Royal Free Foundation Trust

Evidence appendix

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

Facts and data about this trust

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

Name of acute hospital site	Address	Details of any specialist services provided at the site
Royal Free Hospital	Pond Street, London, NW3 2QG	Ian Charleson Centre (HIV)
Barnet Hospital	Wellhouse Lane, Barnet, Hertfordshire, EN5 3DJ	Neonatal care unit
Chase Farm Hospital	The Ridgeway, Enfield, Middlesex, EN2 8JL	Specialist rehabilitation service; Maxillofacial
Edgware Hospital	Burnt Oak Broadway, Edgware, HA8 0AD	Birth unit; Neurology rehabilitation centre; Breast screening unit; Kidney care centre

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

Is this organisation well-led?

Leadership

The trust had a stable, well-connected and senior team with an appropriate range of skills, knowledge and experience to perform its role. The trust board members brought with them extensive experience from NHS organisations, other public sectors and the private sector. Their collective skills and experience included finance, public sector, regulation, research, entrepreneurial, education, management, legal, and health knowledge. The group board was a cohesive and high performing team, who have worked effectively to establish a clear and ambitious strategy for the trust. However, whilst the board provides strong strategic leadership, there was limited awareness regarding detailed implementation status. For example, in our interviews, Board members referred to the Group's plan to financially break even within a three year timeframe, despite recent board papers to the contrary. Also, we found documents that had been presented to the board with numerous incomplete or out of date actions.

Chair Dominic Dodd led the trust's board and David Sloman was the CEO. The board comprised of nine non-executive directors (NEDs) and six executive directors. The executive board was well-established with most members being in post for a significant amount of time. We noted that the board members and senior staff were highly committed to the trust with senior managers who had previously left often returning to the trust as their a careers developed.

The CEO described his approach as, "keep eyes to horizon and nose to the grindstone" he believed the trust work on clinical practice groups (CPGs) was revolutionary. He stated that it had the potential to genuinely transform the way the NHS is run.

Executive directors were responsible for the daily running of the trust and, together with the NEDs, had collective responsibility for setting policies, the strategic direction of the trust, monitoring performance against objectives, and upholding standards of governance and integrity. Board members also sat on the sub-committees which were;

- Remuneration Committee
- Audit Committee
- Clinical Standards and innovation Committee
- People and Population Health Committee
- Group Services and Investment Committee

The trust's executive directors were the CEO, group chief finance and compliance officer, deputy CEO, group chief medical officer and group chief nurse. The longest serving member of the executive team was the CEO who was appointed to their current role in September 2009. The most recent appointment was the group chief medical officer who had been appointed in February 2018.

In response to concerns from NHS Improvement (NHSI) regarding the capacity of the executive team, a Group Chief Finance and Compliance Officer (CFO) was appointed in September 2018. The CFO was well-regarded, however there were concerns about the extent of his capacity to perform both financial and performance roles given that the trust did not have a group chief operating officer. The trust had taken time to recruit. The senior finance team will be complete when the Director of Financial Performance for the Royal Free Hospital joins in February 2019.

Through various interviews with the NEDs and executive team, there was a consistent view of collective responsibility for financial performance, the importance of improving the trust's underlying position, and the trust's inability to deliver recurrent cost savings. There have been improvements to ownership of site financial performance by the respective leadership teams. However, there had been no improvement in underlying deficit over the course of 2018/19, which raised concerns over the level of challenge being applied at the various performance meetings.

There was a commendable focus on innovation through reduction in variation and redesigning pathways, and on a commercial approach to growth through developing a group model.

Further to their operational leadership roles, executive directors held a portfolio of additional responsibilities which were appropriately aligned with their professional skills and expertise. For example, the chief nurse was the trust's lead for adult safeguarding and infection control and the medical director was the lead for CPGs and Never Event learning.

The Non-executive Director (NED) body had significant turnover in the last two years, with six of the eight NEDs being newly appointed. The NED group had a relatively even split of healthcare and commercial backgrounds, with two of the NEDs having a background in finance. The Chair of the Trust's Audit Committee was a qualified accountant and CFO within the private sector, and the Chair of the Group Services and Investment Committee was a venture capitalist and had considerable NED experience.

As a foundation trust, The Royal Free Hospital London had a council of governors drawn from its 26,000 members, chaired by the trust chair. The council was made up of 25 appointed or elected governors made up from the public; patients; rest of England; staff; one academic from University College London; three from the local councils. The most recent elections were in March 2017. The council's role was to advise the trust on issues that were important to patients and to the wider community to ensure the voice of the members and partners was used to inform trust's decisions. The council was also responsible for approving the appointment of NEDs and for holding the NEDs to account for the performance of the board.

Governors we spoke with were very positive about the trust's leadership team. Governors felt they had a good relationship with the board and that their participation was always welcome. They told us that when they raised concerns they were listened to by the board. Governors showed a good understanding of the key issues within the trust and were sighted on recent key board papers including the two recent external consultancy reports. Governors we spoke with told us they had a good relationship with the NEDs and would regularly undertake 'Go See' walk arounds with them.

The trust leadership team had a comprehensive knowledge of current priorities and challenges and acted to address them. All senior leaders we spoke with were familiar with the trust's strategy and key organisational risks. Board members had a good understanding of the financial standing of the trust and there was good clinical input into financial decision-making. NEDs are responsible for holding the executive board members to account for the performance of the trust. We saw that NEDs provided high levels of constructive challenge.

Staff we spoke with felt that there was stronger leadership and supervision for nursing staff than medical staff. Although things had improved with the new medical leadership team, staff and managers felt that medical staff were not as accountable for their poor behaviours as their non medical colleagues.

Of the executive board members at the trust, none were British Minority Ethnic (BME) and 50% were female.

Of the non-executive board members 7.7% were BME and 42.8% were female.

Staff group	BME %	Female %
Executive directors	0.0%	50.0%
Non-executive directors	7.7%	42.8%
All board members	7.7%	46.1%

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

Data from the trust's December 2018 workforce race equality standard (WRES) report recorded that approximately 48% of the trust's workforce were from a BME background. BME representation at overall board level was significantly lower at 7.7% overall with none of the executive board being BME. The trust recognised that the current board composition did not reflect the diverse population that the trust served, nor the diversity of the overall workforce. Part of the board succession planning was to make it more BME with the Chair hoping to achieve representation of at least 25%.

The trust Chair had shown positive leadership and commitment to improving staff BME representation. For example, if a BME candidate was not selected for a role the panel chair was required to write to the CEO explaining the circumstances.

The female representation of all board members was significantly lower than the overall workforce (46% compared to 68%). However, two of the trust's three recent NED appointees were female, with one being from a BME background. The trust had a women's network which aimed to support and encourage women to progress in their careers.

The trust had identified seven levels of leadership from a small team of 'group leaders' (10 staff) down to clinical leadership (1745 staff) and other leaders (1915 staff). There were seven identified levels of leadership and the trust had focused training and development opportunities to support staff as they moved to a higher level. These opportunities were part of the trust 'leadership tool kit' and included, training, coaching, mentoring and also a leadership apprenticeship programme. In the fiscal year 2018/19 1,515 staff had completed the essential leadership module compared to only 916 in the previous year.

The trust had a formal succession plan for executive appointments. It was clear that the CEO was proactive in developing staff for anticipated roles. For example, we found evidence that the trust had been planning for the CEOs replacement when he left the trust.

All executive and non-executive director appointments were subject to the Fit and Proper Persons Test (FPPT) as required by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force in November 2014. The trust had a FPPT policy and we were satisfied with the pre-employment checking processes and that the on-going fitness checks were in line with the trust policy. We reviewed five pre-employment checks and personnel files for executive and non-executive directors and found the process to be robust and effective. Files and checks were complete and comprehensive, including identification and Disclosure and Barring Service checks, references check, occupational health clearance, qualification, and professional bodies checks (where appropriate). It also had an employment history recorded. The FPPT self-declarations and annual appraisals had been completed annually by directors, as required by the trust's policy.

The trust had a ‘group model’ which meant there are separate management teams for each of the three main hospitals at Chase Farm, Hampstead and Barnet. Each hospital had a managing director, medical director and director of nursing. This triumvirate was responsible for operational running of their hospital. Board level staff took a more strategic role on behalf of the trust, which included holding the hospital leaderships teams to account through monthly performance meetings.

Staff told us that board members and the hospital site leadership teams were visible on a day-to-day basis within the trust. There was a range of forums where staff could meet with executive and non-executive members of the board as well as within regular committee meetings. We found that the board held regular formal meetings including staff side representatives, the charity and the governors.

Whilst it was acknowledged that the trust had a high medicines spend, a dedicated pharmacy team monitored appropriateness of usage. In addition, this team reported to a robust multidisciplinary high cost drugs committee who also managed individual funding requests.

The volume of work and recruitment of Band 4 Pharmacy Technicians was a challenge. In addition, the recently announced funding reduction for Pre-Registration Pharmacists would add further financial strain to the trust.

To maintain visibility, the Medical Director participated in ‘ward walks’ with a Lead Nurse. The Chief Pharmacist regularly worked from different sites in the trust and still completed clinical sessions. In addition, skype meetings were used to ensure that pharmacy staff on all sites could attend meetings.

Succession planning was in place. Pharmacy staff were supported with career development and benefited from the trust wide leadership development programme. This encouraged staff from different disciplines to engage and share ideas. Some had also completed the pharmacist prescribing course.

Vision and strategy

The trust had a clear vision and set of values based around ‘ world class expertise – local care’ which involved staff being;

- Positively welcoming.
- Actively respectful.
- Clearly communicating
- Visibly reassuring

The trust’s mission was to ‘deliver world class expertise and local care in services, research, teaching and education’ by;

- Providing excellent clinical services – from routine care for our local populations to internationally recognised specialist services.
- Delivering world-leading research in conjunction with other organisations in UCL Partners and giving our local patients access to the latest national and international clinical trials.
- Continuing our long standing reputation as leaders in medical education, offering exceptional training opportunities to undergraduates, post graduates, GPs and our staff.

The vision, mission and values for the trust are clearly stated, widely communicated and well known across the organisation. There had been a concerted effort to ensure the trust had a clinically owned and led strategy, and the resulting strategy appeared to energise the workforce.

However, following concerns about the robustness of the trust's financial strategy to break even by 2021/22, NHS Improvement asked the trust to commission a review of this strategy. The resulting external report showed a revised base case of a £53.6m underlying deficit in 2021/22, with an upside case of a £24.7m underlying deficit should all of the trust's strategic schemes deliver in full and to time. This was in comparison to the Trust's original financial strategy of a £1.2m deficit.

The trust had subsequently revised its financial strategy twice, and was now targeting an underlying deficit of £55m. This was underpinned by high capital investment plans and a more confident view of the ability of the strategic schemes to deliver than shown in the external review. This plan was currently being reviewed by NHSI for robustness but it was concerning that board members continued to refer to the original break even plan when we spoke with them. In addition, concerns expressed about the ability of the strategic schemes to deliver (for example financial benefits expected from the CPGs) did not appear to have been reflected in the trust's plan. It was, therefore, important the trust underpins its clinical strategy with a robust and credible financial plan, including a realistic capital plan.

It was apparent the organisation continued to focus on the immediate short term financial position. There was some improvement in focus on the trust's underlying position in terms of the reporting to the group board, however this did not yet appear to be tracked at site level (although we were advised this was planned). There also did not appear to be an effective action plan to remedy the underlying deficit. There remained an over-reliance on short term non-recurrent actions to fill the gap in in-year cost improvement, and on weaker long term strategic schemes to deliver the trust's financial recovery.

The trust had a clearly articulated and ambitious strategy and, although the group structure was still embedding, there had been tangible evidence of delivery including:

- The transfer of services between sites, such as the development of Chase Farm as an elective hub
- The use of digitisation to support the CPG approach, most notably the introduction of innovative technology at the new Chase Farm site;
- Targeting scale in back and middle office to drive efficiencies, such as the development of the centralised decontamination unit.

Individuals are able to describe the clinical model and the different options for involvement in the group structure, alongside enabling developments such as 'back office' and 'middle office', in an impressive way. However, the aspiration to expand the group was a potential distraction from moving forward with the trust's sustainability and transformation partnerships (STPs), as the geographical footprints were not aligned.

It was our understanding that the Deputy Group Chief Executive may step into the CEO role on an interim basis from February 2019. Given the Deputy CEO's existing role focusing on the trust's strategy, this will leave a gap in capacity that the trust will need to address.

