with policies and guidelines being updated, the unit performed well. There was a clear vision for the unit and staff were engaged with this vision.

Vision and strategy for this service

- Staff described a clear strategy and vision for the unit. The unit, like the trust, had experienced a period of change, which had meant a large number of new staff. One staff member said, "This is a work in progress, but we provide safe care."

Governance, risk management and quality measurement

- The department was linked with the trust governance department.
- Staff attended multidisciplinary meetings and audits, complaints, incidents and quality improvement were discussed.
- We spoke to some staff who were not aware of some guidelines and policies that were being used in the service. Although we saw evidence that some guidelines and policies were being updated, this had not been filtered down to all members of staff. We fed this back to staff and immediate action was taken to rectify it.
- There was a slight disparity among staff about what they knew of governance and quality. For example, most staff knew there was a guideline for the management of patients with acute respiratory distress syndrome (ARDS), but a few were not aware of it, even though they treated patients with ARDS and were using the guideline. We saw a guideline for ARDS printed on the wall opposite the nurses' station.

Leadership of service

- Staff reported a service that consisted of good leadership, where they were encouraged to use evidence-based practices. The clinical lead told us of their plan for the future. The lead consultant told us that they viewed all staff who practised on the unit as important member of the team, and all contributions from staff were welcomed.

Culture within the service

- One staff member said, "This is a really friendly unit." We observed a multidisciplinary team meeting during our inspection when staff interacted well together. There was no apparent conflict between nurses and doctors. Another staff member said, "There's a very nice environment on ITU."

Critical care

- Staff worked well together and respected each other's opinions.
- They said they were encouraged by the lead consultant to improve patient care outcomes. One staff member said, "We are lucky to work with this consultant.

Public and staff engagement

- Staff and public engagement took place in the form of staff surveys, inpatient feedback and Friends and Family Test feedback.

Innovation, improvement and sustainability

- We were told of improvements to patient care guidelines that were being introduced, such as the 'proning' of patients (nursing a patient on their stomach to assist with lung disorders) and a password system for relatives. Although we were informed of various plans for future patient care, these were still in the early stages.
- They were leads for infection control, tissue viability and practice development.

Maternity and family planning

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

Information about the service

The new maternity unit opened in November 2013 to cater for a predicted 5,000 births. The number is currently 4,355. The unit consists of a labour ward with 10 birthing rooms, four high-dependency rooms for women with high-risk medical or obstetric needs, two obstetric theatres and a recovery area, a four-bed bay and a single room. There is a purpose-built bereavement suite.

A midwife-led birth centre with four 'home from home' rooms and four rooms with birthing pools has about 75 births a month. The unit also houses antenatal clinics, a triage and day assessment unit, and an induction of labour suite. Specialist outpatient clinics cover diabetes, obesity, foetal medicine, genetics, fertility and HIV. An antenatal day unit takes referrals from specialists of women with non-labour complications of pregnancy over 20 weeks' gestation. A neonatal unit is also in this building.

The postnatal/antenatal ward has 32 beds in one of the older hospital buildings. A new postnatal/antenatal ward is due to open in December 2014.

Five teams of community midwives are employed by the trust to run antenatal clinics in local areas and undertake postnatal inspections. The midwives also rotate through the birth centre.

There is an 8-bed gynaecology surgical ward, an emergency gynaecology unit and an early pregnancy assessment unit, as well as clinics. Clinics offer a comprehensive range of gynaecology services, including recurrent miscarriage, colposcopy and hysteroscopy.

We inspected all services in the maternity unit at the hospital and spoke to 23 women and their partners, and 76 staff. These included midwives, doctors, administration staff and managers. We observed care and treatment and looked at care records. We reviewed other documentation including performance information provided by the trust. We received comments from our listening event and from people who contacted us to tell us about their experiences.

Maternity and family planning

Summary of findings

The maternity unit was spacious, modern and clean. Women and their partners said that the staff were caring and friendly. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in planning and decision making. The ratio of births to midwives was higher than the national average, but a review against Birthrate Plus was planned. Additional staff may be needed given the complexity of cases on the labour ward. The postnatal/ antenatal ward was waiting to move to new premises and was cramped by comparison with the other areas, but women were reasonably happy with the care there. We were conscious of shifts being understaffed and of midwives being under pressure. Staff did not seem to be distributed to provide optimum care for mothers.

Midwives we spoke to had a good awareness of safeguarding and there were clear multidisciplinary procedures for safeguarding and child protection concerns.

There was good multidisciplinary team working throughout the service. Staff development and continuing professional development had been somewhat neglected in the move to the new building and staff and system change. The management was in transition and a number of changes had recently been introduced. It was too soon to assess their impact. Although the service appeared to be running well, the trust needs to conduct more audits to assess performance against local and national standards. Risks arising from incidents were promptly and appropriately managed but some issues, such as unfilled shifts or the unavailability of records, were not identified as risks.

Are maternity and family planning services safe?

Requires improvement

The maternity ward areas were spacious, modern and clean, and equipment was regularly checked. The service used the modified early obstetric warning score (MOEWS) system to escalate care if women became acutely unwell. Staff we spoke with were aware of the appropriate action to take if women scored higher than expected and required close monitoring or transfer for more specialised care.

Mothers giving birth in the unit had many risk factors. Although we were told that staffing never fell below safe levels, we had concerns about unfilled shifts on the busy labour ward and about Band 6 staff acting as labour ward coordinators, especially at night. Midwives reported difficulty in taking breaks, and records passed from the labour ward to the postnatal ward were not always complete. Safe staffing was only achieved through ward sisters being counted when they should have been supernumerary. Tight staffing had a knock-on effect on professional development, supervision and appraisals. It also had an impact on the quality of patient notes on the labour ward and the handing over of patients to the postnatal ward.

Hospital records were not always available to staff in clinics nor, more importantly, to staff on the labour ward.

Incidents

- There had been no recent Never Events.
- We saw evidence of full analysis of serious incidents, including root cause analysis of the most serious. Actions from these incidents remained on the maternity risk register until all had been completed.
- The service had a thorough reporting system with an average of 10 risk forms a day for maternity. This was an expected level of reporting for the number of births.
- A daily trust-wide meeting was held to discuss newly submitted risk forms and potentially serious incidents were further investigated within 48 hours. The maternity service undertook one or two 48-hour reports a week.
- There was a strong culture of learning lessons from serious incidents. Lessons were disseminated through team meetings, in a newsletter and on noticeboards. These were evident in clinical areas.

Maternity and family planning

- Perinatal mortality meetings were held monthly.

Safety thermometer

- A monthly maternity dashboard highlighted performance against safety-related targets, including indicators such as staffing levels, unexpected admissions to the neonatal unit, stillbirths and unplanned admissions of mothers to intensive care. Between April 2013 and March 2014, outcomes for these were within national norms.

Cleanliness, infection control and hygiene

- All areas within the spacious maternity unit appeared clean and tidy. We saw staff regularly wash their hands. Personal protective equipment was available.
- New environmental audits had been introduced trust wide in March 2014 to raise infection control standards.
- Space was limited in the temporary postnatal/antenatal ward but this did not appear to affect hygiene.
- The proportion of women swabbed for MRSA was increasing.

Environment and equipment

- The environment in the maternity unit and postnatal/ antenatal unit was safe and well equipped.
- We saw emergency clinical trolleys for premature labour, post-partum haemorrhage and resuscitation. Although trolleys were signed as having been checked, we found a number of out-of- date blood culture bottles on the labour ward.
- There was plenty of room for mothers to move around during labour.

Medicines

- Medicines were stored in locked rooms with swipe-card access. Trust policy was that drugs cupboards and fridges should be locked. They were not locked in the birthing unit on 4 June, although they were locked in other areas of the maternity unit.
- Appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them, there were no gaps in the administration records and any reasons for not giving people their medicines were recorded. If patients were allergic to any medicines, this was recorded on their medication administration record chart.

Records

- The trust was moving from paper records to electronic records.
- Paper records were often not available in clinics and the labour ward could not access paper records outside standard working hours. Not all records were on the new IT system. This was not on the risk register.
- We examined 10 patients' notes on the maternity ward; none had an intra-partum management plan completed, which was disappointing given the complex risks of the local community. The Situation, Background, Assessment and Recommendation (SBAR) sticker that had recently been introduced was not used on any notes seen. Midwives reported that records passed from the labour ward to the postnatal ward were not always complete. Otherwise notes were well maintained and appropriately countersigned for students.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw consent recorded on some mothers' notes. We were told of a drive to improve the recording of consent.

Safeguarding

- The trust policy was that midwives should be trained to level 3. This was not currently the case because of the influx of new staff and other changes to the unit, but midwives we spoke to had a good awareness of safeguarding.
- There was a named safeguarding midwife and there were clear multidisciplinary procedures for safeguarding and child protection concerns. A training package was being developed to cover safeguarding issues that were prevalent in the local population.
- Child protection supervision sessions were held monthly, alternating between the boroughs of Enfield and Haringey.

Mandatory training

- Midwives reported missing training because of staff shortages and they were not undertaking any e-learning in their own time. Records showed completion of mandatory training was low but this issue was trust wide because of the changes made to the recording system by the trust.

Assessing and responding to patient risk

- A full-time diabetes midwife ran clinics, which showed good multidisciplinary working between obstetrician, medical staff and midwife.

Maternity and family planning

- The diabetes midwife also advised the labour ward about the care of diabetic women admitted.
- There were failsafe systems in place to ensure that newborn screening took place and positive results acted on.
- The unit used the MOEWS to manage a deteriorating patient. We looked at completed charts and saw that staff had escalated appropriately.
- The use of a modified World Health Organization (WHO) surgical checklist was becoming embedded in practice in the obstetric theatres. Staff at different levels reported this being used appropriately. The audit for May 2014 showed 87% compliance with the WHO checklist and the compliance in the previous two months had been 95% or more.
- Elective caesarean lists were only conducted when there was a consultant on the labour ward.
- There was a risk that patient test results might be missed because the relevant computer systems were not linked. This was on the risk register.
- Equipment and service issues also on the risk register were out-of-date ultrasound machines in the gynaecology department and the absence of an interventional radiology service, which could result in a higher number of hysterectomies after haemorrhage. The trust hysterectomy level in these circumstances was already high. It was not clear when action would be taken.
- A weekly clinical governance and risk meeting looked mainly at Datix (a system for recording incidents) incidents and drew out lessons learned and actions taken. We noted some recurrent themes in recent minutes, such as incomplete documentation in patient notes, delayed escalation and failure to follow guidelines. Similar themes were evident in the clinic audits. The trust will need to assure itself that lessons learned are effectively disseminated, understood and sustained in practice.

Midwifery staffing

- The midwife establishment was 140 working time equivalent, allowing a midwife to birth ratio of 1:30. Establishment levels were planned for review using the Birthrate Plus tool. Safe staffing was only achieved through ward sisters being counted when they should have been supernumerary.
- Ninety-one per cent of women received 1:1 care in established labour during the first 4 months of 2014.
- The midwife vacancy rate was 5%.
- Overall sickness rates in the maternity unit were low at 3.5%.
- Planned and actual staff numbers were displayed daily in wards and clinics. On the day of our inspection, many areas of the maternity unit were short of staff because of annual leave and sickness, and we were told this was a common occurrence.
- The labour ward was two midwives short. Although a matron was present to assist, the shortfall was a risk to safety given the complexity of the births in the unit. The previous night the labour ward coordinator had had to work clinically at times because staff were stretched.
- Some Band 6 staff had to take on the role of labour ward coordinators, often at night and without adequate training. Midwives said that their concerns about safe staffing had not been taken seriously by managers. Anaesthetists had also raised concerns about staffing levels.
- Midwives were first called from other areas to cover shift shortfalls, and then bank staff were used. Few agency staff were used.
- We observed both medical and midwife handovers in the labour ward; these were structured and discussed staffing and potential high-risk patients. The handovers showed good team working and respect for confidential information.
- The number of supervisors to midwives (1:18) was below the recommended 1:15. Supervisors reported being 'stretched' but able to fulfil their statutory function. There were plans to reduce the ratio to 1:15 with staff who were already in post once the Local Supervising Authority had approved the appointments.
- The service was planning to use the Association of UK Hospitals Acuity/Dependency Tool to assess staff needs on a shift-by-shift basis.

Medical staffing

- Consultant cover for the labour ward was 98 hours a week in line with national recommendations for the number of babies delivered annually.
- Consultant cover was 7 days a week, with a consultant on call out of hours.
- Monday to Friday there were two anaesthetic teams until 2pm.
- Sixteen consultant obstetricians/gynaecologists provided specialist and general services.

Maternity and family planning

- We observed an effective doctors' handover on the labour ward with a midwife present. A consultant was present.
- Consultant-led clinics ran daily.
- There were too few junior doctors to cover all shifts and vacancies at middle grades. Shortfalls were covered by existing team members or locums (usually at night). External locums probably covered one shift a fortnight.