Staff, patients, carers, and external partners were involved in developing the trust's strategy.

Patient co-design was at the centre of the trust strategy for developing CPGs. This work was also supported by the charity and linked to the points of care foundation.

Most staff knew and understood the trust's vision, values, and strategy and how achievement of these applied to the work of their own team. We saw examples of where local service objectives had been developed to support and align with the trust-wide strategy. For example, the trust had a scheme to identify babies needing extra support by means of an orange hat. Most frontline staff we spoke with were aware of their local objectives, and said they felt involved in the creation of local goals to achieve the trust's vision.

The trust was a member of the North Central London Sustainability and Transformation Partnership. Staff at and below board level explained that over the past 12 months the trust had engaged effectively with system partners. Working with system partners to improve the health of its local population was the trust's number one strategic priority. The trust CEO was the Chair of the STP.

The trust's key strategic priorities were reflected in plans with clear medium and long term milestones. The overarching mission and values were translated into a set of governing objectives and a long term vision and strategic objectives, which in turn had been used to set annual business objectives. The trust had a clearly defined set of short term priorities for 2018/20 which linked to its overall objectives.

The trust engaged in developing strategy with numerous external partners including the STP subgroup for children, the STP CAMHS group, and Healthy London Partnerships. For example, an operational and clinical representative attended the CAMHS group, and the trust had worked on a joint bid for a section 136 suite for children and young people in the region and on an out of hours model of nurse-led care.

The activity, workforce and financial planning processes described were robust, and appeared to be led at service-level with very strong clinical leadership. Cost improvement plans (CIPs) were innovative, patient focused and clinically-led. However, they were often weak on how and when financial benefits would accrue. We found that CIPs were regularly missing their financial targets. For example, the trust had not generated the planned cost savings of a recent laboratory centralisation programme.

The trust used the sale of property in the past to reduce their deficit and help to fund new and on going projects. At the time of our inspection, a new site had been acquired and a purpose-built decontamination centre was created. This unit was large enough to decontaminate all surgical and endoscopy equipment from the trust. The plant was still undergoing final testing, prior to being signed off and ready for use. It was stated that the capacity for the plant was large enough to eventually accept decontamination contracts from outside of the trust, to act as an additional source of revenue. Staff currently working within the trust's decontamination unit were advised they would be moved to the new development once this was opened during 2019. The sites that would no longer be required for decontamination had already been planned for either demolition or alternative uses, including the expansion of the theatre area on one of the sites and expansion of the car park on another.

The North Central London Medicines Optimisation Network (NCLMON) had a Medicines Optimisation Strategy and Sustainability Transformation Plan. The trust also had an individual medicines optimisation strategy which took on board recommendations from the Carter report. There was a refocus on pharmacy resources to deliver patient facing clinical care, which supported the trust in the delivery of their vision. Various projects were underway in line with the strategy, for example the implementation of Electronic Prescribing and Medicines Administration (EPMA).

The vision and strategy was embedded in staff roles, and was available on notice boards as well as discussed in team meetings.

Several business cases regarding the increase of clinical pharmacy resource were in progress. For example, the recruitment of a Critical Care Pharmacist and Oncology Pharmacist for the Barnet and Chase Farm sites respectively.

Culture

The trust leaders were aware that there were cultural issues in the trust. The results of the staff survey showed that the number of staff experiencing discrimination at work in last 12 months was worse than the national average (19% compared to 12% nationally), as was the percentage of staff believing the organisation provides equal opportunities for career progression/promotion (76% compared to 85% nationally). Workforce race equality standard (WRES) data showed that BME staff were disproportionately affected in these areas.

Leaders were passionate about trying to improve quality and diversity, and told us of initiatives that were in progress that aimed to improve the behaviours of managers and the experience of BME staff. For example, the CEO requested that for every role for which a BME internal applicant was unsuccessful, the recruiting manager must write to the CEO explaining why. Also, recruiting panels for band 8a and above had to include a BME representative. We found limited evidence of involvement of BME staff in creating and evaluating these initiatives. Some staff commented that the BME member of the recruitment panel was often not listened to.

WRES data showed that 48.1% of staff identified as BME, however, there were no BME members of the executive board. Executive leaders acknowledged that the senior leadership team was not representative of staff and patient diversity and were exploring ways to ensure that this improved in future.

There was an active BME network in the trust. They met regularly and provided support and held events for staff across the trust. Staff we spoke with commented that the trust leaders were aware of the issues affecting BME staff but they were not confident that improvements would materialise.

The trust acknowledged that there was an issue with bullying and harassment. The staff survey results showed that the number of staff who had experienced bullying and harassment was significantly higher than the national average. There had been a recent project where nine videos were created that showed realistic cases of bullying and harassment in the workplace. The trust planned to use these in training sessions with managers to improve awareness and understanding. Some staff we spoke with had heard about the videos and staff, including members of the BME and LGBT networks, had been directly involved in the project. Others had not heard about it, but leaders commented that this was because the programme was in the process of being rolled out and they wanted to ensure the videos were delivered in a focussed way such as during face to face training sessions.

The trust commented that there were concentrated areas where bullying and harassment was more prevalent. They said this was largely due to inappropriate consultant behaviours that had historically gone unaddressed, but that they were now taking serious action to deal with it.

The trust had a Speak Up Guardian who worked alongside 30 speak up ‘champions’, who were positive and proactive. The champions consisted of a variety of staff levels from the various sites of the trust. This included satellite sites such as Edgware and Tottenham kidney centres. There were local posters with names, contact numbers and photos of the champions and there was also information on the intranet. There was a dedicated email address for staff to contact the speak up guardian, which the guardian and their deputy monitored. The trust aimed to increase the number

of champions over the coming months. The role of the champions was to signpost and support people with their concerns. The champions and guardian met together as a group monthly and talked about common issues and identified any support they might need. The speak up guardian and deputy worked with the incident reporting system team to identify any incidents of bullying and harassment that might have been reported via the system, so that they could work to address issues.

The speak up champions attended trust events and staff induction days – the speak up guardian was a standard item on the chief executive induction brief. They also attended junior doctors' meetings. They were planning to implement walk arounds across the trusts to improve their visibility to staff and to encourage staff to come forward if they had concerns. They also wore lanyards identifying them as speak up champions to help staff recognise them and to help them feel comfortable raising concerns. The maternity speak up champion had introduced fortnightly one-hour speak up sessions at Barnet and the Royal Free sites and said the sessions were going well so far.

The trust LGBT network had a very positive and proactive culture. Staff spoke highly of the network and felt that it was very well-supported by senior leaders, including the executive team. Members of the network had been part of leading the project on the anti-bullying videos.

There was also a women's network at the trust which was quite new. The network had only met once which was in July 2018, but planned to run more regular events in 2019.

The trust provided the following breakdowns of medical and dental staff and nursing and midwifery staff by ethnic group.

Ethnic group	**Medical and dental staff (%)**	**Nursing and midwifery staff (%)**	**All staff (%)**
White – British/Irish/Any other white background	9.5%	15.1%	50.6%
BME - British	6.3%	9.9%	33.3%
BME - Non-British	1.9%	4.6%	14.8%
Not stated	0.5%	0.3%	1.3%

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

The trust has 11 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

Key Finding	**Trust score**	**National average**
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.99	3.91
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	92%	90%
KF4. Staff motivation at work	3.96	9.92
KF6. Percentage of staff reporting good communication between senior management and staff	35%	33%
KF12. Quality of appraisals	3.22	3.11

KF13. Quality of non-mandatory training, learning or development	4.10	4.05
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	14%	15%
KF24. Percentage of staff reporting most recent experience of violence	68%	66%
KF27. Percentage of staff reporting most recent experience of harassment, bullying or abuse	47%	45%
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in last month	91%	90%
KF32. Effective use of patient / service user feedback	3.76	3.71

The trust has 17 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

Key Finding	**Trust score**	**National average**
KF5. Recognition and value of staff by managers and the organisation	3.41	3.45
KF7. Percentage of staff able to contribute towards improvements at work	69%	70%
KF8. Staff satisfaction with level of responsibility and involvement	3.87	3.91
KF9. Effective team working	3.69	3.72
KF10. Support from immediate managers	3.69	3.74
KF11. Percentage of staff appraised in last 12 mths	80%	86%
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	47%	51%
KF16. Percentage of staff working extra hours	72%	72%
KF17. Percentage of staff feeling unwell due to work related stress in last 12 months	42%	36%
KF18. Percentage of staff attending work in last 3 months despite feeling unwell because they felt pressure	53%	52%
KF19. Organisation and management interest in and action on health and wellbeing	3.58	3.62
KF20. Percentage of staff experiencing discrimination at work in last 12 months	19%	12%
KF21. Percentage of staff believing the organisation provides equal opportunities for career progression / promotion	76%	85%

KF23. Percentage of staff experiencing physical violence from staff in last 12 months	3%	2%
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	33%	28%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	32%	25%
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	32%	31%

(Source: NHS Staff Survey 2017*)*

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

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

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

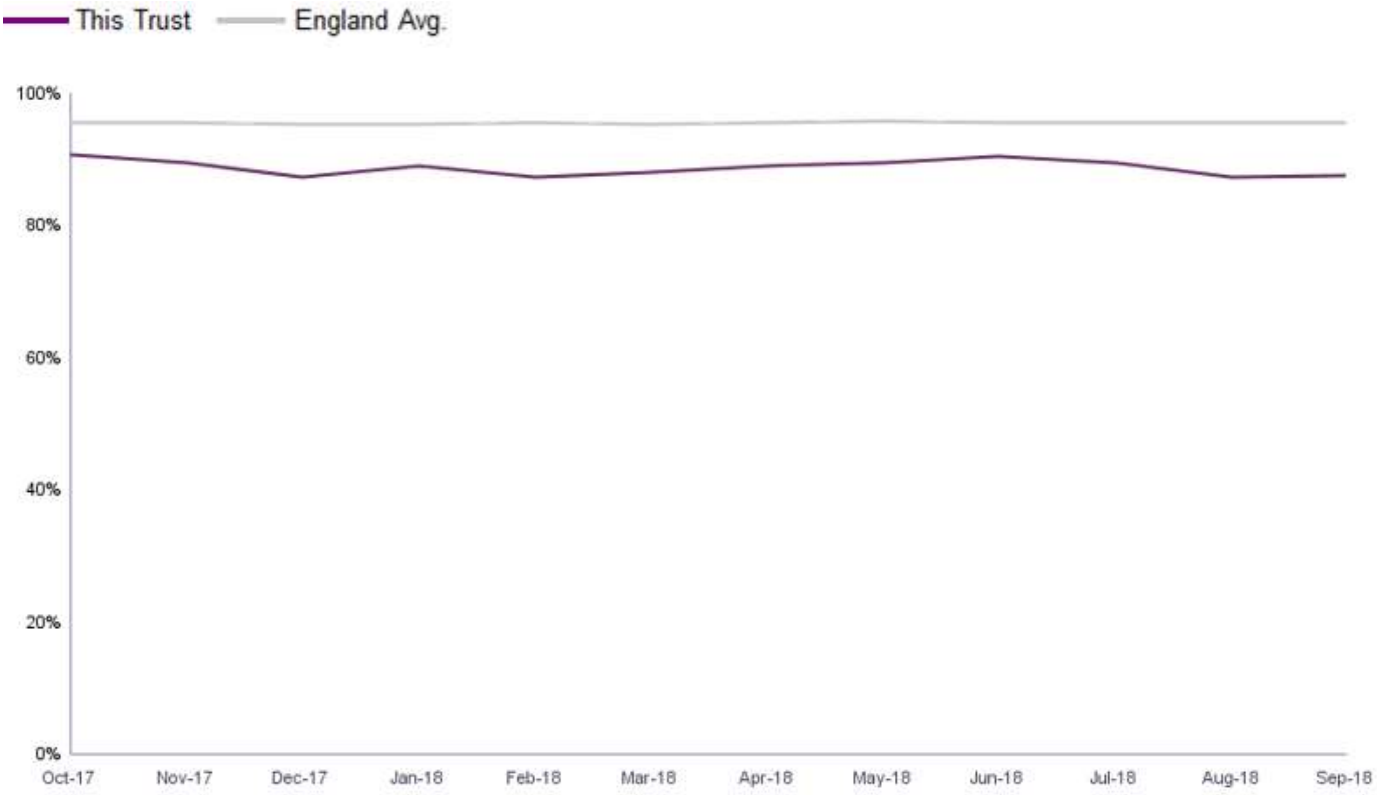
			Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	34%	27%	30%
		BME	31%	28%	29%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	29%	25%	30%
		BME	35%	27%	35%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	84%	87%	85%
		BME	65%	75%	66%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	8%	7%	9%
		BME	17%	15%	20%

All of the four questions above showed a statistically significant difference in score between White and BME staff.