Major incident awareness and training

- There was a trust-wide major incident plan reviewed every 3 years. A copy was in each department.

Are maternity and family planning services effective?

Good

The maternity service used evidence-based national guidance. However, there did not seem to be a systematic process for updating guidance based on national updates. There was good multidisciplinary team working and learning throughout the service between community and hospital midwives, clinicians and midwives, and at the perinatal meetings between obstetricians and paediatricians. Staff development and continuing professional development had slipped because of a change in delivery methods and safe staffing pressures.

Evidence-based care and treatment

- A combination of good practice guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) was used to determine treatment plans. Local policies were based on these. However 10 of a random sample of 15 guidelines were out of date and past their review date. Child protection guidance dated August 2012 did not take account of the revised Working together to safeguard children published by the NSPCC in March 2013.
- We noted that guidelines on sepsis, transfer of babies in or ex-utero and female genital mutilation had been updated this year.
- National audits that the hospital took part in were pre-eclampsia and the MBRRACE-UK surveillance data collection system (MBRRACE-UK is Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK, an organisation that investigates maternal deaths, stillbirths and infant deaths).
- We saw several examples of clinical audits (for example, on obstetric haemorrhage, hypertension and HCG serum). We noted that quality of patient notes and availability of postnatal notes limited the completeness of these audits, although they did not invalidate the findings.
- We accept that the focus of the department this year had been on the smooth transition into the new premises. However, systems for regular audit of performance and the process of following up and embedding changes as a result of the audits needed strengthening. An example was the quality of record keeping on the labour ward which the MOH clinical data audit (June2014) had indicated as a weakness.

Pain relief

- Mothers reported they had good pain relief and staff had been responsive to any pain they reported both during and after birth.
- Detailed protocols for the management of pain relief in labour and hypertension in pregnancy were on the trust intranet.
- There was a low epidural rate which may mean that other forms of pain relief were successful.

Nutrition and hydration

- Eighty-nine per cent of mothers started breastfeeding in February 2014. The target was 95%. The trust sponsored community outreach services in two children's centres to support breastfeeding.

Patient outcomes

- The maternal readmission rates, neonatal readmission rates and puerperal sepsis were below the national average between October 2012 and November 2013.
- The normal birth delivery rate was 65%, higher than the England average of 60.7%. This was positive given the high-risk population. Natural delivery was promoted by the midwives.
- Instrumental deliveries averaged 8%.
- The total rate of caesarean section was 28–30% in 2013. Seventeen per cent were emergency caesarean sections in March 2014, which was higher than the national average of 14.6%.

Maternity and family planning

- Two mothers had been admitted to the intensive care unit (ICU) in April, but none in the earlier months of 2014.
- We observed positive emotional support for women who had had an unplanned caesarean or other complications in labour and birth.

Competent staff

- Junior doctors reported adequate access to training and weekly teaching on the labour ward or in the region. The recent Deanery inspection had rated obstetrics and gynaecology favourably.
- Doctors were well supported by consultants and had good relationships with midwives and other staff.
- Appraisal processes for midwives were through a cascade system. Midwives were not up to date with mandatory training or appraisals in the hospital. This was a trust-wide pattern. Completion rates were higher among community midwives. Overall, 47% of midwifery staff were up to date with appraisals in June 2014.
- Newly qualified midwives had preceptorship for 6 months.
- PROMPT (practical obstetric multi-professional training) was being used and the Safer Births handover tool had been introduced.
- Midwifery managers were supporting doctors on job plans for their revalidation.

Multidisciplinary working

- We observed close working with pharmacists and physiotherapists.
- There were clinics for women with medical problems such as diabetes, obesity and HIV.
- There was access to medical care from other specialties for the many women who had other conditions. Some patients (for example, those with cardiac problems) were transferred to specialist centres.
- There was good communication with the community maternity team, before and after birth, and with GPs during antenatal care.
- Midwives worked closely with GPs and social care services while dealing with safeguarding concerns or risks for child protection.
- Transitional care for babies leaving the neonatal unit was based around that unit until the new postnatal facilities open at the end of 2014.

Seven-day services

- There was consultant cover in the labour ward 8am to 10pm 7 days a week. A consultant was on call at night. There were two registrars and a senior house officer on duty at night.
- There was an anaesthetic team available 24 hours, 7 days a week.
- Pharmacy services were available out of hours but not physiotherapy for babies.
- Ward clerks were not available on the labour ward at weekends, which led to delays in registering babies on the computer system. No other staff were trained to set up these records.

Are maternity and family planning services caring?

Good

Women and their partners that we spoke with said that staff were caring and friendly. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in planning and decision making about the birth. We saw good emotional support for women who had had an unplanned caesarean or other complications in labour and birth.

Compassionate care

- The NHS Friends and Family Test for maternity services was positive for care during labour but below England averages for care in hospital after birth and antenatal care. However, the response rate was only about 28% of mothers. Conversely, all mothers and their partners we spoke with on our inspections praised the care they received before, during and after birth.
- The service used its own patient experience tracker and 'care rounds', speaking with mothers to gain feedback which was generally positive.
- Interpreters visited the ward to support those who did not speak English.
- Throughout our inspection, we observed women being treated with dignity, compassion and respect. Call bells were answered promptly.
- We observed visitors waiting several minutes to be admitted to the wards because staff were busy.

Maternity and family planning

- Partners were encouraged to visit and had longer visiting times. Those attending a birth did not have to pay car parking charges.

Patient understanding and involvement

- Antenatal patients felt well informed and said they had good care.
- Women said they had been involved in decisions about their choice of birth location and the risks and benefits of each. They said they were well supported after their decision.
- Mothers and their partners also said they had been well informed on the labour ward and that staff explanations had been calming.
- Women could have a virtual tour of the maternity unit online.
- Women had a named midwifery team but not a named midwife. They had a number to call if they had any concerns.

Emotional support

- A new clinic, Birth Reflections, had been set up for debriefing women after difficult deliveries. Women could refer themselves to this clinic, as well as being referred by their medical team.
- Support was available to support mothers with breastfeeding both in the hospital and after discharge. The service had a UNICEF certificate of breastfeeding commitment.
- There was a lead midwife for bereavement and, in the event of a stillbirth or sudden death; there was a special room available away from the postnatal ward.

Are maternity and family planning services responsive?

Good

The maternity services were responsive to people's needs. Mothers were able to choose from a range of options for birth, subject to the appropriate risk assessment. This took place at the first booking and identified any communication or language issues, difficulties with housing or the previous involvement of social services. Care was available for vulnerable mothers through specialist midwives for conditions such as diabetes or sickle cell anaemia.

Service planning and delivery to meet the needs of local people

- The number of births between October 2012 and November 2013 was 4,355. The service had capacity for up to 7,000 births a year.
- Services were planned to meet the specific health needs of the ethnicity of the population, including sickle cell anaemia and HIV.
- A security guard was on the door of the maternity ward during visiting hours as a result of incidents in the past.

Access and flow

- Mothers had access to the full range of options for birth, subject to the appropriate risk assessment, although there were few home births.
- The average length of stay was 3 days. There was often pressure on beds in the postnatal ward, but this could usually be managed by moving women due to go home that day to the discharge lounge.
- The maternity bed occupancy between January and March 2014 was 92.4%, which was well above the national average of 58.6%. Occupancy rates above 58.6% can start to affect the quality of care given to patients although we did not observe this.
- The labour ward managed capacity by delaying elective caesareans or induction.
- There were sometimes delays in discharge when there was only one midwife available to assess babies before they left the hospital. Another cause of delay was care packages not being ready. Discharge letters were generated by the computer system.
- The percentage of pregnant women accessing antenatal care who were seen before 12 weeks and 6 days was only 58% in April 2014 against a service target of 78%.
- Labour ward porters were only available from 9am to 4pm. Outside these times, midwives and maternity assistants had to move beds to the ward.

Meeting people's individual needs

- A social assessment was undertaken by the midwife at the woman's first booking. This identified, for example, communication or language issues, difficulties with housing or the previous involvement of social services.
- Care was available for vulnerable patients through specialist midwives for conditions such as diabetes or sickle cell anaemia. There was also close liaison with social care services for mothers with learning difficulties or mental health issues.

Maternity and family planning

- There was a good range of leaflets in English. We saw three in Turkish, but none in other languages. We were told that literacy among mothers was low; however, other family members might read relevant leaflets if they were available.
- Interpreters were widely used, as well as a contracted translation service. It was trust policy not to use family members to translate. Turkish link workers employed by the hospital were available Monday to Friday, 9am to 5pm to act as interpreters.
- The bereavement centre was bland and clinical and contained an integral foetal heart monitor and resuscitaire. The trust had not yet agreed that these could be removed.
- Efforts were made to contact women who did not attend appointments, with two follow-up letters and then a visit from the community midwife. One reason for poor attendance was booking mothers for clinics far from their homes to try to meet booking targets rather than mothers' preferences.
- The antenatal clinic only had one room for counselling, which meant some women might have to be given bad news in other, less appropriate areas.

Learning from complaints and concerns

- There were very few formal written complaints. Patients or relatives would normally speak to the shift coordinator about any concerns.
- There were leaflets in English and Turkish about how to make complaints.
- Women we spoke with knew how to raise concerns or make a complaint.
- The service responded to comments made on NHS Choices.

Are maternity and family planning services well-led?

Good

The head of midwifery and her team were relatively new and the new maternity unit had only been open for 6 months. New midwives had joined from other units that had closed, management restructuring had taken place and there was evidence that the midwifery workforce was not fully settled. Many of the building blocks for the future operation of the unit had been introduced, but too recently to assess their impact. The maternity service did not have a written vision or strategy. The service had implemented some effective innovations in care.

Vision and strategy for this service

- The maternity unit aimed to become the service of choice for women in the area and to provide a safe facility for mothers and babies. Staff were keen to provide a good service to mothers but we did not see a statement of vision and values.
- We did not see a review process or action plan in response to the lower than anticipated number of births.

Governance, risk management and quality measurement

- Maternity was part of the women's and children's service, reporting to the director of operations. The general manager attended the Executive Management Board and the Quality and Risk Group, which reported to the Board.
- In the previous 3 months, 374 incidents had been reported. Eleven per cent of incidents were from the labour ward and delivery suite. The top issue was staff shortages, and we had observed examples of staff shortage on our inspection. Staff shortages were not on the maternity risk register.
- The maternity risk register mainly noted actions following serious incidents**.** Risks were reviewed quarterly although risk meetings were monthly.

Leadership of service

- The general manager was well regarded for her direct style and efforts to improve communications.
- Many changes had been introduced in a short time and it was too soon to assess whether these could be embedded and become sustainable; greater staff engagement was needed.
- There was a high number of specialist midwife roles in relation to the number of midwives.
- The postnatal/antenatal ward was well run, staff morale was high, and mothers and partners were satisfied with their care.

Culture within the service

- Bands 5–7 midwives reported they worked well together and spoke positively about the service they provided to mothers and babies.

Maternity and family planning

- The staff survey showed 26% of midwifery staff felt their careers were limited by discrimination, which was a concern.
- Staff reported a lack of support from the matrons and above for training and development, and expectations that staff could extend their roles without training. This had implications for patient care.
- Some midwives said they did not feel able to raise concerns. Management consulted staff but did not appear to listen to feedback.
- Staff felt they were micro-managed and did not feel that changes were sufficiently well explained. They did not disagree with the direction of change, but wanted to feel a valued part of the changes taking place.

Public and staff engagement

- The general manager actively worked with clinical commissioning groups in commissioning services.
- A Maternity Services Liaison Committee sponsored by the trust met three times a year, run by a consultant midwife.

Innovation, improvement and sustainability

- Ambulatory treatment of hyperemesis (sickness in pregnancy) was regularly used and appreciated by mothers.
- Outpatient induction of low-risk mothers was also appreciated.
- Enhanced recovery was offered to mothers having a hysterectomy.
- The service was piloting discharge after caesarean section in 2 days.

Services for children and young people

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

Information about the service

The service for children and young people consisted of a children's ward, a paediatric assessment unit (PAU), a paediatric day assessment unit (PDAU), an outpatient department, a children's community unit and a neonatal unit (NNU). The children's ward is in temporary premises because the existing ward is being refurbished. The number of inpatient beds has therefore been reduced from 24 to 19.

The paediatric service is a tertiary centre for sickle cell disease, and support for children and parents includes a family clinic where a parent and child are treated together. There is a transition service to support children with long-term illness from the age of 13 to 16 working closely with adult services such as oncology and sickle cell clinics.

Similarly, the PAU and PDAU have been temporarily combined into a 10-bed unit instead of operating as separate units with a total of 20 beds. At the time of our inspection, it was envisaged that the refurbishment would be completed in 3 months.

We spoke with 12 parents, 2 young people and 23 staff, including consultants, doctors, nurses and support staff. We observed care, case-tracked 5 patients and looked at the care records of both acute surgical and medical patients. We reviewed other documentation, including performance information, provided by the trust. We received comments from parents and from people who contacted us to tell us about their experiences.

Summary of findings

Parents and children were complimentary about the care and treatment provided. Parents felt that staff of all disciplines were compassionate, understanding and caring. Staff in paediatrics considered they worked in supportive teams and responded to children's needs effectively.

Children's services had reported no Never Events from January 2013 to the time of the inspection. From January 2013 to March 2014, there had been no serious incidents in the children's services. On 2 June 2014, there was a medication error, which had been reported through the Datix system and an investigation was in progress.

The hospital had recently recruited seven nurses (grade B5) for the children's ward. However, the NNU had a 20% staff vacancies, which was not on the risk register. We were told that recruitment for the NNU was in progress and that regular agency nurses were being deployed to make up staff numbers The rest of the children's services were adequately staffed. The hospital employed 16 consultant paediatricians who also specialised in various medical fields, such as sickle cell anaemia, diabetes, asthma and allergies. A consultant-led seven-day service was provided, supported by a team of registrars and junior doctors, who were on site out of hours.

Services for children and young people

Are services for children and young people safe?

Good

Parents felt involved in their child's care and treatment and parents' informed consent was sought before care and treatment were provided where appropriate. There were enough medical and nursing staff cover to ensure patients received appropriate care and treatment. There was openness and transparency when things went wrong and information had been cascaded down to front-line staff after multidisciplinary meetings. Themes from incidents were discussed at weekly safety meetings.

A recent medication error had been reported promptly using the Datix system. An investigation was in progress. Staff knew how to raise concerns and make safeguarding referrals. Staff had knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. There had been no cases needing the application of Deprivation of Liberty Safeguards. Staff received appropriate training to help them care for patients.

The service used the paediatric early warning (PEW) score charts to measure patients' condition and to determine when prompt treatment was required. It used an adapted version of the NHS Safety Thermometer to support the provision of safe care. Patients' records were appropriately maintained and staff adhered to the trust's policy on confidentiality. The wards were clean but slightly cluttered. Equipment was appropriately checked and cleaned and had been serviced regularly.

Incidents

- No Never Events had been reported by the trust for the children's service in the period from January 2013 to the time of the inspection.
- There was openness and transparency when things went wrong. All staff we spoke with said that they had been encouraged to report incidents. Themes from incidents had been discussed at weekly safety meetings. For example, staff we spoke with were aware of a recent medication error that had occurred on 2 June 2014, described below under 'Medicines'. An investigation was in progress. The incident had been reported promptly using the Datix system.

Safety thermometer

- The service used an adapted version of the NHS Safety Thermometer to support the provision of safe care for children.
- We were shown the safety dashboard that was on display on the noticeboard in the main entrance corridor. The safety charts were updated daily and covered five main areas: MRSA infections, the observation of hand hygiene, checks on identity (ID) bands, venous infusion phlebitis (VIP) checks, and staffing numbers and skill mix.
- Safety charts were displayed at the end of each month together with an action plan for improvement. For example, in April 2014, there were no patients with MRSA. The hand hygiene observation audit scored 91%, ID checks 85% and VIP checks 90%. The results of the monthly patients' satisfaction survey were also displayed.
- Following the April result for VIP checks, all new fluid recording charts now included a section for VIP checks on patients who had an intravenous cannula in place. Each patient's ID bands were checked twice a day.

Cleanliness, infection control and hygiene

- All the ward areas were clean. We found that the environment was slightly cluttered. However, we were told that the normal children's ward was being refurbished and that the current environment was only temporary.
- We noted that separate hand-washing basins with hand wash and a dispenser for disinfectant gel were within easy reach and available in all the units. We saw staff regularly washing their hands and using disinfectant gel between patients.
- Personal protective equipment was available for use by staff in clinical areas.
- Staff wore clean uniforms with arms bare below the elbow, as required by the trust's policy.
- There had been no recent cases of C. difficile or MRSA infection.
- There was a lead nurse for infection control who ensured that staff adhered to the hygiene code of practice and the trust policy.

Environment and equipment

- The current premises used as the children's ward were secure. Access to the ward was by entry phone or swipe card.

Services for children and young people

- There was adequate equipment on the ward to ensure safe care.
- Equipment was appropriately checked and cleaned and had been serviced regularly. Broken equipment was labelled and reported to maintenance for repair. We saw the records for two infusion monitors that had been sent for repair on 6 June 2014.
- All the disposable equipment (such as sterile cannulas, intravenous infusion sets and bags of intravenous infusion packs) were in date and appropriately stored in the lockable storage room.
- There was one resuscitation trolley for the ward; this appeared cluttered, with a suction pump and other equipment on top. We were told that the trust intended to replace this trolley.
- The resuscitation trolley was checked daily by a designated nurse and a log book was kept to record these checks. We noted that the log book showed the trolley had been checked on 3 June 2014 but there was no record of its having been checked on 4 or 5 June 2014. Staff had since been reminded to check the trolley daily and to fill in the log book appropriately.

Medicines

- We were told that on 2 June 2014 there had been a medication error in the PAU. The error had been discovered by staff on the children's ward after the patient's transfer to the ward. The staff and consultant paediatrician had acted promptly to ensure the patient's safety. The ward manager confirmed that the family had been notified of the error and that the patient had since been discharged home. The incident was being investigated by the trust.
- The trust had detailed protocols for the management of pain relief in children with sickle cell anaemia and for the management of medicines when a child had to be transferred to another hospital. We saw these were available to staff on the trust intranet.
- A pharmacist visited the ward each weekday. We saw that they completed the medicines management section on the medicines administration record for every patient to confirm medication reconciliation had been done.
- All medication was stored safely and controlled drugs were managed appropriately.
- We saw there were appropriate arrangements for recording the administration of medicines. These records were clear and fully completed. The records showed children were getting their medicines when they needed them, there were no gaps in the administration records and any reasons for not giving patients their medicines were recorded. If children were allergic to any medicines, this was recorded on their medication administration record chart. These meant children were receiving their medicines as prescribed.

Records

- Patients' records were well maintained by both doctors and nurses within the children's department. We randomly checked some observation records and case-tracked five patients' records. The medical and nursing assessment form was appropriately filled in in each case.
- The recording by both medical and nursing staff was thorough and we noted that care pathways were being followed, such as the one for patients with sickle cell anaemia.
- We observed that standard risk assessments for patients had been undertaken, such as the risk of dehydration and weight loss affecting patients who had feeding reflux problems, the risks for children with head injury and the risks for those who were in pain. The records showed that these assessments had been carried out on admission and reviewed when the patient's condition changed. We checked the PEW score charts and found that they had been appropriately filled in. The pain assessment tool charts were in place for patients who could be in pain because of their medical conditions or after surgery.
- The paediatric pain assessment tool chart was used to assess patients' pain thresholds. The assessment results were recorded in the case notes. The paediatric consultant and ward manager stated that they would be revising the tool chart so that staff would be able to input their findings within the tool chart form itself.
- The patients' clinical notes had been well recorded by the doctors and other healthcare professionals, including assessments carried out by the speech and language therapist and the dietician.
- All patients' clinical notes in paper format were kept in lockable trolleys within the nurses' station.

Consent

- Parents confirmed that their consent had been sought before their child received treatment. They described how procedures had been explained to them by both

Services for children and young people

nurses and doctors. They felt that they had been given clear information and were well informed before they signed the consent form for surgery or treatment where appropriate.

- We observed that this was the case during the ward inspection by a consultant surgeon and their team of doctors. We noted the consultant explaining to the child and the parent about the need for an ultrasound scan before the patient could be discharged. This was agreed by all parties and the scan was arranged and carried out the same day. Similarly, we observed that the consultant paediatricians were conducting their ward rounds and consulting with parents regarding their child's care and treatment.
- The ward manager confirmed that there had been no cases subjected to Deprivation of Liberty Safeguarding. Members of staff were aware of the Mental Capacity Act 2005 and, when relevant, they would adhere to the Act and take appropriate actions in the best interests of the teenager who was over 16.

Safeguarding

- Staff said that they had received training in safeguarding. Nurses had been trained up to level 3.
- Staff could describe the referral process for alleged or suspected child abuse and knew the names of the lead professionals.
- We were shown the safeguarding information board, which clearly displayed a list of safeguarding leads, including a named consultant, a lead nurse for safeguarding and a child protection adviser. The contact numbers for the local authorities were also given. The training dates for the coming safeguarding and child protection training for staff were also on display.
- Doctors told us that they had received very good safeguarding training. Junior doctors had level 2 safeguarding training and registrars had been trained up to level 3. The doctors said that, when a case was being referred, the most senior doctor on duty would be involved.
- We saw a patient being assessed by the consultant paediatrician and their team of doctors before a safeguarding referral was made. We noted a safeguarding referral being made to the local authority and observed that prompt action was taken by the consultant and nursing staff. We were told that a safeguarding strategy meeting had been arranged for the next day. There was appropriate documentation in the patient's record and the reason for the meeting had been explained to the parent.
- Staff demonstrated that the trust's policy, child protection guidelines and safeguarding procedures had been followed appropriately.

Mandatory training

- The trust had recently submitted to the Care Quality Commission (CQC) data on compulsory training and this showed that, for paediatric staff, only 40% of the training had taken place. We were not clear about the accuracy of the central reporting of training.
- The managers for the children's ward, the day assessment unit and the children's community service confirmed that their staff had completed their mandatory training. The manager of the NNU confirmed that not all their nurses had completed their mandatory training programme. Mandatory training was monitored through staff appraisals.
- There was a rolling training programme for all staff, including refresher courses.
- There were systems for monitoring training for new recruits, through the training department. We were told that there was a practice educator overseeing newly qualified staff nurses and those going through their induction period to ensure that appropriate training had been arranged for them. This included mandatory training, mentorship training and competency assessments, such as for the administration of oral and intravenous medication.
- Staff in the children's ward and assessment unit told us that they had received mandatory training such as moving and handling, food hygiene, infection control, safeguarding, and basic and advanced life support.
- Staff said that they encountered problems with the current e-learning facility because the system that had been set up was not effective and did not always record the work done. The trust assured us that this problem was being addressed.
- Staff said they had access to trust policies and updated guidance for trained medical and nursing staff. We observed doctors and nurses accessing the workstation throughout the day.
- One of the consultants confirmed that all paediatric doctors had been trained in advanced life support and junior doctors under the GP training scheme had been

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trained in paediatric immediate life support and basic life support. We were told that practical training on resuscitation using a simulated doll was held every Tuesday for doctors and nurses.

- The registrars and junior doctors gave positive feedback about the training programme. The training for junior doctors was arranged in accordance with the Royal College of Paediatrics and Child Health (RCPCH) programme. Doctors said that they had been given time to attend all the training. They also received practical training daily and felt well supported by the consultants.
- Doctors, nurses and support staff felt they had received appropriate training to meet the needs of the community, including supporting children with a learning disability or those with diabetes or sickle cell anaemia. For example, staff provided a family clinic to support parents and their child with sickle cell anaemia.

Management of deteriorating patients

- The service used the PEW score (Paediatric Early Warning system for deteriorating patients). Clearly printed PEW charts were in use, which gave staff directions for escalation. There were PEW monitoring charts for different age groups, such as children aged 0–12 months, 1–4 years, 5–12 years and over 12 years. We saw that the PEW recording charts had been filled in by nurses on admission and later.
- We looked at completed charts and saw that staff had escalated correctly; repeat observations had been taken within the necessary time frame.
- Staff we spoke with knew the appropriate action to take if a patient's PEW score rose. The PEW records were regularly audited.