(Source: NHS Staff Survey 2017*)*

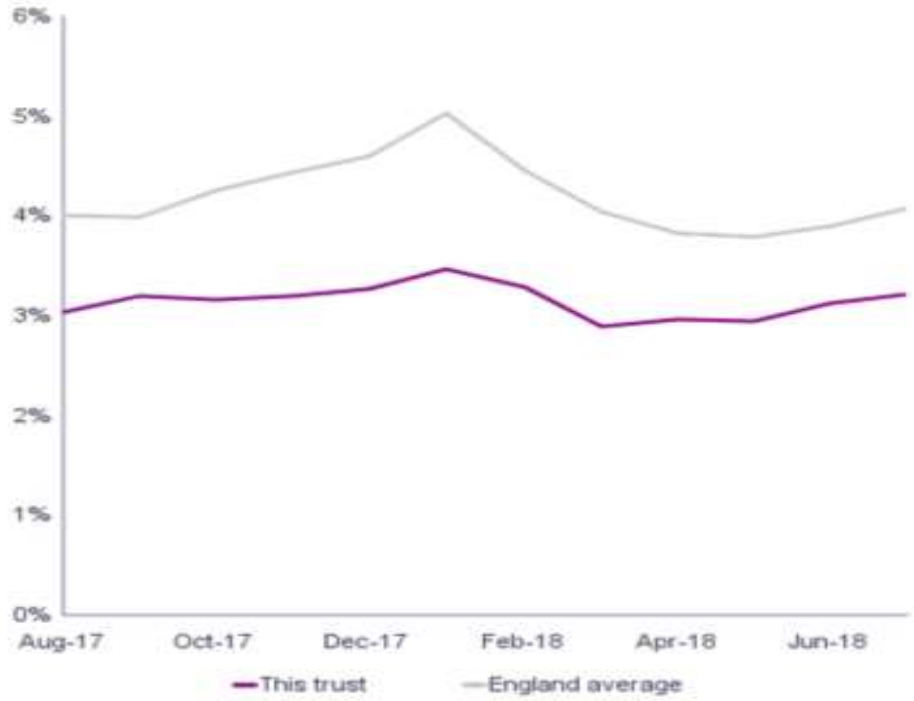
The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

From October 2017 to September 2018, the trust scored below the England average for recommending the trust as a place to receive care. In the latest period, September 2018, the trust scored 87.6%, compared to the England average of 95.5%.



(Source: Friends and Family Test)

From August 2017 to July 2018, the trust's sickness absence levels were lower than the England average.



(Source: NHS Digital)

In the 2018 General Medical Council Survey the trust performed the same as expected for all 13 indicators.

(Source: General Medical Council National Training Scheme Survey 2018)

There was clear evidence the trust's inability to deliver recurrent cost improvement over the course of the financial year, with reviews by two external consultancy firms referring to this as a significant issue.

The trust's financial reporting had been revised to provide a greater focus on the level of recurrent delivery and there was a clear articulation throughout our interviews of the need to prioritise a reduction in the controllable cost base. However, this did not yet appear to have changed behaviours. The target for recurrent cost improvement for 2018/19 was £40m, whereas the month eight forecast was £29.1m. This wass considered high risk given the time of year (quarter four). This had been a consistent issue in previous years, with an average of 46% of the target achieved recurrently between 2015/16 and 2018/19.

The lack of improvement in the underlying position indicates that a culture of financial grip in dealing with the underlying deficit was missing from the organisation. From our interviews with senior staff we found that they all acknowledged the need to reduce the underlying deficit but little effective planning or progress in the area.

There was a consistent view that there was a healthy working relationship between the executive team and the NEDs, and between group and site leadership.

Although progress had been made in developing PIDs for the strategic schemes, it was clear significant uncertainty remains regarding the likely quantum and timing of savings to be made. In addition, the schemes were underpinned by a potentially unaffordable capital plan. While we understood that improvements had been made to strengthen the business case process, in order to ensure a clear benefits case was shown, we found an inability to articulate the financial benefit to be gained from some of the trust's structural changes under the group model. The capital plan was heavily reliant on the sale of the trust's last remaining high value site, which was not a sustainable model on an ongoing basis. There was also some uncertainty about the timing of the disposal.

We met with the guardians of safe working hours. At Barnet hospital, junior doctors were able to attend a forum with the medical director to raise any issues they felt were relevant. Attendance at these forums with junior doctors was poor; it was possible this was due to a backlog of issues raised prior to the current guardians being placed in post. Junior doctors had reported their issues to the union due to lack of action of the previous guardian. A quarterly report was produced and sent to the local executive committee (LEC) and group executive committee (GEC). On occasions, they dialled into the executive board at Barnet hospital.

Junior doctors were more open and happy to speak with the guardian of safe working hours on a one to one basis. They felt comfortable raising issues individually. The guardian was able to act and represent those requesting assistance and, in many cases, able to resolve their concerns. The guardians introduced themselves at the junior doctors induction programme. Email addresses and contact details were also provided for ease to all trainees and junior doctors.

Confirmation was given that fines were issued where junior doctors and trainees had worked over their agreed number of hours. The guardians of safe working hours were unaware as to how the

money was released and what this was spent upon. Cost codes and processes were not clear, although they were able to state where some of the money from fines had been utilised. Junior doctors were made aware that it was their responsibility to ensure they claimed their time off in lieu (TOIL) for working over hours.

Culture amongst junior doctors and trainees with their teams was inconsistent and contradictory. At some sites, it was believed there was none or very little presence of bullying and harassment, with a good reporting culture; however, at other sites the opposite was reported.

The guardians encouraged a positive reporting culture via the electronic reporting system, to enable issues to be raised and resolved, and to protect the member of staff.

All staff were encouraged to log medicines errors via the online incident reporting system. All medicines related incidents were received by a Clinical Governance pharmacist and the Medical Director (who was also the Medication Safety Officer for the trust).

Learning from medicines incidents was shared across all sites using various mechanisms. For example, via medicines bulletins, medication safety meetings and the clinical pharmacist practice group.

Pharmacy staff received a formal annual appraisal. The appraisal rate was about 80% at the time of inspection. Staff had various mechanisms for receiving supervision and support depending on their role such as regular assessments and accompanied ward visits. This was integrated into their training programmes.

Where possible, pharmacy staff provided medicines information to patients while they were on the ward. On discharge, patients were given a medicines information number to call with any queries. Staff could access medicines information leaflets in different languages if needed. There was a trust translation service that staff accessed when needed.

Governance

There was an ongoing dialogue within the trust and with external stakeholders, such as NHSI, in relation to the need for a board sub-committee specifically focusing on financial performance. The trust's assertion was that finance was so important, given the trust's involvement in the Enhanced Oversight programme, that the finance deep dive should take place at the group board meeting.

There was a consistent view from all NEDs and executives we spoke with that this was the right arrangement for their trust and that finance formed a significant part of board debate.

Interviews with NEDs did demonstrate that financial sustainability was high on the board's agenda, with consideration given to the need to deliver recurrent savings in 2018/19 to support the trust's journey to financial sustainability. However, it would appear that debate at the board meeting was still at too high level, as reference was consistently made to 'a plan to break even' despite Board papers recently tabled showing a 2021/22 underlying deficit of £55m.

The NED chairs of the board sub-committees were clear regarding their roles and responsibilities and could articulate how they interacted with and reported to the board.

In July 2017, the trust established a group governance structure with site leadership teams and a Group Executive Committee (GEC). This structure continued to develop and evolve over the past 18 months with, for example, clinical governance arrangements for the sites being reframed to align to the group model in April 2018, and the setting up of a separate Group Clinical Services business unit in September 2018. There was still work to be done to embed group structures and to ensure responsibilities, roles and systems of accountability are clear.

Senior staff we spoke with made it clear to us that the recommendations made by the two external consultancy reports stating that there was a greater need for more focus on detailed financial review had been considered and that an action plan was being developed. The trust still had considerable work to do to ensure all of the recommendations are addressed. However, we understand the trust made improvements to the remit and attendees at change board and the bilateral performance meetings in particular, in order to increase the level of executive focus on the strategic schemes and on site level financial performance. Changes have also been made to the deployment model for the transformation team, to ensure there was coverage on all the strategic schemes and a clearer process to ensure use of these resources was prioritised. However, work remains to consider the role of the transformation team in relation to the CPGs, in particular regarding benefits realisation.

The trust provided their Board Assurance Framework, which details five strategic objectives within each and accompanying risks. A summary of these is below.

- Trust board – risks to the overall delivery of the group goals
- Clinical standards and innovation – failure to reduce unwarranted variation
- Group services – failure to achieve lower costs / higher quality position for clinical and non-clinical services
- People and population health – failure to develop leadership capability and improve value effectiveness of healthcare for our population
- Group executive – failure to deliver excellent operational and financial performance

(Source: Trust Board Assurance Framework – P106 File 1)

There was evidence of a structure for the oversight of risk registers, complaints, incidents, never events, clinical audit and learning. Group board to ward oversight was enabled by a governance structure in which each of the three (site) hospital boards held divisions to account at monthly divisional performance meetings, (quality performance finance). The three hospital boards were, in turn, held to account by the trust group board.

Clinical quality was overseen by the clinical standards and innovation committee (CSIC) a sub-committee of the group board. It was chaired by a non-executive director and met bi-monthly. Each of the hospital board medical directors provided a summary report at this committee meeting.

The non-executive directors (NEDs) were experienced professionals within their field of expertise. Some held multiple NED positions outside of the NHS. They utilised their experience within their professional businesses to work with the trust to implement financial improvement plans (FIPs) to better the trusts financial position.

There were three medical directors that chaired site based serious incident review panels (held weekly), clinical performance and patient safety committees (held monthly) and finance performance and compliance committee (held monthly).

Hospital directors of nursing chaired patient and staff experience committees. These meetings were supported by the quality and performance metrics /dashboards. Site medical directors also met regularly with their heads of governance. We noted that the governance and complaints support had been negatively impacted by the trust's move to a hospital based model; whilst the new governance structure became operational in May 2018 the trust acknowledged backlogs in incident management and delays in complaints handling. Temporary staff had been engaged to assist with reducing the backlog.

Each CEO of the three hospitals was held to account for their own finances. They reported to the group finance officer, who collated the data and reported to the board. Overall accountability for finance for the trust remained with the board level finance director for all three sites. The trust did not have a finance committee; they stated they made finance 'everyone's business', therefore all teams and management were accountable, rather than a single person or committee. This encouraged the teams to understand their financial position.

Each hospital within the group had a set of performance and financial targets, as well as financial improvement plans (FIPs). The management team at each site was responsible for delivering their FIPs independently, as well as collectively. The accountability for FIPs for each site sat with the individual site CEO.

There was evidence of challenge from the NEDs to the trust board on matters affecting the group (of the three hospitals). As the NEDs were from many backgrounds, challenge took place on many levels, with evidence their views were listened to. All NEDs received a trust induction; they were placed on a rota system that ensured they visited the hospital at least every four to six weeks.

NEDs were planned on 'go see visits'. These were walks and visits to areas of the hospital sites conducted on a pre- arranged date with a governor of the trust. Some NEDs were more proactive than others and made time to attend the trust earlier than the scheduled visit time, or attend also on a further date, in areas not identified for visit; for example, one of the NEDs arrived an hour early for their meeting to visit those staff based within the payroll department. In general, NEDs visited areas of the hospital that had undergone a transformation or building works, rather than randomly selecting a department or group of staff to meet with.

The audit committee (sub-committee of the group board) governed the internal audit programme which had reviewed complaints and serious incident reporting during 18/19. The audit committee was led by a NED with a finance background. They audited to provide assurance to the trust regarding the accuracy of the data provided. Audits for accident and emergency waiting times and referral to treatment times (RTT) were identified by the audit committee as falling below the expected standard for accuracy. The committee returned the results to the accountable managers and teams for repeat auditing to improve the adequacy of the data. The teams were instructed not to return to the committee with the inadequate data areas until the committee were satisfied of the quality of data produced and presented. At the time of the inspection, this was an ongoing process in the areas identified.