Nursing staffing

- The service followed the Royal College of Nursing (RCN) guidance on staffing levels.
- The children's ward had been reduced to a 19-bed unit in a temporary location while refurbishment was in progress to upgrade the 24-bed normal site. The two ward managers confirmed that the staffing level and skill mix were adequate for the 19-bed ward. We were told that bank nurses and agency nurses had been deployed as necessary to make up the numbers when needed.
- The NNU had its own manager who confirmed that recruitment had been in progress because of staff leaving or retiring. The NNU had 20% staff vacancies at the time of our inspection, and dependent on agency and bank staff. The agency staff worked there regularly and we were told that their qualifications and experience had been checked before they were accepted. This ensured safe care for patients.
- The children's community team employed 13 nurses, including three specialist nurses in diabetes, one specialist nurse in human immunodeficiency virus (HIV) and one specialist nurse in sickle cell anaemia. The team felt well supported by the managers and matron. The range of treatment provided included oncology, palliative care and diabetes. The service was available 7 days a week from 9am to 5pm and also provided an on-call service for end of life care.
- In the children's ward, the current number of used beds was 14, with no high-dependency patients. The ward manager told us that the staffing complement was usually five nurses (one grade B6 and four grade B5s), four student nurses, an activity play specialist and support workers. A ward manager was on duty weekdays. We were told that at weekends there were usually a grade B6 nurse in charge, four nurses (grade B5/B6) and one healthcare assistant. One of the two managers helped out at weekends as required. We were told that additional nurses were deployed if a patient required one-to-one care.
- The children's ward had recently recruited seven nurses (grade B5). They were currently being supervised by the practice educator, who had organised a training package for each of them, depending on their training needs. All new recruits had competency assessments, in accordance with the trust's policy.
- Because of the refurbishment programme, the PAU and the PDAU had been combined. The number of beds in these two services had been reduced from 20 to 10. There was a manager overseeing the two services and the paediatric outpatient department. However, the nurse covering the PAU came under the children's ward e-rostering system. We were told that the staffing level at the present time was adequate. We noted that the staffing complement in these units consisted of three staff nurses (grade B6) and four student nurses.
- A wide range of support and specialist nursing staff were employed, including specialist nurses in diabetes, asthma and sickle cell anaemia, dieticians, speech and language therapists and a clinical practice educator. Staff felt that more sickle cell specialist nurses would be needed because there were 16 patients in transition. This had been proposed in the trust's business plan.

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- We were shown the staffing rota using the e-rostering system. The ward managers said the system was effective in determining the number and skill mix of staff.
- We observed a dedicated team of staff working together. Ward handovers were done during shift changes, once in the morning and once in the evening, when the night shift started.

Medical staffing

- The trust had employed 15 consultant paediatricians to date and we were told another would be joining in July 2014. The consultant paediatricians specialised in particular fields such as diabetes, sickle cell anaemia or allergies.
- Doctors were available 24 hours a day. There was consultant cover 7 days a week, including nights. There was appropriate cover from junior and middle grade doctors on the children's ward, day and night.
- The PAU and PDAU had a registrar and junior doctors on shift each day. Similarly, the children's ward had a registrar and junior doctors on shift cover.
- Children in the PDAU were seen by their consultant before admission and by the anaesthetist and theatre staff in the unit before surgery.
- Staff handovers between the night team and the day team took place in the morning and a consultant was present.
- Doctors' ward rounds took place twice daily. The afternoon ward round ensured that new patients were seen by the consultant on the day. Inspections from the surgeons took place outside main ward rounds.
- We noted that the consultants on duty were readily available on the ward throughout the day, and we observed them supporting the registrars and junior doctors.
- Registrars and junior doctors had been encouraged to give presentations and there had been discussions afterwards. They felt the consultants were approachable and supportive.
- Junior doctors felt that they had received good training in paediatrics and clinical governance. Doctors confirmed that they were given feedback on incidents reported via Datix and safeguarding referrals. Incidents had been highlighted during daily handovers as well.

Are services for children and young people effective?

Good

Care was provided in accordance with evidence-based national guidelines from organisations such as NICE and the RCPCH.

Staff followed specific care pathways and used pain assessment tools to ensure that patients received appropriate care and treatment, and effective pain relief. They ensured that patients' nutritional and hydration needs were closely monitored and maintained. The PEW scoring chart was used to identify patients whose condition needed medical intervention.

The ward managers carried out appraisals for nursing staff, identified training and development needs and maintained records of staff training. Ward meetings and handovers were used to discuss issues and concerns.

A 24-hour consultant-led service was provided, with medical and nursing cover for the children's ward, PAU and PDAU 7 days a week.

Multidisciplinary working was employed within the children's department, with other services in the trust and with external organisations. This ensured that patients received continuity of care.

Evidence-based care and treatment

- The trust's hospital protocols were based on NICE and RCPCH guidelines. Local policies were written in line with these and had been kept up to date. Staff knew where to find policies and local guidelines, which were available on the intranet.
- There was a good system for feeding back from clinical governance meetings.
- Nursing staff confirmed that they had attended departmental meetings every 6 weeks and changes to policies, procedures and guidance had been discussed.
- We observed that children and adolescents needing a psychiatric assessment had been referred to the Child and Adolescent Mental Health Service (CAMHS).

Pain relief

- We observed that a variety of tools were used to assess pain, depending on the age of the child and their ability

Services for children and young people

to understand. The pain assessment chart was readily available in each patient's clinical case file. For a younger child, we noted that the pain assessment tool using 'smiley faces' had been used. The child had been asked to choose a face that best described their own pain. A face, legs, activity, cry, consolability (FLACC) behavioural tool was used for a child with a learning disability. For a patient with sickle cell anaemia, there were prescribing guidelines to allay sickle cell pain.
- Parents confirmed that their child had been given pain relief appropriately.

Nutrition and hydration

- Patients with poor food and hydration intake were observed closely. The care pathway observation chart included a section for nurses to monitor the food and fluid intake of these patients. This ensured that patients' nutritional and hydration needs had been monitored and maintained.
- Parents and children commented that there were choices in the menu offered each day and that the food provided was "good". The menu card was given to patients to select their menu in the morning and hot meals were served twice a day. Sandwiches and snack boxes were available throughout the day.
- We saw that children had drinks by their bedside.
- Both the ward and the PDAU had facilities for parents to prepare their own meals and drinks.

Patient outcomes

- For 2012/13 the trust participated in all but four of the 55 national clinical audits for which it was eligible. The children's service participated in all the national audits for which it eligible. These included the paediatric fever (College of Emergency Medicine [CEM]), paediatric diabetes (National Paediatric Diabetes Audit), childhood epilepsy (Epilepsy 12 Audit) and neonatal intensive and special care (National Neonatal Audit Programme) audits.
- There was a well-defined core care pathway in place and separate pathways for patients with certain conditions such as sickle-cell anaemia, head injury or asthma. The PEW score was used to identify patients needing medical intervention. There was a nurse-led inpatient asthma weaning protocol for children with asthma.
- We case-tracked four patients' care plans, three in the children's ward and one in the PDAU. We found that appropriate care and treatment had been provided and records had been well maintained. For example, in the case of an infant with reflux and other feeding problems, specialist professionals such as the dietician and the speech and language therapist had been involved in assessing the patient, with constant care and supervision by the nursing staff and clinical supervision by the paediatric teams. This had ensured good outcomes for the child.
- The PDAU staff worked closely with adult oncology and sickle cell clinics giving support to adolescents from the age of 13 until they reached 18 when they would be transferred to the adult services

Competent staff

- The ward managers carried out the appraisals for nursing staff, identified training and development needs and maintained records of staff training. Ward meetings and handovers were used to discuss issues and concerns. Staff felt well supported by manager. Mentorship was in place for student nurses. They felt well supported and said they had good opportunities to gain experience and good learning opportunities. They said they were able to get competencies signed off.
- The healthcare assistants had good support to develop their knowledge and skills.
- Staff reported that they had attended induction on starting employment and had undergone mandatory training. They said they were supported to gain new skills and had opportunities to attend courses when they were advertised.
- Most of the nurses had received training on cannulation and phlebotomy; there were mentoring arrangements for new recruits (grade B5 nurses).
- Junior doctors had appraisals three times during their 6 months' training: in their first month, after 3 months and shortly before their assignment ended.

Multidisciplinary working

- There was multidisciplinary working within the children's department with other services within the trust and with external organisations. For example, the paediatric oncology service and the children's service served as a tertiary centre for children with sickle cell anaemia. Staff worked closely with other hospitals and GPs who had made referrals.
- There were good shared care arrangements with surgeons and other services, such as orthopaedic, dental, urology and psychiatry.

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- There were several multidisciplinary team meetings each week, including a safety meeting to discuss safeguarding and other matters and a weekly psycho-social meeting. A consultant usually presided over these meetings. The care and treatment of each patient was discussed and different views were listened to before making decisions in the best interests of the child.

Seven-day services

- There was a 24-hour consultant-led service with medical and nursing cover for the children's ward, PAU and PDAU 7 days a week.
- The child and adolescent mental health service, allied professionals and other services provided 7- day cover between 9am and 5pm.

Are services for children and young people caring?

Good

Parents were complimentary about the way staff cared for their child. They felt that staff were compassionate and caring, and that they kept them well informed and involved in the care and treatment of their child.

Psychological support was available and included referral to a specialist child psychologist if needed. Clinical nurse specialists were available in various disciplines, such as sickle cell anaemia and diabetes.

Compassionate care

- Throughout our inspection, we witnessed good staff interaction with patients and parents. We observed good, friendly and appropriate communication between a doctor and a parent whose ability to speak and understand English was limited. We observed how the nurses assisted parents and their child in distress because of a fracture, and we saw how a consultant supported and listened to a distressed parent who was worried for their baby.
- Parents were all complimentary about the care their child had received, and the staff who provided the care. Both children and parents were treated with compassion, dignity and respect. One parent told us how the staff "try to accommodate" their child and added that "even the teacher offered… a choice of subjects."
- Two family members confirmed that they had been involved in the patient's care and treatment and that they had been kept informed of the patient's progress.
- Comments received included, "The doctors and nurses are very kind and considerate" and "All the staff are very caring."

Patient understanding and involvement

- Parents felt well informed before they signed the consent form for surgery or other treatment. They felt that they had been involved in the care and decisions regarding their child's treatment.
- We observed doctors explaining the treatment and allowing both the child and the parent to ask questions. There was a named nurse for the child.

Emotional support

- All the parents were complimentary about the staff of every discipline. One parent felt reassured and commented, "The staff explained things to me and I understood what they said. I am pleased with the care provided."
- We were told that, in the case of long-term patients who required emotional support, the medical team had made referrals to the specialist child psychologist.

Are services for children and young people responsive?

Good

People were able to access children's services through their GP and the A&E department.

Staff had received appropriate training to meet the needs of the community, including children with long-term illness, such as sickle cell anaemia, and other health conditions.

The service maintained good communication and good relationships with local GPs, local authorities and other healthcare providers. This ensured that patients received continuity of care when discharged from the hospital.

Services for children and young people

Service planning and delivery to meet the needs of local people

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

Access and flow

- There was a good flow of patients, day cases and inpatients.
- Staff had adapted to the temporary accommodation for the children's ward while the normal premises were being refurbished. Risk assessments had been in place to ensure the 3 months.
- Families did not have to wait long for appointments. Many patients were referred by their GP or came through A&E. Patients were triaged to either the PAU or PDAU where children were seen by a nurse within 15 minutes and by a doctor within an hour. Patients who needed admission would be transferred to a ward.
- Parents reported their child had received good continuity of care on the children's ward. One parent whose child had sickle cell anaemia said they felt their care needs had been well met.
- Parents were aware of the plans for their child's discharge and felt well informed.
- Parents were given information about community nursing and a referral if required.

Meeting people's individual needs

- Care and treatment records were personalised.
- Support was available for patients with different medical needs, such as diabetes, sickle cell anaemia or a fracture. A parent of a young child with feeding problems felt that staff had understood and provided good support. They had explained things slowly to them because of their limited understanding of English.
- There were information leaflets available for many different medical conditions, including child-friendly leaflets on diabetes, asthma and sickle cell anaemia.
- There were activity facilities provided in two rooms with toys, colouring books and games to entertain young children on the ward and in the outpatient clinics and triage areas. Play activity specialists covered the ward to assist inpatients. Because of the refurbishment of the children's ward, the current play areas were temporary and limited. Parents had been informed of the situation. Some adolescents said that they had been bored. The staff tried to accommodate one patient in a cubicle by providing a portable television until they were discharged home.
- The outpatient department had good play areas, including an outside facility for younger children.
- Children were given educational support 5 mornings a week. A parent told us that the teacher gave their child a choice of subjects and the patient chose mathematics. Because of the child's hand injury, the parent helped with writing down answers. One of the teaching staff spoke to the children and their parents when patients were admitted. All activities were documented in accordance with education guidelines. There were pupils who attended regularly.
- There was a good range of information leaflets available, including leaflets on the various medical conditions and on how to make a complaint. These leaflets were available in the children's ward and in the outpatient department. The information leaflets for patients had been updated regularly.
- Patients' (and parents') satisfaction survey questionnaires were available and the results published on the dashboard.

Learning from complaints and concerns

- Staff confirmed that the ward manager had discussed at staff meetings any concerns or complaints raised and the lessons learned. We were told that there had been no formal complaints since 2013. However there were a small number (under 12 annually) of minor concerns raised, mainly about delayed outpatient appointments.
- Issues discussed at multidisciplinary team meetings attended by managers were fed back to staff at local staff meetings.
- There were information leaflets displayed on how patients could provide feedback on the service they had received, and how patients and relatives could make a complaint.

Are services for children and young people well-led?