Quality impact assessments were undertaken as part of the financial improvement programme. Site medical and nurse directors signed off programmes as part of the approval process. Each clinical FIP the trust introduced had to pass an independent clinical reviewer process prior to any changes being made. The trust were aware of FIPs that had been put in place that affected patient care.

A patient safety pathway review (to support the implementation of LOCSSIPS) in three clinical areas was overdue; it was unclear who was being held to account. We saw a presentation on a spinal treatment pathway which had delivered good results and was embedded as practice within the emergency department.

Complaints, serious incidents and never event investigations were completed to a good standard, however they were frequently beyond required timeframes. There was a clear structure in place for reporting incidents and cascading their outcomes and learning. News letters, emails and team meetings were some of the communications utilised for sharing learning across the teams with in the hospital group as well as trust-wide.

The Board Assurance framework (BAF) was embedded in the group board sub-committee minutes, however actions and timescales were not specific, measurable, achievable, realistic and time scale appropriate. As observed at CSIC, there was no evidence of grip or traction to address this. This was the case in the majority of action plans we reviewed from serious incidents (SIs), never events, complaints, learning from deaths reviews and board assurance framework.

Action plans were closed with poor evidence of completion. Follow up was difficult to evidence as this was a cohesive approach to trust / system / site learning.

Clinical pathway groups were working across the trust to improve quality and efficiency supported by a quality assurance methodology, however evidence of impact was difficult to evaluate as outcome measures were not always clearly described.

Implementation of the electronic patient record (EPR) was stated as key to using data effectively. Some pathways had been digitised at Chase Farm Hospital (CFH) but a new server was required for the level of data and speed needed for the system.

Medicines optimisation was well embedded and was discussed at various trust wide committee meetings. The trust was a member of the North Central London Medicines Optimisation Network (NCLMON). Their aim was to 'promote the safe, effective and economical use of medicines within the NHS across North Central London'. The NCLMON consisted of the Joint Formulary Committee and the North Central London Medicines Optimisation Committee. The adoption of new guidelines was considered by the trust Drugs and Therapeutics Committee.

The group chief nurse was the controlled drugs accountable officer (CDAO). The chief pharmacist met regularly with the CDAO to discuss any concerns regarding the management of controlled drugs. Regular controlled drug (CD) occurrence reports were sent to NHS England.The chief pharmacist reported to various Medical Directors within the trust. There were monthly governance meetings to ensure that outsourced pharmacy services were meeting their key performance indicators. Complaints, medicines incidents and expenditure were also reviewed at these meetings.

There was a plan underway for the trust to phase out the use of external pharmacy contractors. Eventually the trust would use a wholly owned subsidiary to manage medicines supplies across all sites.

Pharmacy staff were involved in staff training during trust induction. They were also involved in the junior doctor assessments as well as patient education days. A lead nurse maintained oversight of PGDs within the trust and ensured that staff understood when and how to use them.

Safeguarding of adults and children was given sufficient priority by the trust. The safeguarding leaders worked across all trust sites, providing advice and oversight of safeguarding. They were supported by specialist staff on the acute sites. The team were proactive and introduced changes in line with national guidance.

Management of risk, issues and performance

There was a clear and consistent articulation from the NED and executive teams regarding the key risks facing the trust: patient flow, high number of never events and bullying and harassment. There was also consistency regarding the key financial risks being the ability to transact recurrent cost improvements and issues with commissioner affordability, as well as problems with retention of staff. However, there did not appear to be a finance risk register in place to monitor key issues and to ensure action plans are in place to address them.

There was a risk-based approach adopted in setting the annual internal audit plan with oversight provided by the audit committee. Reports were disseminated to site executive committees to ensure recommendations were implemented at an appropriate level.

The financial performance of the trust was concerning, having posted deficits for the last two financial years. The trust had a financial strategy that did not set out a return to break even over the following three financial years. The trust entered the enhanced oversight programme in May 2017 and was under increased scrutiny from NHS Improvement (NHSI). Although the NEDs and Executive team members that we spoke with could clearly articulate the purpose of the BAF in identifying and tracking key risks to the Trust, there did not to appear to be any reference to the underlying financial position in this document.

The BAF was subject to monthly board review and individual risks were assigned to each of the board sub-committees for more in-depth review. We expected to see indication that the BAF was a live document showing evidence of movement and the impact of remedial action. However, there were a large number of static risks on the BAF which had not been updated for some time and a lack of risk tracking in relation to the financial bottom line.

All management we spoke with were able to identify similar concerns within the trust. The management team were aware of the number of never events and serious incidents that had arisen over the previous 12 months. The learning from these incidents had reached each of the areas within the teams through communications. We were notified of an incident that had occurred just prior to the inspection that was not placed on the risk register. This was an incident involving the new generators at Chase Farm Hospital site. The incident occurred during a routine test of the generators. A human error occurred which meant the generators would not have started in the event of a power cut. This error had been identified during the testing process; the issue was rectified immediately, and ongoing action plans were put in place with safeguards to ensure the issue did not arise again. The safeguards were still in place at the time of our inspection, until such a time that specific processes were in place formally to prevent against further error. This incident was not placed on the risk register for ongoing monitoring or further learning. The generators, in general were on the risk register, and prior to the incident, however this had not been updated in light of the new incident.

Further concerns regarding electrical wiring were noted, and on the risk register as a general point, rather than listing specifics. An example was given where a small fire had broken out at the trust, relating to electrical wiring; however the fire incident had not been updated onto the risk register. This incident had occurred within two months prior to the inspection.

With the examples given and evidenced, we were not assured all risks were reported, monitored and updated at regular intervals. In turn we were unable to ascertain if the trust board had oversight of the risks within the trust at each of the group hospital sites if they were not recorded or updated on the risk register.

We saw minutes from the discussions presented at the BAF and noted the risk register was not an agenda item, nor was it discussed at the meeting. This was a concern that also confirmed the trust board had lack of oversight of the risks within the trust.

	Historical data		**Projections**	
Financial metrics	**Previous Financial Year (2016/17)**	**Last Financial Year (2017/18)**	**This Financial Year (2018/19)**	**Next Financial Year (2019/20)**

Income	£1.0bn	£1.0bn	£1.0bn	£1.0bn
Surplus (deficit)	(£44.2m)	(£2.1m)	(£65.8m)	(£48.5m)
Full Costs	£1.0bn	£1.0bn	£1.1bn	£1.1bn
Budget (or budget deficit)	£15.5m	(£11.2m)	(£65.8m)	(£48.5m)

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

The trust provided a document detailing their 14 highest profile corporate risks. Each of these have a current risk score of six or higher.

Date risk opened	Title	Description	Risk score (current)	Risk level (target)	Expected closure date
April 2011	Core network end of life	The core network equipment which operates the entire IT environment is now end of life and becomes unsupportable in September 2017. They are housed in risers on service floors across the Royal Free Hospital. These areas suffer from inadequate air conditioning and substandard access control, leaving the equipment at risk of failure and accidental/ deliberate damage from unauthorised access. Core network is also critical to the Chase Farm project and delivery of a digital hospital. The impact of these systems failing would leave the hospital with no IT or telephony services leading to clinical harm, reputational damage, adverse media, financial cost and penalty(s).	20	4	March 2018
July 2017	Cyber security - all issues - for TRR	This risk brings together all related issues inc: external cyber attacks, internal safety infrastructure and software patching as well as users' behaviour and information governance challenges that might expose trust's vulnerability. This risks replaces 1108 on the trust risk register (TRR). Please refer to the individual items for particulars.	20	10	January 2020

Februar y 2015	Inadequate patient flow, reducing hospital capacity	Inadequate patient flow through hospitals, resulting in delays for patient admissions either through ED or for elective procedures. This increases the waiting time in ED, and the referral to treatment (RTT) waiting time for some specialties.	20	12	May 2019
May 2017	IT Disaster Recovery: hardware, software & back up infrastructu re	This risk represents IT Disaster Recovery issues comprising of: 1448-IT Disaster recovery- Hardware Virtual server environment- Royal Free Hospital 1449-IT Disaster recovery- Hardware Virtual server environment- Barnet Hospital 1450-IT Disaster recovery- Software Virtual server environment- Barnet Hospital & Royal Free Hospital 1451- IT Disaster recovery - Back Up Capacity Virtual Server Royal Free Hospital 1452- IT Disaster recovery - Back Up Infrastructure Age – Royal Free Hospital (overarching aggregated risk)	20	4	August 2018
Septem ber 2016	Outdated telephony software - RF & CFH	The trust has over 7,000 telephone extensions across the Royal Free Hospital and Chase Farm Hospital sites including emergency services. The unified communications software that operates telephony is now two versions behind the latest standard and therefore no longer supportable by the manufacturer. Contractual SLA's no longer apply and trust can only rely on best endeavours support. In the event a software corruption, the only option to recover will require upgrade or rebuild of the system to the latest version. This could take up to 16 weeks and costs well over the £100,000 investment required to upgrade now. Corruption of telephony software will likely cause loss of critical data that cannot be recovered leading to clinical harm, reputational	20	6	December 2018

		damage, adverse media, financial cost and penalty(s).			
June 2015	Chase Farm Redevelopment, continuity of clinical service delivery in the environment of poor condition of buildings	Lack of continuity of clinical services during the construction programme could affect service delivery and patient experience. Lack of infrastructure and services to support the new development leading to unforeseen breakdowns and therefore loss of service.	16	4	September 2018
March 2015	Fire safety: non-compliant wards and satellite sites	There are fire safety non-compliant wards at the Royal Free Hospital relating to: main compartmentation at external walls, sub compartmentation, fire hazards, and fire detection. This could lead to issues with fire detection and fire spread. Satellite sites: At the present time the Trust have not visited all the sites to undertake the tenant's fire risk assessments. Under the Regulatory Reform (Fire Safety) Order 2005 the landlord has statutory obligations for fire therefore a fire risk assessment should have been undertaken and any identified risks mitigated.	16	8	March 2019
December 2014	High reliance on temporary/ agency staff	High reliance on temporary/agency nursing, midwifery, locum doctor and other staff. There is an increased difficulty in recruiting qualified staff caused by national shortages. This causes potential impacts on service delivery, quality and staff morale.	16	12	March 2019

March 2018	Concrete cladding falling from the Royal Free Hospital and causing damage	Some areas of the external cladding of the building have fallen in the past. This could lead to injury to persons and/or damage to property.	15	5	November 2020
September 2017	Retention of staff in medical electronics - effect on performance and ability to implement National CAS safety alerts	Of the eight technicians looking after Royal Free Hospital equipment and central alerting system (CAS) alerts three posts are vacant and we are waiting on a further formal resignation. Consequence is that KPI of planned preventative maintenance has fallen below 80%, the benchmark minimum. Failure to complete PPMs a) does not give assurance that equipment is working; b) leads to increased unplanned downtime due to existing failures. Failure to monitor, implement and provide assurance on CAS and safety alerts could create safety and reputational risk.	15	6	August 2018
August 2017	The patient safety programme ends in March 2018; patient safety improvements may be reduced	The patient safety programme (PSP) funding ended at the end of March 2018; however, the trust's aim to become a zero avoidable harm organisation continues on to 2020. It is proposed that a reduced number of key workstreams will continue via the development of a patient safety clinical practice guideline (CPG). This reduces the number of future patient safety priorities within the Quality Accounts. PSP staff have left and/or have changed roles, which has decreased the current quality improvement (QI) capability and capacity on which the quality strategy depends.	12	6	June 2018

October 2012	Use of medical devices by staff without appropriate training or competence	Staff may use medical equipment without completing the required training or being competent in its use. Because of the brevity of trust induction, staff will start on the wards before training assessments e.g. point of care testing (POCT) are undertaken. The trust does not have a unified system for recording training on medical equipment. Being competent in the use of medical equipment cut across professional standards, Medicines and Healthcare products Regulatory Agency (MHRA) guidance and H&S legislation.	12	6	September 2020
April 2015	Water quality, risk of legionella	There are dead legs in the water system which could lead to stagnated water increasing the risk of legionella bacteria and pseudomonas multiplying within the water system. There are also some challenges specific areas that need to be addressed, for example a cold water tank at Barnet (Reference: Alert EFA/2013/004). There is no authorising engineer (water) appointed. This means there is no independent advice/audit of the water system (Reference: HTM 04.01).	12	4	November 2018
May 2013	Dictate IT system discrepancies with unapproved letters	Following the introduction of the Dictate IT system 2, the trust can now clearly identify electronically unapproved letters. It is uncertain whether these letters have been sent to patients/GPs etc, as this process may have been completed outside the electronic system.	6	6	September 2018

(Source: Trust Corporate Risk Register – P106 File 3)

Key performance indicators linked to the medicines optimisation strategy were reported to the board and medicines related audits were regularly completed. The trust medication safety officer and the clinical governance pharmacist received all medicines related incidents. A serious incident panel was held monthly at every main trust site and a senior pharmacist attended each meeting.