Services for children and young people

Good

The service had clear line management arrangements. Staff felt well supported by the matron and the consultants. Senior clinicians were visible and approachable.

Staff felt they had been kept informed of trust changes and improvements and that good communication was established.

Systems were in place for clinical governance. The consultant-led team of medical staff held regular meetings, such as clinical governance meetings, safety meetings, and psycho-social meetings where issues were discussed by the multidisciplinary team and decisions made to improve care and services.

There was a risk register for the directorate and risk management issues were discussed at directorate meetings. Although risks had been identified, they were not always escalated and put on the risk register (an example was the 20% shortage of nursing staff in the NNU).

Vision and strategy for this service

- Staff were aware of the name of the chief executive officer and some other Board members. They confirmed that they had been kept informed of developments at trust level through emails.
- Staff were aware of the meaning of the trusts vision and strategy but could not quote the statement. However we were assured that staff were aware of the vision.

Governance, risk management and quality measurement

- Systems were in place for clinical governance. There were weekly paediatric patient and staff quality and safety meetings, psycho-social meetings and other multidisciplinary team meetings where issues were discussed and decisions made to improve care and services.
- Incidents were reported through Datix, which was effective. Senior managers held a daily Datix meeting to discuss incidents raised and to follow up investigations and outcomes.
- Risks were identified, such as the 20% nursing staff shortage in the NNU. However, as mentioned earlier, this had not been escalated and put on the risk register.

Leadership of service

- There were clear line management arrangements. Staff knew the matron, the director of nursing and the general managers of the directorate. However, staff felt that Board members had not been seen on the ward or units for some time.
- Staff told us the matron for the children's department and the consultants were supportive. The consultants were visible on the ward and were approachable.

Culture within the service

- Staff had confidence in the multidisciplinary working and said that they enjoyed working in the children's service.
- They felt supported by the consultants and managers, who were approachable and supportive.
- The service was open and transparent. Staff felt they had been kept informed of trust changes and improvements, and that there was good communication.

Public and staff engagement

- Patients and those close to them gave positive feedback about the care and treatment received.
- Staff felt that they provided good care and interacted well with patients and parents.

Innovation, improvement and sustainability

- One of the ward managers said staff had noticed that the service had been admitting a high number of young people with mental health conditions in recent months. This had prompted a new project undertaken by one of the paediatric registrars to audit the numbers of admissions since January 2013 and study the trends in causes and outcomes.

End of life care

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

Information about the service

North Middlesex University Hospital provides end of life care to patients with progressive life-limiting illness. Conditions include cancer, advanced organ failure (such as heart and renal failure) and neurological conditions.

Staff on the wards are supported by a palliative care team, consisting of two nurse consultants and a part-time medical consultant. This team also provides training to staff on the wards in various aspects of palliative care. Between 1 April 2013 and 31 March 2014, 384 patients were cared for with input and advice from the palliative care team. The trust had seen a rise of 31% in recorded palliative care deaths since the review of services. This was due to coding issues at the trust.

We spoke with a number of patients and their relatives, the palliative care team, bereavement services, mortuary staff, chaplaincy, nursing, medical staff and allied health professionals.

Summary of findings

We found that many of the services that supported end of life care to patients were working under considerable pressure, due to workload. Staff working on the wards felt able to contact the palliative care team for advice but this service only operated during weekdays within office hours. This meant that, most of the time, advice was not available, and patients received a different level of service outside normal office hours.

Staff were using an end of life care bundle, adapted from the Liverpool Care Pathway (LCP) that had been phased out across the trust. The relatives we spoke to felt that all staff were caring and the palliative care team was supportive and had involved them in decisions about their relatives' care. They also said they had been allowed to spend time with their loved one outside of normal visiting hours.

The palliative care team was aware of which patients were under their care. We saw records that showed they had reviewed and amended medication, and had prescribed additional anticipatory medication if needed. We also saw evidence, however, that staff were concerned about giving this medication because of possible side effects and in some cases did not administer it. This meant that patients did not always receive the medication they could have had to ease their symptoms.

End of life care

There were inconsistencies in the completion and review of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, and people who lacked capacity were not routinely having their capacity properly assessed and documented.

The mortuary staff and bereavement team showed a strong sense of ownership and went out of their way to ensure the deceased were treated with respect and dignity and that families and friends received compassionate care. On the day of our inspection, some of the deceased were being housed in temporary fridges that had been in use since December 2013. We saw data that showed there had been times when the mortuary was close to being unable to house any more people.

Are end of life care services safe?

Requires Improvement

We found, overall, that people were protected from abuse and avoidable harm, and received safe end of life care. Staff were using the correct documentation. There were inconsistencies in the completion and review of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, and people who lacked capacity were not routinely having their capacity properly assessed and documented. In most cases, there had been no discussion with the patient regarding the decision because of what was noted as 'lack of capacity'. In only two cases had staff completed any documentation to assess capacity, and in these cases the form they had used was different. In all other cases, there was no documentation to show how staff had arrived at the decision that the person was not able to be involved in the discussion. This meant that there was no evidence that those caring for the patient knew the rationale for the decision.

Specialist palliative care and advice to staff were only available during office hours, and rapid discharges for those people who wanted to die at home were not possible outside these times. This was because of a lack of specialist palliative care staff.

Incidents

- Staff could not recall any incidents that related to end of life care, although all those we spoke to were clear about how they would report any incidents that occurred.
- All the staff we spoke with said they were encouraged to report incidents.
- There had been no reported Never Events in relation to end of life care during the past year.

Medicines

- Anticipatory medicines are medicines that are prescribed in the event of worsening symptoms to ensure that patients are not left for long periods in discomfort. When we examined this area of practice, we saw that such medicines were prescribed appropriately on the prescription charts of those receiving end of life care. We looked at the prescription charts of the person receiving end of life care and found that they were clear and comprehensive.

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- Appropriate syringe drivers were available to deliver subcutaneous medication if required. However, the palliative care team told us that these devices were often in short supply and led to delays in people being discharged home. They told us that they had ordered more devices some time ago but that these had not yet arrived.

Records

- We reviewed 32 DNA CPR forms.
- All had been signed by a senior clinician and had the correct name and date of birth data. All but one form were placed at the front of the notes, making it easy for staff to identify patients with this order quickly.
- Every single member of clinical and administrative staff we spoke to either knew who on the ward was subject to a DNA CPR order or knew how to find out.
- In 22 cases, we found parts of the form that were incomplete, particularly parts about review and other health professionals consulted about the decision. This meant that staff and families could not be sure who had been involved in the discussion.
- In 26 cases, some details on the form were very unclear because of poor handwriting.
- We did not find consistency in the documentation of medical staff's discussions with families. In one case, we saw handwriting next to the section of the form relating to family that said simply 'inform niece' but it was not clear whether they had been informed.
- We spoke to the trust's resuscitation officers who conducted quarterly audits of DNA CPR documentation. The audit had also found documentation to be weak, particularly around review of the decision. However, the resuscitation team also said that clinicians were receptive to their feedback and there was willingness to improve this aspect of care. They did not currently audit documentation around mental capacity.
- Nurses used a computerised handover sheet to hand over key information. Part of the handover sheet that staff used to write in a patient's DNA CPR status was removed in a recent update. Currently nursing staff had no dedicated part of the document in which to enter this crucial information. This could lead to confusion among staff as to the DNA CPR status of a patient they were caring for.
- The palliative care team told us that they had no computerised management system for managing referrals or people known to the service. This affected their ability to examine themes in referrals or plan their workload efficiently.
- We saw 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms filled in appropriately and included in patient records in the surgical area. Discussions about DNA CPR with family members were documented to show their involvement in the decision making.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke to relatives of patients who had been subject to a DNA CPR order. They told us they had felt involved in the decision making and had been supported by staff in this process.
- In most cases, there had been no discussion with the patient regarding the decision because of what was noted as 'lack of capacity'. In only two cases had staff completed any documentation to assess capacity, and in these cases the form they had used was different. In all other cases, there was no documentation to show how staff had arrived at the decision that the person was not able to be involved in the discussion. This meant that there was no evidence that those caring for the patient knew the rationale for the decision.

Mandatory training

- The palliative care team had produced an education and training programme that was delivered on wards to available staff. This consisted of six standalone sessions that included topics such as symptom control, communication skills and spiritual care. The palliative care team reviewed attendance at these sessions and had a league table of attendance with which to target those who were not attending training. The training was currently being facilitated by a nurse who had been seconded to the palliative care team for a short time, and the team was not able to tell us the long-term plan for this provision. All staff we spoke to told us they had found it useful and the palliative care team told us they had seen an improvement in referrals and care since providing the training.
- Palliative care training was currently included as part of the hospital induction for all staff; however, it was not

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offered to junior doctors who joined the trust. We spoke to one junior doctor who said, "We are often the ones delivering the care so it would be really helpful if we had guidance on how it works here."

- We were told by the palliative care team that they were promoting the development of end of life care champions across all the adult wards. We spoke to two ward champions. Both were enthusiastic about their roles and felt that their extra training would benefit the patients being cared for on their respective wards.

Assessing and responding to patient risk

- Staff we spoke to were inconsistent when asked when they would involve the palliative care team. This meant that people requiring end of life care may not have received the benefits of specialist palliative care as early as they could have done.

Nursing staffing

- The palliative care team consisted of one consultant and two palliative care nurse specialists. They offered a weekday service from 9am to 5pm with no cover at weekends, nights or on bank holidays. When we spoke to staff on the ward, they told us there was a noticeable difference between the support and advice they could access out of hours and that available from the palliative care team. Information was available in fodders on the wards for reference out of hours.

Medical staffing

- The trust employed one palliative care consultant on a part-time basis who worked at the trust five days a week. At other times, palliative care was provided by the hospital's medical team. When there was consultant staff annual leave, there was no palliative consultant cover on site and telephone advice was available from a palliative care consultant based at a local hospice within working hours.

Are end of life care services effective?

Requires Improvement

People's care and treatment achieved good outcomes and was evidence based. However, there was no consistent palliative care input into multidisciplinary team discussions for most patients. This meant that specialist palliative care advice was often sought later in the patient's disease progression. The services were also not available over the whole week and this led to patients receiving different levels of service.

Evidence-based care and treatment

- The Department of Health had recently asked all acute hospital trusts to undertake an immediate clinical review of patients receiving end of life care. This was in response to the national independent review, More Care, Less Pathway: A Review of the Liverpool Care Pathway (LCP), published in 2013. As a result of this report, the trust had amended its guidance on end of life care in line with the recommendations made.
- The trust had taken part in the National Care of the Dying Audit (2014). It was adhering to some aspects of the key recommendations, such as providing an adequately staffed pastoral care team and undertaking an audit of the views of bereaved families. In other respects, including the provision of a 7-day-a-week service, the trust was not compliant with the recommendations.
- All staff we spoke to were aware of and using the end of life care pathways. In addition, the intensive care unit (ICU) was using an 'advanced care plan', which was completed daily showing what level of care, such as invasive ventilation, had been agreed.
- A recent audit conducted by the palliative care team identified that 80% of palliative care patients had anticipatory medicines prescribed appropriately. However they also found that these medicines were not always given when it would have been appropriate to do so. The team identified staff concerns over potential side effects as the key reason for this, although they felt this concern was due to a lack of staff training. The team provided a member of staff to facilitate training to address this issue.

Pain relief

- We reviewed the prescription chart for a patient who was on the end of life care pathway. We saw that pain relief had been prescribed effectively. We also saw that medication to remediate the side effects of the pain-relieving medication had been prescribed. This ensured that the side effects of people's medication were eased effectively and did not cause undue distress.

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Nutrition and hydration

- We saw input from dieticians in the medical notes of patients. Nursing staff on the ward told us they could always ask for dietetics advice.
- There was no specific dietician support for the palliative care team and this meant that end of life nutritional support was provided by dieticians across the trust.

Patient outcomes

- Before our inspection, the hospital had seen an increase in patient deaths that had been coded 'palliative care'. The trust showed us data that indicated that this had risen more than 10% from 10% in 2009 to a spike of 31.48% in 2012 before falling again to 20.19% in 2013.
- The trust explained that the reason for this spike was coding staff shortages. These had led to a delay in the coding of these patients and they had been accounted for in the following financial year's figures. Apart from this spike, the trust's palliative care outcomes had followed both London and national trends very closely. During the course of our inspection, we found no evidence that contradicted the figures and data analysis from the trust regarding this issue.

Documented guidance for staff involved in end of life care

- Whilst the trust has a flow chart on referral to the palliative care team we found that staff caring for adult patients were unclear as to what should instigate a referral to the palliative care team, or what the decision-making process should be.
- We did find that written guidance for staff who were initiating end of life care was clear. For adult patients, the policy was concise and included easily followed flowcharts for common conditions such as nausea. For children, procedures were also clear and accessible. Guidance for staff included discharge planning, consultation with the health team and discussions with parents. This meant that advice was readily available to staff for reference and guidance.