Pharmacy staff were involved in the review of all never events as the trust adopted a multidisciplinary approach to their management.

Medicines related risks were recorded on a pharmacy risk register. Medicines risks were discussed at clinical meetings and the clinical governance pharmacist was involved in allocating a risk score. Risks were visible at trust board level.

Patient safety alerts were managed centrally. A team was responsible for ensuring that they were disseminated appropriately and checked that necessary actions were completed. Alerts from the Medicines and Healthcare Products Regulatory Agency were sent directly to staff within the pharmacy team.

An error occurred where a patient received an incorrect chemotherapy regime. The items should have been administered on different days, but were all given on the same day. Due to this incident, this process was reviewed. Staff now delivered chemotherapy to the ward only on the day that it was due.

We saw potentially dangerous substances (such as cleaning fluids) being left unattended in public places and on wards. We raised this concern with one of the executive directors who took immediate action to mitigate the risks. By the end of the inspection visit the trust had ordered new trolleys that had a lockable storage box and taken steps to ensure all staff were aware of the risk from substances which should be stored securely under the Control of Substances Hazardous to Health Regulations (2002). This demonstrated that the trust responded appropriately when new risks were identified.

Information management

The trust had a senior information and risk owner (SIRO) in place. Prior to joining the trust, the SIRO had undertaken training in this role at a previous trust. On joining The Royal Free, additional external courses relating to the role were completed.

The SIRO was not affiliated to any external networks, however there were good relationships with other SIROs from external courses and within other trusts that could offer help and advice if required.

There was a quarterly meeting where information and data was reported, which was chaired by the data protection officer. Prior to reaching the data governance group, the information provided was sent to the group executive committee and information governance group for review and approval.

The trust was well informed regarding information governance. They had experienced issues with a third party that had been well reported and known through the media and reported by the trust themselves. They used their experiences to gain learning to improve their information governance protocols. To this end, they have identified information asset owners across the trust and were able to evidence best practice through internal audits and (general data protection regulation) GDPR data review.

Quarterly meetings took place to review information governance. These were used to track learning from incidents from across the trust. The group categorised the incidents, reviewed any mitigation and impact on the services and patients and how the learning should be applied from each.

To assure the board that the level of risk surrounding information governance was to an accepted level, the information governance (IG) tool kit was used. This was a form of self- assessment used by the trust to monitor and review their IG. The trust also took part in annual internal and external audit and results were reported to the board.

All incidents throughout the trust were reported on an electronic reporting system. IG incidents were filtered and sent to the SIRO for review. There was evidence that the trust had overview of all IG breaches or incidents and were able to take necessary actions. This included reporting to the Information Commissioners Officer (ICO) as required by regulation. To improve their IG, the trust invested in an IT system that sent an alert when a file or patient information was open on the system. This was to alert the user, and to make sure details were not open or held for an unnecessary length of time that could be classed as a risk.

The trust were able to show learning from IG incidents. A diary with patient data on a mobile device was lost by a clinician. This was reported and learning taken from the event. The learning and actions taken from this situation lead to electronic tablet devices being implemented where possible, that encrypt patient information. Where implementation of these devises was not possible, green security carry bags had been introduced.

The trust also removed all the fax machines within the trust. They risk assessed the item and decided other forms of communication were safer and less open to human error and misdirection.

At the time of our inspection, the trust was still working towards compliance with the GDPR. There was an action plan in place to deal with outstanding items; the trust stated they were aiming to be fully complaint by the end of September 2019, with minor actions outstanding.

During December 2017, the trust formally launched its electronic patient records (EPR) system. The EPR went live across 25 of the trusts units and Chase Farm Hospital became paper free. This system was also utilised for diary and clinic management, and self-referral appointment bookings. This system also allowed for patient observations to be entered onto the system from the appropriate monitoring machine, and their national early warning score (NEWS) to be automatically calculated. Not all sites across the trust were on this system. Some of the sites were also only partially utilising the full EPR, while others were awaiting further add-ons to fully upgrade them to allow all observational statistics and results to be automatically uploaded and recorded.

At the Chase Farm site, whole teams from different departments would meet to identify risks and agree any mitigation required to be put in place. This included disaster recovery and alarm fatigue. The clinical risk management group worked to identify risks and mitigation prior to the EPR system being implemented. While this took place, the chief digital officer monitored clinical governance.

Feedback from clinicians and those that used the EPR system was varied. There was some pushback by some staff who preferred the paper records, however others welcomed the change. The consensus started to become more positive as the use of the system progressed, and was more accepted amongst clinicians as they could see the positive impact on their work and the service. Staff were also becoming involved and engaged with the new EPR system and its roll out and development.

Clinical staff were involved in developing electronic prescribing, as well as the tools for paediatrics and medical patient needs. They hoped involving staff (three consultants and three trainees), that they could develop the system to remove cumbersome or unwanted integrations, and include those found as helpful and useful to enhance patient care and treatment. The target was to include 60 care pathways on the electronic system.

The trust aimed to have the EPR system rolled out across all sites by early 2020, meaning all patients records could be accessed at any site due to the confidential sharing of patient data on the system.

The system had governance procedures and assurances in place. Security features were robust to protect data, however the trust was did experience unsuccessful cyber-attacks but no outages. External assurances were also in place as an added quality assurance measure.

Across North London, the clinical commissioning groups (CCGs), the trust and GPs were utilising the EPR system so that patient data could be accessed across the range of healthcare providers. This meant clinicians were able to see a patient's medical history and any treatment they were undergoing and create continuity of care for better outcomes.

The new group structure includes finance and performance committees at a site level (where divisional performance was reviewed by site leadership), bilateral performance reviews (where site performance was reviewed by the group executive) and a group board meeting (where overall group financial performance was reviewed). The board receives a report from the group services and Investment Committee and the Group Audit Committee each month, as well as a presentation of the previous month's financial and operational position from the group CFO.

The group board papers set out the previous month's financial position at a group and site level, but showed the underlying position only at a group level. There was no review of the medium-term financial position, limited commentary on the cost improvement programme and no rolled up reporting of the strategic, multi-year schemes. There did not appear to be a forum in which the NEDs could challenge site and divisional leadership teams on their underlying financial and operational performance. We received assurances from the board that a significant portion of time was spent discussing finance at the private board meetings but this was not reflected in the minutes.

We did not observe an increased focus on the trust's underlying performance by site, deeper dives into the key areas of cost improvement and detailed progress reports on delivery of the trust's strategic schemes. The trust prepared a detailed response to the two external consultancy reports but had yet to put many of the planned actions into effect.

There were ongoing challenges around RTT following the Barnet and Chase Farm hospitals acquisition in 2014 due to historical issues with the patient tracking list (PTL). The trust was rebuilding the PTL with external support and the programme was overseen by an RTT steering group. The group was chaired by the CFO and was attended by NHS Improvement.

The trust plans to implement an electronic prescribing and medicines administration (EPMA) system were ongoing. EPMA for chemotherapy was already embedded in the trust. Medicines incidents were recorded and their progress monitored using an online incident reporting system.

A pharmacy electronic dispensing system was used to obtain financial data, which allowed medicines expenditure to be monitored.

Trust staff attend meetings with other trusts around the country that have the same EPMA system and provide feedback. This facilitated continual improvement to the system as well as sharing of learning from other organisations. An EPMA implementation team in the trust ensured that issues were identified and resolved as soon as possible. Following patient consent, pharmacy staff and prescribers accessed patients' GP summary care records to complete medicines reconciliation.

Engagement

There were many good examples of how patients and service users were involved in the business of the organisation; this included patient user groups and how governors were engaged within the trust.

The trust's CPG approach to reducing variation and to redesigning pathways was innovative and appeared to have had a very high level of clinical buy in, in large part due to the involvement of a variety of clinical staff and patients with the programme. There was effective clinical engagement with regards to the implementation of Electronic Patient Record (EPR) at Chase Farm.

The trust was aware there was work to do in relation to issues with bullying and harassment, and also with diversity and equality. Staff provided positive feedback around the level of focus by senior management, which included the appointment of around 30 freedom to speak up guardians and the development of anti-bullying videos. However, many staff questioned the impact of these initiatives to date.

There were affordability issues with the trust's CCGs and therefore the level of challenge had been historically high. The trust had good relationships with its clinical partners and wider group members, but seemed to prioritise these above local relationships across the STP.

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives.

The trust had a large number of members that consisted of members of the public, patients, carers and staff. The trust held membership elections annually to elect and appoint governors from its members. The council of governors was in place to ensure that the voice of the public, patients and staff was used to inform the trust's decisions and improve medical care and patient experience.

The Royal Free council of governors acted as a source of ideas about how the trust could best provide its healthcare services in ways that met the needs of members and the wider local community. In addition, it ensured that the trust follows NHS values principles and the terms of its trust licence. The key roles included:

- Working with the board of directors to produce plans for the future development of the trust
- Representing members' views
- Receiving copies of the trust's annual accounts, auditor's reports and annual reports at a public meeting
- Agreeing the payment levels of non-executive directors (including the chairman)
- Appointment/removal of the chairman, non-executive directors and the trust's external auditor
- Approving the appointment of the chief executive
- Ensuring the board acts in accordance with the trust's identified aims and fulfils the requirements of NHS Improvement
- Acting in an advisory capacity to contribute to the strategic direction of the trust
- Adhering to the trust's code of conduct
- Attending meetings of the council of governors, occurring seven times a year
- Attending the annual general meeting and any other meetings identified by the council.

Governors attended the public board of directors meetings. The chair of the board of directors was also the chair of the council of governors. They were responsible for ensuring that the board and council work effectively together and that they receive the information they need to undertake their respective duties.

There were patient representatives on the council of governors. There were also local council members for each of the three main sites to ensure that local issues could be addressed and people from the different areas covered by the trust were engaged. Governors held “governors’ surgeries” where members and other patients could speak to governors and raise any issues or suggestions.

The trust held regular “Medicine for members” events open to patients, staff and the public. They were hosted by governors and offered the opportunity to hear about services offered at their local hospital. Past events included “Pathways to better health” in January 2019 at Barnet Hospital, featuring the work done by staff on the Starlight neonatal unit which cares for premature babies. Barnet Hospital had the only unit in the UK to have specialist rooms enabling parents and their babies to stay together 24 hours a day throughout the neonatal journey.

The trust had a patient experience strategy which was due to be reviewed in 2019. The key values were: address and refer to patients by the name they choose, not their disease; let patients and families know who you are and your role in the patient’s care; welcome and respect those defined by the patient as a “carer”; allow the patient and carer time to ask questions; your name badge: ensure patients can read it; and show patients and families the same respect you would expect from them. The strategy took into account “the provisions of the Equality Act 2010 and the general and specific duties, ensuring as far as possible that the trust eliminates discrimination, advances equality of opportunity and fosters good relationships”.

The patient experience committee was chaired by the CEO for the Royal Free Hospital and met every two months. It reported to the people and population health committee. Standard agenda items included complaints and compliments, the Friends and Family Test, quality, and compliance.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. For example, they published a monthly staff, members and governors’ magazine called “Freepress”.

Patients, carers, and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust relied on national initiatives such as the NHS Friends and Family Test (FFT) and PLACE and inpatient surveys for measuring patient experience. The trust monitored its FFT performance as part of the way it received feedback.

There was a quality improvement plan about to be rolled out regarding care plans for carers, which included their preferences on method of communication and how they wished to be addressed.

The trust had a structured and systematic approach to staff engagement.

In addition to the annual staff survey, the trust engaged with staff via:

- Staff Friends and Family Test (run quarterly)
- Exit interviews
- Ipsos Mori survey across the North Central London STP to better understand staff engagement factors and retention
- Local staff surveys in the following hospitals/teams: Chase Farm Hospital, liver, liver transplant, ICU, imaging, and maternity.

Various listening events had been held regularly focusing on specific issues such as anti-bullying and harassment week and events to hear about BME staff experience.

In June 2018, the trust held a ‘what matters to you day’ for all staff that’s asked via team meetings 3 key questions:

- What makes for a good day for you?
- What makes you proud to work here?
- When we are at our best, what does that look like?

Following on from feedback received from this day, there were numerous local improvement programmes underway being led by staff themselves.

The trust clinical practice groups (CPGs) were multidisciplinary and were clinically-led. Most were led by doctors but the trust said there would be more nurse-led CPGs in the near future.

The LGBT network had a high level of staff engagement and gave us examples of where members were engaged with changes in the trust. The trust's transgender policy was being drafted at the time of inspection and members were involved with that. The policy included transgender patients and staff. They had also engaged with HR about training for staff around communicating with and caring for transgender patients. This was as a result of staff feedback.

There was a large independent trust charity consisting of approximately 800 volunteers. The charity was highly engaged with the trust and had good working relationships with leaders. There were two members of the trust executive team on the charity's board. The volunteers were split across the three main sites plus Edgware neuro rehabilitation, Finchley Memorial Hospital, and Tottenham Hale Kidney Centre. The charity worked with the trust to ensure the volunteers were utilised to the benefit of patients and the hospitals, for example they had recently worked closely with discharge teams and put in place volunteers to assist patients leaving hospital. The volunteers were from diverse backgrounds including a range of ages and ethnicities, reflecting the patient population.

The charity chair and deputy commented that the senior leadership team were passionate about volunteers. They were personable, knew the leads and some of the volunteers and took time to speak to them. They were supportive of events such as the volunteer parties, and senior members of staff who came along to speak would often stay on for the rest of the party. There were localised events, with one at the Royal Free Hospital and one at Barnet Hospital. The volunteers were also involved in staff awards, and the trust gave out volunteer recognition awards as well.

External stakeholders we spoke with prior to the inspection said they had an open and transparent relationship with the trust. The trust was open to responding to issues that were raised with them. Comments from stakeholders were supportive.

The trust engaged with external partners including the STP subgroup for children, the STP for child and adolescent mental health services (CAMHS) group, and Healthy London Partnerships. For example, an operational and clinical representative attended the CAMHS group, and the trust had worked on a joint bid for a section 136 suite for children and young people in the region and on an out of hours model of nurse-led care.

Pharmacy staff views were sought both formally and informally through weekly staff meetings and comment boxes. The trust had a variety of positive collaborative relationships with external partners. For example, the North Central London (NCL) Joint Formulary Committee (JFC) ensured that local trusts were cohesive in their decisions regarding the entry of new drugs. Clinicians from various specialties were members of the JFC as well as representatives from primary care and mental health organisations. This ensured that sector wide implications for any decisions made were considered.

The chief pharmacist met regularly with other NCL chief pharmacists and networked with all London chief pharmacists. This allowed for the sharing of good practice. The trust led on the

development of local CPGs which involved local organisations. There was a plan to involve primary care in the future. The CPGs used digitised pathways to monitor adherence to specific pathways. For example, the management of a child presenting with wheezing. The CPGs all involved the specialist pharmacists relevant to the pathway.

Learning, continuous improvement and innovation

The trust had a strong reputation for research innovation and continued to build on this with its approach to CPGs, which were designed to systematically reduce unwarranted variation in clinical practice and generate efficiencies on a total pathway basis. In addition, there was a focus on achieving scale in back and middle offices to drive down costs within the group. This included the centralisation of corporate back office functions in Enfield civic centre and the development of a centralised decontamination unit.

The trust used digital technology to support the CPG approach and was awarded Global Digital Exemplar (GDE) status for Chase Farm. This programme included the successful implementation of Electronic Patient Record (EPR) within ambitious timescales to be in place for the opening of the new hospital in September 2018. The site pioneered the use of innovative technology such as self check-in kiosks and use of mobile devices to access patient information, which positively impacted the patient experience. The trust planned to roll out this approach to other sites within the group, which expected to generate significant savings.

There was a structured training programme in place within the finance function which included accreditation with the main accountancy bodies and the provision of internal training sessions for staff. The CFO and Deputy CEO were actively involved in both the HFMA and Future Focussed Finance and a number of other senior managers participated in leadership development training.

The trust had a strong focus on continuous learning and improvement at all levels of the organisation, including participation in research and the development of clinical and strategic partnerships. The trust had a proactive approach to seeking out and embedding new and more sustainable models of care and recognised the importance supporting partners in the wider health economy to deliver better outcomes for patients.

We saw numerous examples of where learning, continuous improvement and innovation were used to improve patient safety, drive efficiency and improve patient experience.

Working closely with its clinical partners, the trust was committed to delivering its strategic objective of reducing variation in clinical processes. A key factor in delivery of this strategic ambition was implementation of digital innovation. Having achieved global digital exemplar accreditation, the trust were in the process of rolling-out a new electronic patient record (EPR) system.

At the newly re-developed Chase Farm Hospital, the design of the new barn theatres, the introduction of the new EPR system and the new electronic nurse calling system were just some of the ways technology and new developments were being implemented to improve patient safety, drive efficiency and improve patient experience.

The trust-wide clinical pathway group (CPG) model aimed to standardise clinical pathways by using evidenced-based practice to remove unwarranted variation in patient care in order to deliver better outcomes for patients. The development and implementation of this standardised approach was being used to drive improvements in patient outcomes across a range of clinical services from neonatal care to teledermatology. For example, at Chase Farm Hospital, CPG pathways for pre-operative assessment and elective hip and knee procedures had been digitalised. This ensured effective multidisciplinary input as all staff had access to the relevant information. With 320

clinicians working on 44 CPGs, we were told that the new CPG model had “transformed clinical engagement.”

The CPG programme was embedded into the trust’s group operating framework for delivery of the clinical strategy. The core CPG team worked with CPG Chairs who were also divisional directors, to agree the priority CPG pathways for their CPGs based on a four quadrant analysis, as follows:

1. Clinical Outcomes and Patient Experience
2. Activity Levels
3. Trust wide performance on 4 hour target, waiting times, cancer targets
4. Cost

Once the group executive, hospital sites and divisional teams had agreed the CPG priorities the core CPG team worked with the CPG Chairs to mobilise the multi-professional pathway teams who facilitated and supported in developing the new pathway. During the redesign, opportunities for improvement and to reduce unwarranted variation were identified.

The trust’s stated goal for the CPG programme was to work across 60 percent of its total activity by the end of financial year 2021/2022. At the time of the inspection, the trust were working across 44 pathways which equates to 40 percent of their total activity.

The trust had developed a strategic partnership with The Institute for Healthcare Improvement (IHI), a leading global organisation for teaching quality improvement (QI) methodology in healthcare.

In 2017 the trust began a multi-year programme to build capacity in continuous quality improvement (QI) across the organisation, and had embed improvement into the daily work of staff and into the way they led and managed. Currently over 500 staff have been trained by a QI coaching team of 66 staff, supported by 219 team-based practitioners. In addition, the trust had 40 divisional and other leaders, including trust executives, who had been trained in supporting improvement initiatives as project sponsors. The trust currently has 95 active improvement projects registered on their improvement tracking system. Many of these projects were delivering sustainable results for patients and staff

Although the trust’s CPG model had been based on this methodology, the trust acknowledged there was still work to be done to formally embed the QI methodology into business as usual. For example, it was acknowledged that there was a need to provide protected time for staff in certain roles to undertake QI work which was not currently available.

The trust had a positive culture of sharing learning identified from patient safety incidents, complaints and deaths. There were numerous systems and processes in place to ensure learning was shared at all levels of the organisation. These included newsletters, bulletins and safety huddles. The trust was in the process of developing a new communication strategy to ensure staff and stakeholders received consistent and timely information relevant to their role.

However, there was limited evidence of thematic analysis across complaints, incidents and deaths to identify and mitigate emerging themes.

Incidents

The trust had a robust governance process for investigating and reviewing incidents. However, we were not assured that there was sufficient central oversight of action plans to prevent avoidable patient safety incidents from re-occurring. Governance structures were relatively new and still embedding. The trust recognised they had more work to do to gain assurance that changes introduced, in response to incidents, were sustained.

The pace of change in response to avoidable patient safety incidents had been slow. We were told this was partially due to resourcing and the impact of the recent restructuring of the governance system. This was reflected in the number of avoidable patient safety incidents that the trust had reported over the 12 months prior to our inspection.

The trust had recently carried out an internal audit of its serious incident (SI) processes which had provided an assurance rating of 'significant assurance with minor improvement opportunities'. Whilst the audit recognised the trust had a robust process for categorising, assessing and investigating SIs it also highlighted several areas for improvement. These included the timeliness of finalising investigation reports, with the majority of cases missing the 60-day target, and the lack of effective oversight of outstanding actions. The limited use of thematic analysis and inconsistency between the quality and content of investigation reports were also highlighted as areas for improvement.

Staff reported patient safety incidents via the trust-wide electronic reporting system. Potential serious incidents (SIs) were reviewed locally at serious incident review panels (SIRPs) held weekly at each hospital site. SIRPs were chaired by the hospital's medical director and attended by a panel of clinical and non-clinical governance staff. Local clinical performance and patient safety committees (CPPSCs) on each hospital site discussed SIs and never events and provided a summary report of key issues and risks to the trust-wide clinical standards and innovation committee (CSIC).

Investigation reports we reviewed for both SIs and never events were completed to a high standard. Root cause analyses and recommendations were clearly identified and there was evidence of appropriate levels of senior clinical input. Immediate actions to mitigate risk to patient safety were identified early in the process via a 72-hour review. Root causes, contributory factors and recommendations were used to develop detailed action plans. However, we found there was no effective central system to provide assurance that actions arising were appropriately completed. Evidence provided to demonstrate that actions were completed was not always robust and did not provide sufficient assurance that reoccurrence of the incident would be prevented.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between April 2018 and October 2018, the trust had reported nine never events. These included incidents of wrong site surgery and retained foreign object post-procedure.

From April 2018, a new governance structure had been introduced across the trust to align with the new organisational group structure. The new structure was based around each hospital site having a local governance team with responsibility for management of the SI investigation process. However, we found that there was a lack of central oversight of actions arising from incidents, leading to a lack of consistency. The trust's policy on incident reporting and learning had not yet been updated to reflect the changes in processes. The trust recognised this new way of working was yet to be fully embedded.

This was apparent in the trust's response to never events. Each hospital site had carried out individual risk assessment and developed an assurance plan with the aim of preventing further never events. Other than at Chase Farm Hospital, responsibility for completion of actions appeared to primarily sit with the governance team rather than within the clinical divisions.

The trust recognised that improved central oversight was required to monitor the completion of actions. Actions from all never events had very recently been combined into one central trust-wide action plan. Many actions had not yet been completed and progress appeared to have been slow.

Other than the establishment of a patient safety CPG, there was little evidence of other local safety standards for invasive procedures (LocSIPPS) having been developed.

We were told that the implementation of the patient safety CPG would prevent further never events. However, it was not clear why the areas for initial focus (endoscopy, radiology and cardiology) had been chosen.

The trust told us that there had been an increase in the number of 'near-miss' safety incidents reported by staff, demonstrating an improvement in understanding and awareness of the importance of incident reporting in facilitating shared learning across the trust.

Complaints

We reviewed a random sample of seven closed complaint cases and found that the trust's responses were all of a good quality, with evidence of multi-professional input.

However, we also found that responses were not always provided within the agreed timeframes. The trust's standard policy on complaints was that all complaints should have a written response within 35 days. Where this was not possible, we saw evidence of effective communication with the complainant to manage their expectations, negotiate and agree timeframes and keep them updated throughout the complaints process. Three of the seven complainants had received multiple extension letters which was not in line with the trust's policy and the trust acknowledged this was not best practice.

It was not always clear from the records why there had been a delay in responding to a complaint. Staff told us that since trust's governance processes had only recently been re-aligned with the group model, there had been some issues with resourcing the complaints team.

We were concerned that there was a lack of central oversight of actions arising from complaints and therefore opportunities to learn and improve were overlooked. We saw evidence that learning from complaints was shared locally and within divisions, however there was no joined up approach to following up on actions to ensure they were embedded and learning was shared across the trust. There was also no process to risk assess actions arising from complaints, or to cross-reference with SI analysis, to identify themes and key priorities for learning and improvement.

Deaths

The trust's mortality review process was well established and there were effective systems in place to identify and learn from unanticipated deaths.

The trust had implemented the recommendations of the national quality board's guidance on learning from deaths framework and had published an updated policy on how it responded to, and learned from patient deaths. Learning from deaths was shared via a quarterly report to the board as well as through other trust-wide publications such as the quality and safety bulletins.