Multidisciplinary working

- The palliative care team had established links with other providers of end of life care, predominately hospices and community nurses. However, when the team was not on site, staff told us that it was sometimes difficult to arrange rapid discharges to hospices outside office hours.
- There were no social workers, pharmacists or allied health professionals attached to the palliative care team as these were ward based, making true multidisciplinary working within the trust very difficult.
- We were told that there was no input from the palliative care team in standard multidisciplinary team meetings for non-surgical patients because there was no consultant cover in the palliative care team. The trust had set a deadline of April 2014 for this to be resolved, but this deadline was missed because there were no care staff to attend the meetings.
- The mortuary department had good links with local funeral directors, which helped in managing flow within the mortuary.

Seven-day services

- The palliative care service was only available Monday to Friday within working hours.

Are end of life care services caring?

Good

Staff involved people in their care and treated them with compassion, kindness, dignity and respect.

Compassionate care

- Throughout the inspection, we saw that patients were treated with compassion, dignity and respect. We spoke to relatives of those who were being cared for. Many were complimentary about the care that their loved ones had received. One relative we spoke to felt that staff had kept them informed about their loved one's care and had been suitably realistic about the short-term prognosis. The same relative described the palliative care nurse consultant as "excellent and very professional. She (the nurse) explained everything very clearly."
- We spoke to a radiographer who had the specific role of reviewing the side effects suffered by patients undergoing radiotherapy. She told us she would review patients after their first few sessions and provide advice and support to help them manage side effects if they occurred.
- We were shown the last bereavement survey conducted by the trust. The results of this audit were positive: many

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described the care given as "excellent" and more than one respondent commented on the staff's compassion. However, one relative commented that once a person has accepted end of life care "nobody comes near you."
- Patients and relatives were consistently positive about the care they were receiving, although many commented on how busy the staff appeared to be.
- There was a relatives' room in most ward areas, which meant that conversations could be held in private.
- There was no evidence on any ward we inspected that staff who were caring for a patient at the end of their life would routinely lower their voice during a conversation.
- Patients' records and nursing care plans showed that the care provided included ensuring that people were kept comfortable.
- We discussed pastoral care and multi-faith support with the hospital's full-time hospital chaplain. It was very clear that the multi faith team supported not only patients but also relatives and staff. We were told by staff on the wards that they offered multi faith support regularly and all the patients we spoke to about this aspect of care told us that it had been offered.
- We found that staff felt a strong sense of ownership of their individual areas; this was particularly true of the palliative care service, chaplaincy and mortuary.
- We saw that staff went to great lengths to identify next of kin and, if a deceased person had no next of kin, they would organise a funeral.
- Staff told us that they tried hard to ensure that people's religious wishes were adhered to. This included the speedy processing of the deceased for religions where rapid burial of a body is customary.
- We saw that staff in the mortuary were respectful, referring to deceased people by name.

Patient and relative information

- We also looked at the information kiosk that was supported by the Macmillan cancer charity; this kiosk had a private area for patients and relatives to discuss their information needs and questions. The area was audio-visually screened to allow people to discuss issues in privacy. Information leaflets were available on a range of topics including specific diagnosis and support groups. Information was available in other languages on request.
- There was written information available to patients and relatives on the wards we inspected. On one ward, we saw a comprehensive staff information board on the subject of end of life care. This included best practice guidance and further information sources.

Emotional support

- We could not find assessments for anxiety and depression within the notes of the patients we looked at.
- While we were told by patients and relatives that staff had been supportive towards them, we found that staff themselves had not been offered routine psychological support or supervision. Although nursing staff we spoke to had had appraisals, these were mainly centred on career development rather than discussions around staff psychological coping. Staff consistently told us that this type of support would be useful to them.
- The bereavement office staff said that they were proud of the support they delivered, comforting relatives and making sure people left confident and knowledgeable about what to do after a death.

Are end of life care services responsive?

Requires Improvement

While many of the services available to people needing end of life care were individually responsive, we found that services' responsiveness differed depending on the time of week and that people's wishes were not always addressed effectively as a result. This resulted in patients dying in a place not of their choice.

The mortuary department would often have more patients than space so a temporary mortuary fridge had been erected. Whilst action had been taken to address this these arrangements were temporary and required review to ensure compliance with regulations.

Access and flow

- Staff working on the ward told us they found the palliative care team very approachable. All could name the palliative care nurse consultants and told us that they would attend quickly to review patients if on site.
- We discussed the provision of side rooms for people needing end of life care. Staff displayed an understanding of individualised care in this area by

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telling us that side rooms would be made available if at all possible but that some patients preferred to be cared for on wards and were comforted by having other people around them. In this way, staff showed that they were responsive to individual needs.

- We visited the mortuary area and spoke to staff there. We saw mortuary attendance data that showed a 31% increase in usage during the first 5 months of 2014 compared with the same period the previous year. Patients were being stored in a refrigerator that was a temporary measure. However, this had been in use since December and staff told us that the mortuary was, on occasion, full to capacity.

Meeting people's individual needs

- The chaplaincy department had written its own performance targets including a response target of a maximum of 45 minutes for emergency calls. This target applied 24 hours a day 7 days a week. Staff and patients on the ward told us that the chaplaincy team came quickly if they needed support.
- The trust told us that a survey conducted in 2013 identified that only 15.1% of people died in their preferred location. When we spoke to ward staff about this, they identified a lack of 7-day palliative care team support and difficulties in arranging equipment such as hospital beds and commodes for the person at home. On member of staff told us, "Sometimes it (the provision of equipment) takes 5 days, depending on the borough and that's hopeless in this situation."
- During our inspection of medical notes and care plans, we found that there was very limited documentation on dementia assessments. This meant staff could not respond to an individual's needs based on thorough assessment.
- Staff and relatives told us that translation services were provided if required and that there was generally no delay in arranging this.
- There was no system for staff to fast-track patients who were close to the end of life from the hospital's A&E up to wards that could provide appropriate care more effectively.
- The mortuary staff had a number of different leaflets for relatives who had just experienced bereavement. We saw that there was written information available for families. This was clear, concise and thorough in explaining the steps that had to be taken to register death. However, there was no information available in languages other than English.
- The mortuary area was clean and close to the main area of the hospital. The waiting room had been equipped with one-way glass so that relatives waiting to see a loved one were not visible from outside. There was also a small private outside area where relatives could stand.
- While in other areas of the trust, relatives' rooms were clean and suitably situated away from noisy ward areas, we found that the viewing room in the A&E department was sandwiched between a busy thoroughfare and the resuscitation area. While the room had doors on either side, it was still possible to hear conversations in the resuscitation area. The decor of the room was shabby and there appeared to be no effective way to dim the lights or make the room less clinical.

Learning from complaints and concerns

- No staff we spoke to could tell us of any formal complaints regarding end of life care. The palliative care team had conducted a thematic analysis of negative comments raised by the recent bereavement survey. We saw evidence that they were taking steps to address the concerns raised. However, it should be noted that many of these concerns related to aspects of care out of their direct control, such as GP provision.
- The mortuary staff told us they had recently had a slight increase in poor preparation of deceased people before transfer to the mortuary. They had alerted a senior nurse within the trust who had visited the mortuary and then met staff on the ward in question to feed back the concerns raised. This ensured that the problems were addressed quickly.
- The palliative care team had recently changed syringe driver manufacturers after a concern about the safety of the drivers currently in use.
- On one of the wards we inspected, the ward sister had identified concerns about the level of English spoken by some of the newly appointed staff. In response to this, she had arranged training with a local further education college and had amended the ward rota to ensure that staff could attend these sessions.

Are end of life care services well-led?

End of life care

Requires Improvement

While on an individual level people were well cared for, we found that there were aspects of oversight by senior management oversight that required improvement.

Vision and strategy for this service

- At the time of our inspection, there was no non-executive director with responsibility for end of life care. This is a recommendation from Norman Lamb after publication of the review of the Liverpool Care Pathway in his letter to NHS Trust Chairs and Chief Executives in July 2013.
- The palliative care team was compiling a business case to employ a further palliative care consultant. However they were unsure as to the long-term funding for the nurse conducting staff education and felt that patient care would suffer if this post was removed. They told us that they found it difficult to plan training because they had been given no indication as to the trust's willingness to fund this post after the beginning of July 2014.
- Staff told us that any improvement in service provision had to include funding for extra staff because they had no further capacity within the current service workforce.

Governance, risk management and quality measurement

- The medical director had conducted a review of palliative care patients following the spike in diagnosis and personally signed the response by the trust addressing the concerns. The response demonstrated a high level of understanding, particularly of issues concerning staff.

Trust policies relating to end of life care

- We were told by staff that there was limited advice relating to the preparation of deceased people for the mortuary. The trust policy stated that the deceased should be 'appropriately labelled'. Staff told us they did not refer to this policy in practice and asked senior colleagues. Mortuary staff we spoke to told us that there were some wide variations in practice across the trust.

Leadership of service

- Staff felt that their line managers were supportive and visible.
- Staff in the mortuary told us they had escalated concerns about the lack of capacity to senior managers, who had visited the mortuary to inspect the current provision.

Public and staff engagement

- We were told that staff engagement with end of life care had improved in the months leading up to our inspection. This included a 'care of the dying week' within the hospital, which had included events raising the profile of effective end of life care.

Outpatients

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The hospital had over 265,855 outpatient appointments in 2013/14. Outpatient services are provided 5 days a week between the hours of 8am and 5pm. The general outpatient area includes a variety of specialisms including hepatology, ophthalmology, dermatology, neurology, pain management, trauma and orthopaedics, fracture, urology and diabetes. There is a dedicated area for cardiology, HIV, anticoagulation, endoscopy, oncology, radiotherapy and for breast clinics, which have the facilities to provide a one-stop clinic. There are also dedicated women's and children's outpatient clinics.

We inspected the general outpatients, a breast clinic, oncology, radiology, women's and children's outpatient clinics and cardiology department. We spoke with 18 patients and five family members or carers. We also spoke with 36 members of staff including managers, doctors, nurses, administrators and receptionists. We observed care and treatment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

The service provided by the outpatient department was required improvement in terms of protecting people from avoidable harm. There were systems for reporting and investigating incidents; however, not all staff were aware of the actions that had been taken in response. Other aspects of safety were suitably monitored. Records of staff training showed that some staff were not up to date with their mandatory training. The hospital did not ensure that outpatient clinics were adequately staffed at all times.

The hospital ensured that suitable clinical guidelines were followed for different patient pathways. Some patients had limited access to follow-up appointments. Staff were competent and knowledgeable; however, not all of them had been appraised. We found good examples of multidisciplinary working. Services were provided 5 days a week.

Outpatient services were caring. We observed patients being treated with compassion, dignity and respect. Many of the patients we spoke to felt they were offered a kind and caring service. We were told that staff were helpful and polite most of the time. The hospital was able to provide emotional support to patients who had received bad news.

The hospital was not responsive to the needs of patients. They were not meeting the national waiting time targets of 2 weeks for urgent cancer referrals and 18 weeks for non-urgent appointments. Some of the clinic

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appointments were cancelled at short notice. Clinics were busy and some patients had to wait for longer than 18 weeks before they were treated. Some appointments were booked at unsuitable times and some clinics were overbooked in error. The trust did not respond to patients' complaints in a timely manner.

Although we observed strong local leadership and examples of good team work, the senior management of the hospital was not visible in the outpatient departments. Some of the staff said they had not been listened to regarding key service changes affecting their day-to-day work. Staff were not aware of how they had performed in relation to referral to treatment targets. They were also unaware of the key performance indicators set for their clinics.

Are outpatients services safe?

Requires improvement

The service had a system for reporting and investigating incidents; however, not all staff were aware of the actions that had been taken in response. Records for staff training showed they some staff were not up to date with their mandatory training. The trust did not ensure that outpatient clinics were adequately staffed at all times. There had been no serious incidents in the outpatient department. The environment was clean and hygienic. Medicines were checked and stored securely. Patient records were stored securely and were mostly accessible when required.

Incidents

- There had been no recent Never Events reported in outpatients or radiology.
- Staff had access to an online reporting form and were trained in using it.
- The outpatient department demonstrated a good culture of reporting incidents.
- Reported incidents were assigned to an appropriate service lead for investigation. Risk ratings and outcomes were decided by the senior management team, who reviewed every incident report to ensure that the issue had been addressed.
- The completed report was automatically sent back to the person who had reported the incident so that they received feedback.
- Staff told us that they were encouraged to report incidents but they had not always received feedback from the management team on actions to be taken.
- The matron participated in regular meetings where serious incidents that occurred at the hospital were discussed.
- We were given examples of learning from incidents. Wider learning was cascaded to lead nurses. However, we found that there was no effective system to ensure that all staff were aware of the outcomes of an investigation and the lessons that should be learned.

Cleanliness, infection control and hygiene

- Clinical areas we inspected appeared clean, and we saw staff washing their hands and using hand gel between patients.

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- The 'bare below the elbow' policy was adhered to by staff in the clinic areas.
- All the toilet facilities and waiting areas we inspected were clean.
- Personal protective equipment, such as gloves and aprons, was available for staff to use whenever necessary areas.
- Staff told us that contractors cleaned the clinic rooms each day. We saw that checklists had been completed to indicate that areas had been cleaned.
- There were hand-washing facilities and hand gel dispensers in every consultation room.
- We saw that the hand hygiene audit was undertaken weekly and, when non-compliance with hand hygiene protocols was found, feedback was given to the individual staff members.
- The outpatient departments achieved 100% hand hygiene compliance 11 weeks out of 13 between March and May 2014.
- Staff told us that there was no infection control audit of clinic rooms or the outpatient environment.

Environment and equipment

- The environment in the outpatient areas was safe and accessible.
- Overall, staff told us they had enough facilities and items of appropriate equipment. If additional equipment was needed, then it was provided.
- Equipment was appropriately checked and it appeared clean. Staff told us there was adequate equipment available in all the outpatient areas.
- In some clinics, staff said the equipment was outdated. This included two machines used in the nuclear medicine department (gamma cameras). We noted that outdated equipment was on the risk register and was due to be exchanged.
- Medical engineers were responsible for the maintenance of some of the equipment. Other equipment was serviced by external contractors.

Medicines

- Medicines were stored securely. They were kept in locked medicine cabinets to which nurses had access.
- All emergency medication and emergency equipment were in place as were resuscitation trolleys which were checked daily.

Records

- Patient files were stored securely within the records department at the main hospital site. When older than 3 years, they were despatched to off-site storage.
- The clinical records kept were a combination of electronic records and paper files. When records were in the outpatient department, they were stored securely, locked away or on password-protected computers.
- Staff told us that occasionally they could not locate patient records. We checked individual medical records in one of the clinics and noted that three out of the 42 needed for the day had not been provided by the medical records team. Staff told us that missing notes could often be located promptly but sometimes they would cause delays to patients' appointments.
- We were told that a temporary record was made for those patients who were seen without a full set of notes. Some doctors refused to see patients without a full set of notes because they would not have all the information they needed to ensure the patient's safety. Details such as allergies and past medical history might not be known to them.
- There was a routine audit of missing notes for the outpatient clinics which showed 27% of notes could not be found. The reasons why the notes were missing were not always identified and rectified.

Consent, Mental Capacity Act and Safeguarding

- Patients were asked appropriately for consent to procedures. They told us that staff always spoke to them about any procedure before carrying it out and gained their consent.
- Staff were clear about their responsibilities in line with the Mental Capacity Act 2005.
- The matron of outpatients told us they had not had any safeguarding issues or referrals.
- Staff told us that, if they had a safeguarding or capacity issue, they would call the safeguarding lead nurse practitioner to assist.

Mandatory training

- The trust told us that staff working at the specialist medicine and support services clinical business unit achieved 49% compliance with mandatory training.
- Staff felt training was beneficial to their role. Cover was arranged to allow them to attend training when required. Some training was delivered online while other training was face to face.

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- Core training topics included information governance, infection control, moving and handling, fire safety, child protection (levels 1, 2 and 3), safeguarding, health and safety, conflict resolution, and equality and diversity.
- Staff told us that they had attended basic life support training and knew how to apply it.
- Some healthcare assistants were not clear whether they had received health and safety training. A senior nurse told us that healthcare assistants were no longer asked to attend a training session where health and safety and fire safety awareness were covered, and it was not clear what was offered instead.

Nursing and medical staffing

- There was a good level of retention of staff within outpatients.
- The senior sister was responsible for maintaining the staffing rota. We reviewed the staffing establishment in relation to the number of qualified nurses and clinic support workers.
- The matron for outpatients was supernumerary so was able to supervise and assist staff.
- We noted that sickness rates varied between outpatient clinics. For example, the sickness rate for the fracture clinic between April 2013 and April 2014 was 0%, for the gynaecology outpatient clinic 1.7%, for urology 1.9% and for radiotherapy 4.7%. The sickness rate among outpatient nursing staff for the same period was 5.3% and among oncology administrative staff 11.5%. The average reported sickness rate was 3.35%.
- There was an insufficient number of staff in some of the clinics to meet the increasing demand for appointments. We were told that extra staff would be recruited to the radiology department and breast, fracture and orthopaedic clinics.
- Some of the nurses had been affected by a shortage of administrative and clerical support and were required to prepare medical records or greet patients when the reception area was unstaffed.
- The trust told us that, in April 2014, 9.8% of the clinical staff working within the specialist medicine and support services clinical business unit (CBU3) were temporary. This was above the trusts 5% target.
- The vacancy rate for the clinical staff working in CBU3 in April 2014 was 9.7% against a 7% target.

Are outpatients services effective?

Not sufficient evidence to rate

The trust ensured that suitable clinical guidelines were followed for different patient pathways. However, some patients had limited access to follow-up appointments. Staff were competent and knowledgeable; however, not all of them had been appraised. We found good examples of multidisciplinary working. Services were provided 5 days a week.

Evidence-based care and treatment

- We were told that guidelines, such as the National Institute for Health and Care Excellence (NICE) guidelines, were followed when appropriate (for example, the multidisciplinary care pathway for patients with lung cancer, or related to assessment and diagnosis of recent onset chest pain, or discomfort of suspected cardiac origin).
- The endoscopy unit had achieved Joint Advisory Group (JAG) accreditation for 2014. We inspected it and found it well organised and well-staffed.

Patient outcomes

- There was a limited capacity to organise follow-up appointments in some of the outpatient clinics. This included dietetics, nephrology, paediatric urology or hepatology where no appointments were available within 5 weeks. The trust told us that all specialties had plans to address follow-up capacity issues.
- Staff reported occasional delays against internal targets in x-ray and histology reporting times, which could cause delays in diagnosis. This issue was also highlighted in the corporate risk register in April 2014. We spoke with the manager of the radiology department, who told us that the department was short staffed and was looking to recruit an additional radiologist in order to improve the service.

Competent staff

- Staff were competent and knowledgeable when spoken to.
- All annual appraisals were completed by staff at the appropriate level. Many of the staff had had an appraisal in the past 12 months. Over 85% of the nurses working in CBU3 were appraised.

Outpatients

- Appraisal rates between different groups of staff varied. Nearly 39% of the administrative and clerical staff and over 32% of the allied health professionals working within CBU3 were due an appraisal.
- The trust told us that the appraisal rate for doctors across the hospital was 82%.
- Clinical academics were encouraged by the British Medical Association to prepare for and participate actively in job planning on an annual basis.
- Regular supervision or one-to-one operational meetings were organised on a 'when required' basis.
- There was a competency framework for new staff to the service, completed within the first 3–6 months.
- There was a teaching programme for staff development. Staff told us the trust supported training.

Multidisciplinary working

- We saw some examples of good multidisciplinary team involvement.
- Shared pathways were effective and patients told us that, when external agencies were involved, the communication was effective.
- The trust told us that they had not always managed to report outcomes of the outpatient consultations back to the referring GP within 48 hours of the outpatient appointment.

Seven-day services

- Most of the outpatient clinics ran from Monday to Friday. Clinics were scheduled to run from 8am to 5pm.
- The x-ray service offered a walk-in GP service 7 days a week.
- Occasional Saturday morning clinics had been organised in the main outpatient area in order to reduce a backlog and the risk of breaching the waiting time limits.

Are outpatients services caring?

Good

We observed patients being treated with compassion, dignity and respect. Many of the patients we spoke to felt they were offered a kind and caring service. We were told that staff were helpful and polite most of the time. The trust was able to provide emotional support to patients who had received bad news.

Compassionate care

- We observed patients being treated with compassion, dignity and respect. This included reception staff being polite and explaining if there was a waiting time.
- The nurses and healthcare assistants called for patients in the waiting room in a dignified way. They greeted them, introduced themselves by name, apologised if there had been a delay, and took them where they needed to go.
- Patients told us there were "lovely staff at outpatients" and that when an appointment was late the "nurse and doctor were very nice and apologetic and explained what was happening." Others mentioned that "corridors were very long between outpatients and the discharge lounge."
- Patient consultations took place in private rooms.
- The environment in the reception area of the outpatient department did not allow for confidential conversations. In many of the clinics, the waiting areas were situated in link corridors where confidentiality could not be guaranteed. Staff were sensitive to the lack of confidentiality; they told us that, if there was a need, they would use a quiet room to discuss confidential matters.
- We saw that patients' families or carers could accompany them into the clinic.
- Chaperones were provided when required. Staff told us that they had not received any specific chaperone training.

Patient understanding and involvement

- Most patients we spoke with said they felt involved in their care.
- The results of the Cancer Patient Experience Survey 2012/13 suggested that patients did not always feel fully involved in decisions about their care and treatment, nor were they given full information about potential side effects, tests results or choice of treatment.
- The trust developed an action plan in response to the survey. Planned actions included recruiting additional oncology consultants and providing extra training for staff. In addition, the Macmillan Cancer Support Centre, which gave information, advice and support to patients and their families, carers and friends, was opened in April 2014.

Outpatients

- Patients we spoke with said that, if they had any queries about appointments, they would contact the individual clinics or medical secretaries. However, some of them told us that it was sometimes difficult to get in touch with the right person.

Emotional support

- Staff told us they could give patients a quiet place and spend time with them after their appointment if they had received bad news.
- The trust worked in partnership with the Helen Rollason Cancer Support Charity to provide a counselling and support group for cancer patients and carers. Patients were offered alternative therapies such as massage, reflexology and aromatherapy.
- There was support available to patients with sight problems or who were told there was no further help available for their eye condition. The trust worked in partnership with a charity supporting blind or partially sighted people and they were able to offer immediate support to ensure that the patients were aware of all the services available.

Are outpatients services responsive?

Requires improvement 

The trust was meeting the national waiting time target of 2 weeks for urgent cancer referrals and 18 weeks for non-urgent appointments. Some clinic appointments were cancelled at short notice. Clinics were busy. Some appointments were booked at unsuitable times and some clinics were overbooked in error. The trust did not respond to patients' complaints in a timely manner.

Service planning and delivery to meet the needs of local people

- Since December 2013, the number of patients attending some of the clinics had gradually increased. The trust told us that this was linked to implementation of the Barnet, Enfield and Haringey clinical strategy and was in line with expectations. Staff felt that the trust had failed to recognise its impact on some of the outpatient clinics and plan service delivery accordingly. A significant increase in number of patients had been noted in the fracture and breast clinics among others. For example, in March 2014, the radiology department had observed a 26% increase in demand year on year. The trust has plans to increase staff within this area.
- We noted that there was a limited capacity to organise extra clinics to deal with the increased number of referrals. Staff told us that this was because of a limited number of consultation rooms or lack of staff.
- We were told that there were plans to employ additional staff in the registration team, fracture clinic and radiology department. Staff felt that the trust had delayed recruitment of clinical and clerical staff. Both nurses and doctors felt there was insufficient administrative support available to them. We observed that the breast clinic did not have a receptionist and the duties were performed by a nurse.
- Staff told us that occasionally, when additional ad-hoc clinics had been organised, patients had failed to attend because they had been given insufficient notice.
- There was minimal communication between staff responsible for access, cancellations and registration team and individual outpatient departments. For example, staff responsible for booking appointments were not aware of weekly meetings attended by doctors or of the on-call rota. This meant that some appointments were booked at unsuitable times and some clinics were overbooked in error.
- A number of doctors told us that clinics were overbooked without their permission. We noted that in one clinic patients were turned away at the consultant's request. In another, 30 patients were booked for 18 slots of 10 minutes each.

Access and flow

- One-stop clinics were in place for breast conditions and for the diagnosis and treatment of prostate cancer. In some cases, results were provided on the same day.
- Eye clinics offered walk-in urgent treatment, triaged from the main accident and emergency (A&E) department. Same-day appointments could be offered to patients with HIV Monday to Friday. There was a rapid access chest pain clinic (RACPC) that provided a quick and early specialist cardiology assessment for patients with new onset of exertional chest pain. This was also available to those attending the cardiology outpatient clinics. A plain x-ray walk-in service was available every day, 8am–10pm. Phlebotomy also provided a walk-in outpatient service.