Most deaths at the trust were reviewed for learning through existing processes which included the SI investigation process, coroner's inquests, and complaint investigations, amongst others. As a result of the national guidance the trust had extended its criteria for review of deaths and introduced the structured judgement reviews (a mortality tool developed by the Royal College of Physicians). The trust used structured judgement reviews (SJRs) to review a sample of all other deaths, not identified through other processes.

We reviewed a sample of SJRs which provided assurance that the trust was applying the methodology appropriately. Generally the SJRs we reviewed were of a good quality and completed to a high-standard however we did find some omissions in documentation of action plans. In two of the five cases, categorised as unavoidable, no actions to address areas for improvement were documented. We saw that all deaths which had been rated as 'Strong evidence

of avoidability' had already been identified and investigated via the trust's serious incident process which provided assurance that the SI identification process was working effectively.

Each hospital site held a monthly mortality review group where all cases reviewed where discussed and areas for improvement along with positive outcomes and areas of best practice were identified and recorded. A mortality report also went to the trust-wide clinical standards and innovation committee (CSIC), in addition to the trust board.

The trust acknowledged that they needed to move away from just reviewing categorising deaths and place more focus on identifying themes which could help improve patient experience. We saw this was discussed at CSIC and that there were plans in share learning around earlier identification of dying patients and approach to palliative care. Communication plans were under review at the time of our inspection.

Summary of Innovation/learning identified from core service reports

Surgery at CFH

We saw numerous examples of innovation within the surgical service at Chase Farm Hospital. The design of the new barn theatres, the introduction of the new EPR system and the new electronic nurse calling system were just some of the ways technology and new developments were being implemented to improve patient safety, drive efficiency and improve patient experience.

The trust-wide clinical pathway group (CPG) work aimed to standardise clinical pathways using evidenced based practice. With the introduction of the EPR system the CPG pathways for pre-operative assessment and elective hip and knee procedures had been digitalised at Chase Farm Hospital. This ensured effective multi-disciplinary team (MDT) input as all staff had access to the relevant information. The development and implementation of this standardised approach was being used to drive improvements in patient outcomes.

New initiatives introduced as a result of learning from patient safety incidents included 'stop at the shop' where staff completed an enhanced prosthesis check to prevent the wrong implant being used during a procedure. Simulation training provided staff with an opportunity to learn for patient safety incidents in a safe environment.

Critical Care at BGH

There had been improvement in mortality following the introduction of mortality and morbidity meetings and 'learning from deaths' methodology had been followed for the last two months. This alongside the discussions at governance meetings provided opportunities for learning and improvement.

The service made changes, developed protocols and provided additional training as needed in response to audit and incident investigations. The lead consultant told us the diabetic ketoacidosis protocol was recently changed to make it bespoke to critical care. The changes were made in consultation with endocrinology and pharmacy, and matron attended the consultant meeting to discuss.

The service was part of the local adult critical care network and attended meetings for sharing learning, for example from serious incidents. There was little direct shared learning across Barnet and Royal Free critical care services

The trust provided formal training in quality improvement (QI) methodologies, several staff told us they planned to attend.

Matron had won a trust quality improvement award for the project 'Reducing Nursing Turnover in ICU by Improving Joy in Work'. This was completed with the support of the Institute for health

Improvement, there was a clear action plan as a result and we saw actions had been taken. This resulted in greater staff satisfaction and higher retention rates.

A physiotherapy audit of compliance with CG83 NICE guidelines on rehabilitation of critical care patients was presented as a therapy services QI project It resulted in improvement particularly in the quality of information for patients and identified areas still needing to be addressed.

The end of life care lead nurses were working with end of life physiotherapist on an end of life quality improvement project

Staff were recipients of trust wide awards, an administrator received an unsung hero award for their work supporting staff rotas and fund raising. The equipment manager was nominated for an award for innovative work to improve value for money in the purchasing and use of equipment.

ED at RFH

Members of the leadership team told us how the environment in the new department improved patient experience and was a safer and more efficient working environment. There were plans in progress to develop a multi-disciplinary urgent treatment centre. We were told there was joint learning between primary and secondary care staff with regards to streaming within the hospital and redirection of patients to other points of care in the community.

The structured approach to improvement work in the department was carried out using the quality, innovation, productivity and prevention programme (QUIPP). The department recently won first prize in a local competition for their streaming work which was presented by the institute for healthcare improvement.

UCC at CFH

The service was involved in a quality improvement (QI) project for the retention of emergency nurse practitioner (ENP) with the aim to reduce agency usage by 50% in the next two years. The service had applied to NHS England for funds for training and developing nurses to band 8A advanced nurse practitioners.

Staff felt they had opportunities to develop their career and this was evident in the on-going development of ACP and emergency care practitioner (ECP) staff. A programme of training pharmacists and paramedics to be ECPs was currently underway within the department during inspection as part of the QI project.

The service had improved the medical staffing provision and had moved GPs from their previous agency into the hospital temporary staffing with arrangement of indemnity insurance in place covered by the hospital. This had helped improved medical cover and fill rate.

The service had a band 6 sepsis champions who would be leading on a sepsis QI project following committee approval as part of their leadership programme as the service. This QI project was necessary as the service did not take or carry out blood tests and to support staff if a patient was identified with sepsis and awaiting ambulance transfer.

The service had applied to be an education faculty and had accredited the minor injury and minor illness service.

The hospital had plans to set up a patient council in 2019 to improve patient engagement

Medicine at CFH

The endoscopy team received the outstanding staff celebration and rewards (OSCAR) award 2017/18 for being Chase Farm Hospital clinical team of the year.

A new digital patient check in system (In Touch) has been implemented which allowed patients to check in themselves when they arrived at the hospital and guided them to where they need to go to.

Most of the trust's plans from our last inspection had been implemented. These included completion of the new Chase Farm Hospital and a dementia and therapy garden on Cape town ward.

Surgery at RFH

Evidence provided by the trust and discussion with staff showed there was continuous learning, improvement and innovation amongst staff.

The service promoted learning and development, and research and innovation. Staff were positive about the support they received to challenge existing practice and try out new ideas.

We saw a number of examples of staff participating in international, national, regional and local research projects and recognised accreditation schemes in order to ensure patient care was evidence based.

The transport and specialist services (TASS) hosted the National Amyloidosis Centre and the Institute of Immunity and Transplantation, a centre dedicated to research and clinical care for immune related disorders.

Senior staff told us there were a number of development programmes for staff which supported continuous learning and development.

The surgical specialities run simulation training to support learning in for staff in the operating theatres and other clinical areas. There were audit days for all surgical specialities to support and develop learning, in addition to quality medical rounds and Schwartz rounds.

Schwartz rounds are a multidisciplinary forum in which healthcare staff within an organisation discusses the care of their patients.

The supra-regional assay service (SAS) and TASS participated in the Leading for Improvement: Programme Outline and Objectives, dated April 2018.

This programme included five workshop days that would take place every quarter over an 18 month period. The programme included areas such as:

- Improvement and high impact leadership fundamentals
- Measurement for improvement and building an effective learning system.
- Managing improvement
- Coaching for improvement, the psychology of change and joy in work.
- Moving from patient centred care to partnering with patients and the community

Maternity at RFH

The trust's maternity service was involved in a number of projects led by one of the matrons, a consultant midwife who was a clinical lead and care pathway co-ordinator. All staff participated in one way or another to achieve positive results and enhanced quality care and good outcomes for mothers and babies. The various projects resulted in good multiagency relationships and peer support, especially in the North and Central London areas.

There had been a number of innovative projects undertaken, such as the launch of the National Maternity Voices Partnership (MVP) group in 2016. RFH worked in partnership with service users,

in a holistic and inclusive manner to provide high quality safe maternity care to families residing in the local geographical area as part of the NHS England Better Birth Strategy.

The trust worked with the 'keeping mothers and babies together' initiative and developed a scheme for all staff to be able to quickly identify babies needing extra support. Vulnerable babies wore an orange hat that was knitted by volunteers for easy identification by staff This allowed for staff to take timely observations, blood sugar tests and give extra support to establish feeding so mothers and babies could stay together. The initiative proved successful and the trust has asked for additional volunteers for the project.

The Unity team for vulnerable women gave a 45 minutes presentation 'Partnership working for vulnerable women' at a Royal College of Midwives seminar on the integration of care pathways for women with complex psycho-social morbidity. This talk has been nominated for the RCM Slimming World Award for Partnership Working. The project involved working with a multi-professional team involving social workers for children and family support services.

The maternity service team at the Royal Free site had been nominated for the Royal College of Midwives Award for Outstanding Partnership Working and the presentation ceremony is on 6 March 2019.

ED at BGH

A matron recently wrote an article on the use of mindfulness for a professional journal. There was a clear focus on staff members' mental health and acknowledgement of the impact of stressful events on staff wellbeing. Staff were encouraged in the practice of mindfulness to reduce stress and build resilience.

The hospital introduced a 'care in a chair' initiative to decrease the time ambulances spent handing over patients to ED. This had resulted in an improvement in the numbers of patients being handed over in 15 minutes from 43.35% in March 2018 to 72.5% in November 2018.

ED staff held monthly multi-agency meetings with the psychiatric liaison team to discuss patients in the ED with mental health needs. These meetings were attended by the police, ambulance service and local authority approved mental health professional (AMHP) service.

Medicine at BGH

The trust recently introduced the 'perfect ward' which would enable matrons to monitor performance across the wards. This would enable wards to identify what they were doing well and where they needed to improve.

Patients were able to access the TREAT (triage and rapid elderly assessment) service via their GPs and refer patients to the to the frailty multidisciplinary team (MDT) in the community for ongoing care. The TREAT service also identified patients who required end of life care and were able to coordinate palliative care for patients in their homes if they did not want to go into hospital.

On the concourse on the third floor, a pop-up café with tables and chairs brought together patients from care of the elderly wards. Staff brought patients from wards, in their beds and wheel chairs as well as patients who could mobilise for a social afternoon with music, tea and cake which was run by hospital volunteers and staff. During inspection in the afternoon, we observed the café was supported by local school children who came to sing Christmas carols.

On one of the care of the elderly wards, a wardrobe had been set up for clothing for patients to wear to encourage patients to get out of their night wear during the day. This helped to improve patients' dignity especially when walking around the ward area.

Surgery at BGH

The department introduced a monitoring system that allows to carry out local audits and benchmark outcomes against other departments within the trust. It was a smartphone application for healthcare inspections which assisted nursing teams with monitoring the quality of care.

The hospital also introduced an electronic patient record system in November 2018 and was in the process of minimising use of paper record across the site. Staff gave positive feedback on using the new electronic record system. They were provided with training and adequate face to face onsite support to help with resolving any initial implementation problems.

Critical Care at RFH

The service ran simulation training for a variety of subjects which were valued by staff.

A Quality Improvement project on staff retention in ICU had been nominated for a Nursing Times award.

The service participated in relevant quality initiatives, such as research trials. Research was valued by the team as a way of improving patient care. Examples of research were HERALD-1: HEpatic Resection Analgesia and Length of time to Discharge which aimed to assess how best to achieve optimal pain relief for recovery after liver surgery and Timelord, a study of tissue metabolism and blood flow in critically ill patients exploring the ability of cells to take up and use oxygen to learn what determines survival in in critically ill patients. Such studies provided some evidence base for the unit's work.

Pharmacy

Pharmacy staff worked with primary care to provide clinical supervision to a pharmacist based in a GP practice. This post encouraged joint working. The trust took on 14 pre-registration pharmacists each year, and they received a structured training programme. This offered newly qualified pharmacists career development as well as post-graduate education. Pre-registration pharmacists were also given audits to do as part of their training.

All pharmacy staff within the trust were supported to undergo training and development.

Trust staff developed an application containing information on antimicrobial guidelines which gave staff access to information on their phones. The antimicrobial policy was shared with the Royal National Orthopaedic hospital. In addition, an application was developed that identified patients with acute kidney injury (AKI). The application analysed patient data on clinical markers and sent out alerts to clinicians of patients requiring attention.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	To respond within 35 working days	Royal Free Hospital – 88% Barnet & Chase Hospitals – 78% Trust – 84%
What is your target for completing a complaint	To respond at the first time of asking (be that via phone call, letter or meeting) and to have 6% or less of complaints re-opened.	Royal Free = 5% (30 of 641 cases have been re-opened YTD) Barnet & Chase = 4% (19 of 486 cases have been re-opened YTD) Trust = 4% (49 of 1,127 cases have been re-opened YTD)

If you have a slightly longer target for complex complaints please indicate what that is here	The deadline remains to respond within 35 working days or an otherwise agreed timeframe (extension if felt necessary).	N/A
Number of complaints resolved without formal process in the last 12 months (September 2017 – August 2018)?	N/A	6,724 (September 2017 – August 2018)

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

The trust received 1,605 complaints from September 2017 to August 2018, taking an average of 30.6 working days to resolve them; 665 of these complaints (41.4%) were about all apsects of clinical treatment and 212 complaints (13.2%) were about attitude of staff.