Outpatients

- Information on appointment delays was displayed in most of the clinics. We saw that one clinic was running late by 20 minutes and another by 30.
- Patients told us that waiting times varied between 20 minutes and 2 hours.
- The average waiting time to see a specialist for non-urgent matters was 7 weeks from the time when the GP referral was received. The shortest waiting times were reported for the breast, cardiology, oncology, trauma and orthopaedics clinics (2–6 weeks). Patients waited for approximately 9 weeks to see a specialist in the hepatology, neurology and dermatology clinics, and 13 weeks to see one in the pain management clinic.
- Patients told us that clinics were occasionally cancelled for various reasons. One told us that their appointment had been cancelled on three occasions with no reasons given. Another said that an appointment for a simple medical procedure was cancelled because of broken equipment.
- On average, 10% of outpatient clinic appointments were cancelled by the hospital and 7% at patients' request between April 2013 and June 2014.
- The highest cancellation levels by the hospital were recorded in the pain, endocrine and nephrology clinics (a 22–33% cancellation rate). Some of the paediatric clinics had also recorded high cancellation rates (respiratory 26%, gastroenterology 23%, and paediatrics ophthalmology 19%).
- The highest cancellation levels by patients were recorded for colposcopy (17%), neurology (12%), paediatrics ophthalmology and some of the other eye clinics (11–12%).
- Staff told us that some of the patients' cancellations were linked to letters, informing them of clinic appointments, not being sent out on time. Patients reported not having received them in time. This was recorded as 'did not attend' (DNA) when actually patients had not been provided with correct information or information which was sent out at short notice.
- The trust had introduced a text-messaging service in January 2014, which alerted patients with mobile phones of their appointment 5 days before the due date.
- The trust was meeting the national waiting time target of 2 weeks for urgent cancer referrals and 18 weeks for non-urgent appointments.
- The trust was unable to meet the 2-week waiting time target for urgent cancer referrals in the upper gastro-intestinal and dermatology clinics.
- For non-urgent referrals, there were delays in colorectal surgery, dermatology, gastroenterology, neurology, ophthalmology (adults and children) and pain management clinics.

Meeting people's individual needs

- Staff told us that they had ready access to a translation service if they needed it. This meant that patients, for whom English was not their first language, could engage fully in their consultation.
- Staff told us that many patients were Turkish. We noted that a number of leaflets were available in Turkish and staff told us that Turkish interpreters were employed by the trust in order to support patients during appointments.
- Requests for interpreters at short notice could be arranged by telephone.
- There was guidance available for staff on how to communicate with people with hearing difficulties.
- We saw there were some leaflets in the clinic areas that gave helpline numbers and details of support networks for specific disease areas, such as cancer.
- There was written information available for patients. Some of these leaflets had been produced by the trust and others had been provided by external agencies such as the Royal College of Ophthalmologists.
- Drinking water and other refreshments were available in the waiting areas.
- The monthly summary report from the pharmacy showed that from January to May 2014 the average time a patient had to wait for prescriptions to be dispensed was 43 minutes.
- On average, 50 outpatients a week used the discharge lounge where nursing staff often arranged collection of medication from the pharmacy department so that patients did not have wait at the dispensary.
- Patients told us that occasionally they found it difficult to locate clinics. There was limited information available to patients at the main reception desk.
- Staff at the main reception desk were not aware of where individual clinics were taking place because they were not given an up-to-date clinic list.

Outpatients

- There was limited seating in some of the clinics, such as the eye, fracture and urology clinics. We did not observe people standing; however, staff told us that occasionally clinics were very busy and patients did need to stand for a short time.
- Since December 2013, many of the clinics had experienced gradual increase in the number of patients attending. A matron and a lead nurse in one of them told us that there was a limited number of consultation rooms and it was sometimes difficult to organise extra clinics when these were needed.

Learning from complaints and concerns

- Information on how to complaint was readily available in the waiting areas.
- We were told that initial complaints would be dealt with by the outpatient matron. If they were not able to deal with a concern satisfactorily, the patient would be directed to the Patient Advice and Liaison Service.
- There was no effective system to ensure that all staff were aware of outcomes of the investigations related to complaints and that lessons would be learned. Only the senior members of staff were aware of recent complaints and what actions had been taken in response to improve the service.
- Two patients told us that they had submitted written complaints to the trust but had not received written responses. One said they had written directly to a member of the executive team but had not received either a response or an acknowledgment.
- Only 50% of all complaints related to CBU3 and recorded in April 2014 were responded to within the specified 25 working days. The trust told us the target was set at 80%.

Are outpatients services well-led?

Requires improvement

Although we observed strong local leadership and examples of good team work, the senior management of the hospital was not visible in the outpatient departments. Some of the staff said they had not been listened to regarding key service changes affecting their day-to-day work. Staff were not aware how they had performed in relation to referral to treatment targets. They were also unaware of the key performance indicators set for their clinics.

Vision and strategy for this service

- The trust vision and values were not always understood or fully supported by the staff. Some staff told us that there was limited opportunity to express their concerns related to developments within the trust and how these affected their day-to-day work.
- Senior staff we spoke with were informed about the issues related to capacity and cancellations.
- Staff told us that they did not always feel involved in the development of outpatient services.
- Most of the staff were unaware of how they had performed in relation to referral to treatment targets. They were also unaware of the key performance indicators set for their clinics.

Governance, risk management and quality measurement

- Audits and quality improvement projects were not always discussed with staff. There was a limited opportunity for learning to take place.
- Staff were able to identify the challenges they saw to their own service. They told us these were mostly linked to limited capacity to accommodate an increased number of patients in some of the clinics after some of the services had been moved from the Chase Farm Hospital.
- Risks were suitably identified and there was an appropriate monitoring system to ensure they were addressed.

Leadership of service

- Staff working in each department told us that they could talk to their line manager and were often able to contribute to the running of the department. However, the senior management of the hospital was not very visible in the outpatient departments.
- Most of the staff told us that they did not see the hospital executive team, and that they were unaware of them inspecting their department.
- There were varying levels of appraisal and mandatory training uptake across the department.

Outpatients

- We talked to staff members responsible for different clinics. They were knowledgeable and had the qualifications necessary for their job. Most of them had many years' experience. They told us that they had been supported by the trust to develop their careers.
- The senior nurses in the individual clinics told us they had not always felt involved in the management decisions that affected their clinics. Although they were mostly consulted on issues regarding service delivery their views, were not always listened to. Similar concerns were expressed by doctors. One doctor said, "We are able to talk but we are not always heard."
- Monthly performance meetings were organised by the trust and attended by the lead staff. We saw that key action points from each of those meetings had been recorded and allocated to individual staff members.

Culture within the service

- Staff we spoke with were focused on providing a good experience for patients who visited their department. They were patient-centred and aimed to provide a better service.
- We were told by staff that their immediate line managers encouraged them to report any concerns they had. They said they could discuss any issues with their manager.
- Most staff felt supported in their work.
- We observed that staff worked well as a team. They spoke about supporting each other and helping out whenever required.

Public and staff engagement

- Patients attending the outpatient clinics were able to provide feedback by using touch screens available in the waiting areas. However, it was not clear how this feedback related to individual outpatient clinics and staff told us that summaries were not shared with them.

Innovation, improvement and sustainability

- A senior member of staff told us that the trust was working on the development of self check-in facilities for patients, which would reduce the numbers of reception staff and speed up the check-in process.
- The trust had implemented the NHS Friends and Family Test in the outpatient anticoagulant clinic before the national roll-out of this test. This was used to improve patient experience.
- A specialised electronic patient record system had been introduced in the HIV clinic. This improved clinical work streams and supported efficient, multidisciplinary, patient-centred care.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had developed partnership working with local primary care providers to address the poor use of primary care services by the local population. This included regular teleconferences with local authorities and other services to tackle frequent inappropriate visits to the trust by the same patients, and delayed transfers of care.
- The trust had recently launched a health bus to inform the local community about the availability of, and access to, primary care services, and to offer basic health checks to people in its catchment area.
- The trust had developed an in-house database to improve the quality of care to patients with HIV; it was marketing this database to other providers.
- The department had an innovative pathway for patients with sickle cell conditions. Staff displayed a high level of knowledge in diagnosing and treating this specialism.

Areas for improvement

Action the hospital MUST take to improve

- Take action to ensure that the outpatients department is responsive to the needs of patients in that appointments are made in a timely manner, those with urgent care needs are seen within the target times, cancellations are minimised and complaints are responded to.
- Take action to improve its training – both mandatory and non-mandatory – and its recording and administration of training records and training renewal requirements.
- Ensure that the provision of ambulatory care maintains people's privacy and dignity.

Action the hospital SHOULD take to improve

- Review the needs of people living with dementia across the hospital to ensure that they are being met.
- Review the use of the decontamination room in A&E which poses a contamination risk to the rest of the hospital. This was closed during our inspection following highlighting our concerns.
- Ensure that medicines are stored safely in A&E and that systems for recording take home medication are consistent throughout the hospital.
- Ensure that A&E staff undertake risk assessments for those patients at risk of falls or pressure sores.
- Review the risk assessments for the ligature points noted in the psychiatric assessment room in A&E.
- Ensure that there is adequate provision of food and drink for patients in A&E who are waiting for long periods including at night.
- Improve patient discharge arrangements at weekends.
- Improve investigation and response times to complaints particularly in A&E and outpatients.
- Ensure that the lines of responsibility between A&E and children's' services over the responsibility for the paediatric A&E are clear to staff during a period of change.
- Review arrangements for the consistent capture of learning from incidents and audits and ensure that learning and audit data is always conveyed to staff.
- Improve medical recording to remove anomalies and inconsistencies in records, paying particular attention to elderly care wards and take steps to improve the security of records in Surgery.
- Review the provision of specialist pain nurse support across the whole hospital.
- Ensure consistent ownership and knowledge of the risk register across all nursing and medical staff.
- Review decisions made at a senior non-clinical level being unchallenged and having a potential clinical impact on patient welfare.
- Review development and promotional prospects and progress for staff such as healthcare assistants.
- Review and implement a system for updating national guidelines in maternity and palliative care.
- Improve documentation around assessment of mental capacity in end of life care.

Outstanding practice and areas for improvement

- Improve consistency of use of early warning scores for deteriorating patients.
- Improve documented guidance for staff around referral of patients to palliative care.
- Increase mortuary capacity beyond current temporary arrangements.
- Appoint a non-executive director with responsibility for end of life care.
- Review clinic cancellation processes to avoid clinic appointments being cancelled at short notice.
- Review appointment arrangements to ensure that appointments are not booked at unsuitable times or clinics overbooked in error.
- Review the waiting areas in outpatient clinics, particularly the eye, fracture and urology clinics at busy times to prevent people having to stand while waiting.
- Review follow-up outpatient appointment arrangements to increase capacity to organise follow-up appointments in some of the outpatient clinics. This includes dietician, nephrology, paediatric urology and hepatology clinics where no appointments were available within 5 weeks.
- Improve communication with outpatient staff and their involvement in the development of the service to ensure service vision and values are understood and fully supported by staff. Allow staff increased opportunity to express their concerns related to developments within the trust and how this affects their day-to-day work.
- Accelerate plans to move to 7-day working across all core services. The support for patients recovering from surgery is limited at weekends with no access to occupational therapists, physiotherapists or clinical nurse specialists. Improve access to electronic records for community midwives.
- Improve the recording of care on the labour ward.
- Improve access to records for community midwives.
- Review the impact of the Barnet, Enfield and Haringey strategy, its impact on staff and its potential impact on quality of care.
- Review the heavy reliance on agency staff due to a 20% shortage of paediatric nurses in the neonatal unit.
- Review inconsistency around documentation of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms.
- Improve training for junior doctors on palliative care.
- Improve the privacy and dignity of patients during the reception process and waiting times to see a clinician within the Urgent Care Centre during the reception process.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services did not always have their health and welfare needs met by sufficient numbers of appropriate staff in that: Mandatory training records did not accurately reflect training undertaken across the trust. Dementia awareness training was not undertaken across the trust.

Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London

19 September 2014

Future Work Plan

1. Work Plan

1.1 Members are requested to consider any potential items for future meetings of the Committee.

1.2 Issues already identified as potential future items for meetings are currently as follows:

21st November (Barnet)

1. Integrated Care
2. Royal Free acquisition of Barnet and Chase Farm – Ongoing progress
3. Primary Care – Case for Change
4. Winter Planning
5. NELCSU – 5 Year Plan
6. Spend levels between primary and secondary care
7. Hospital parking

16th January (Enfield)

1. Royal Free acquisition of Barnet and Chase Farm
2. NHS 111/Out of Hours
3. Complaints

20th March (Camden)

1. Whittington Hospital; Five Year Plan/Development of Integrated Care (
2. Cancer/Cardiology Reconfiguration - Update
3. Maternity Services
4. Stroke/Dementia

To be arranged

1. Academic Health Science Partnership
2. NMUH – Foundation Status

- Spend levels between primary and secondary care
- Complaints
- Primary care - Case for Change (standing item)
- Whittington Hospital; Five Year Plan/Development of Integrated Care