The medical care core service received the most complaints with 399 (24.9%); with a prevalent theme of clinical treatment with 183 complaints (45.9%), followed by appointments, delay/cancellation (out-patient) with 65 complaints (16.3%). Surgery core service had the second highest number of complaints with 383 (23.9%), of which 217 (56.7%) were about clinical treatment.

The table below shows a breakdown of complaints by core service:

Core service	**Total number of complaints**	**Proportion of complaints**
Medical care (including older people's care)	399	24.9%
Surgery	383	23.9%
Other/ not stated	334	20.8%
Urgent and emergency services	163	10.2%
Maternity	98	6.1%
Outpatients	77	4.8%
Services for children and young people	55	3.4%
Gynaecology	50	3.1%
Diagnostics	33	2.1%
Critical care	7	0.4%
CHS - Children, young people and families	6	0.4%
Total	**1,605**	**100%**

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

From September 2017 to August 2018, the trust received 954 compliments.

A breakdown of compliments by core service is in the table below:

Core service	Total number of compliments	Proportion of compliments
Medical care (including older people's care)	228	23.9%
Provider wide	219	23.0%
Surgery	148	15.5%
Outpatients	103	10.8%
Urgent and emergency services	101	10.6%
Diagnostics	84	8.8%
Maternity	29	3.0%
Services for children and young people	13	1.4%
Critical care	10	1.1%
Gynaecology	10	1.1%
End of life care	9	0.9%
Total	**954**	**100%**

The medical care core service had the highest number of compliments with 228 (23.9%), followed by provider wide with 217 (23.0%) of the total compliments.

A breakdown of compliments by location/site is in the table below:

Location/site	Number of compliments	Proportion of compliments
Royal Free Hospital	434	45.5%
Barnet Hospital	414	43.4%
Chase Farm Hospital	76	8.0%
Mary Rankin	9	0.9%
Edgware Hospital	7	0.7%
Not RFL Service (external/other trust incident)	5	0.5%
Enfield Civic Centre	2	0.2%
Hadley Wood Hospital	2	0.2%
Potters Bar Hospital	2	0.2%
Finchley Memorial	1	0.1%
Mount Vernon	1	0.1%
Other Royal Free London site	1	0.1%
Total	**954**	**100%**

Royal Free Hospital had the highest number of compliments with 434 (45.5%), followed by Barnet Hospital with 414 (43.4%).

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

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	Service accredited
Joint Advisory Group on Endoscopy (JAG)	Endoscopy unit – Chase Farm Hospital
Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189	ISO 15189 Accredited: HSL Haemophilia Laboratory Royal Free - January 2018 Anthony Nolan Lab Royal Free – July 2018 CPA: Accredited: HSL (Analytics) LLP /Royal Free London 1060 Department of Cellular Pathology 1061 Department of Medical Microbiology 1062 Department of Virology 1065 Department of Immunology 268 Department of Clinical Biochemistry 1066 Department of Haematology & Blood Transfusion Royal Free London NHS FT 1761 Department of Microbiology
CHKS Accreditation for radiotherapy and oncology services	The Royal Free, Radiotherapy Department ISO 9001:2000
MacMillan Quality Environment Award (MQEM)	Royal Free Hampstead (Macmillan Cancer Information and Support Centre) Date: renewed March 2017 (3 yearly review)
Psychiatric Liaison Accreditation Network (PLAN)	Liaison Psychiatry Team Royal Free, London (Provided by Camden and Islington NHS Foundation Trust) Accredited to December 2020
Operational delivery networks for hepatitis C Care in adults	NHS England Peer Review
'Quality in Primary Immunodeficiency Services (QPIDS)	Royal Free Clinical Immunology (accredited under the UKPIN accreditation scheme)
National Peer Review: Trauma Units	Royal Free Hospital Trauma Unit: September 2017 (yearly peer review)

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

Barnet Hospital

Wellhouse Lane
Barnet, Hertfordshire
EN5 3DJ

Tel: **020 8216 4600**

www.royalfree.nhs.uk/barnet-hospital/

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

Urgent and emergency care

Facts and data about this service

Details of emergency departments (A&E) and other urgent and emergency care services

- Royal Free Hospital emergency department
- Barnet Hospital emergency department
- Chase Farm urgent care centre

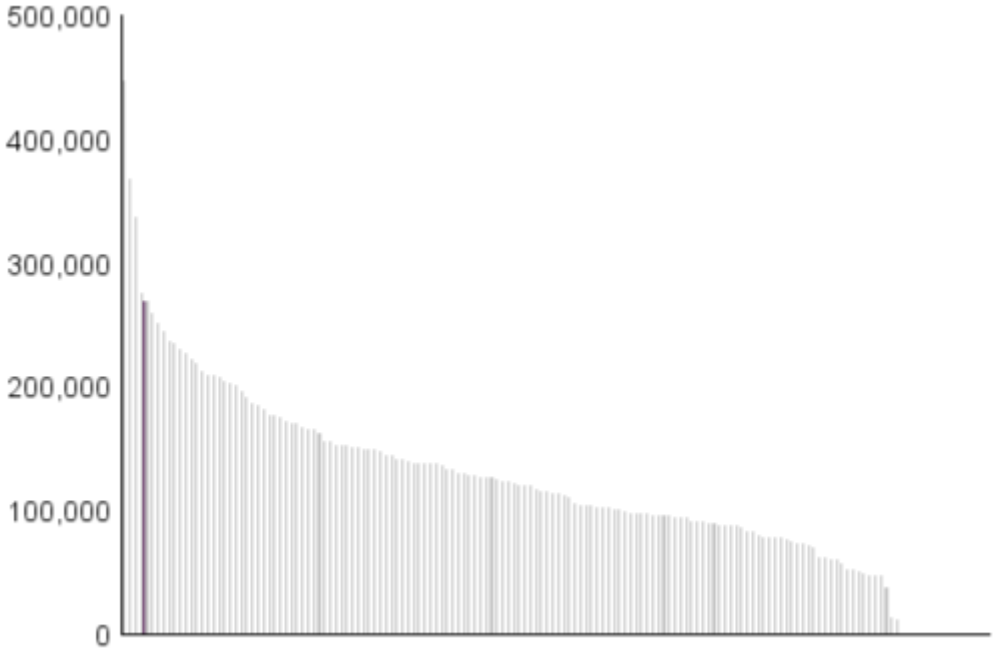
(Source: Routine Provider Information Request (RPIR) – Sites tab)

The Trust has two emergency departments (also known as A&E and the ED), one at Barnet Hospital and another at the Royal Free Hospital. Barnet A&E is a type 1 consultant led department and trauma unit. The urgent care centre at Chase Farm Hospital is open 8am to 10pm every day, staffed by GPs and emergency nurse practitioners. This report covers the A&E at Barnet Hospital.

(Source: Routine Provider Information Request (RPIR) – Acute context)

Activity and patient throughput

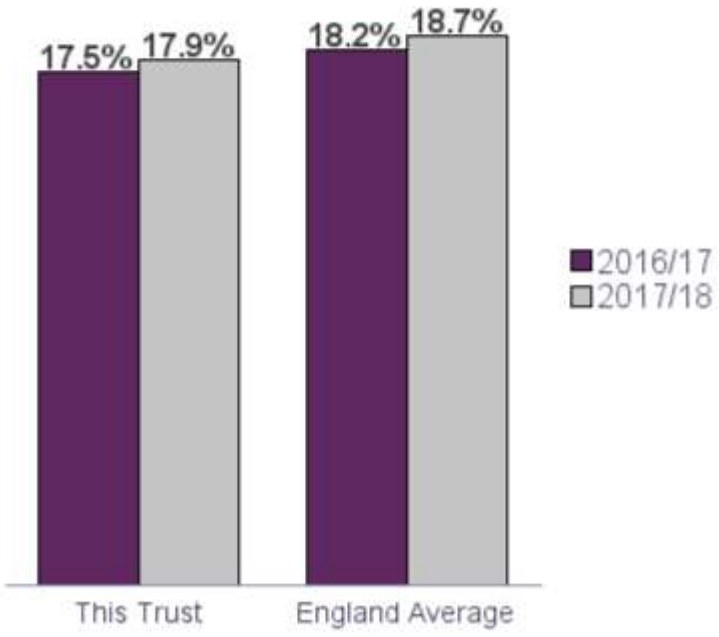
Total number of urgent and emergency care attendances at Royal Free London NHS Foundation Trust compared to all acute Trusts in England, July 2017 to June 2018



From July 2017 to June 2018 there were 267,920 attendances at the Trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

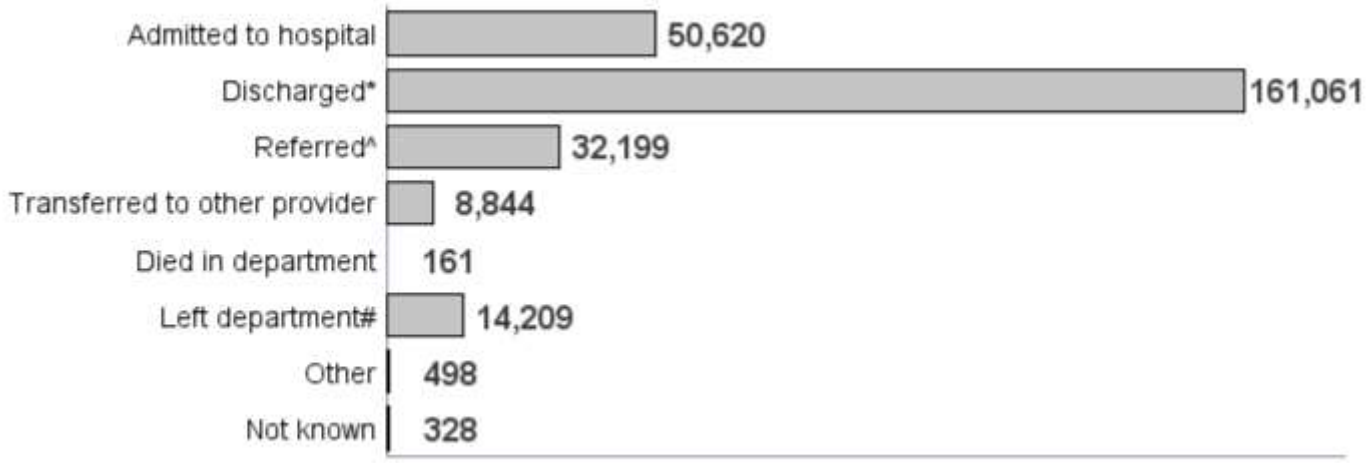
Urgent and emergency care attendances resulting in an admission



The percentage of A&E attendances at this Trust that resulted in an admission remained similar in the most recent year compared to previous year. In both years, the proportions were lower than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from July 2017 to June 2018



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

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The Emergency Department (A&E) provided mandatory training in key skills to all staff. However, we found all staff did not complete this in a timely way.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	178	181	98.3%	85%	Yes
Resuscitation L1	175	181	96.7%	85%	Yes
Infection Control L1	169	181	93.4%	85%	Yes
Basic Radiation Safety	159	181	87.8%	85%	Yes
Health & Safety Awareness	157	181	86.7%	85%	Yes
Emergency Planning	156	181	86.2%	85%	Yes
Fraud & Security	155	181	85.6%	85%	Yes
WRAP	144	170	84.7%	85%	No
Waste Management	149	181	82.3%	85%	No
Equality, Diversity & Human Rights	144	181	79.6%	85%	No
Moving and Handling	141	181	77.9%	85%	No
Information Governance	137	181	75.7%	85%	No
Conflict Resolution	123	181	68.0%	85%	No
Fire Safety	122	181	67.4%	85%	No

Infection Control L2	120	181	66.3%	85%	No
Resuscitation L2	118	181	65.2%	85%	No
Blood Transfusion	110	181	60.8%	85%	No
RTT L1	63	181	34.8%	85%	No

At trust level in urgent and emergency care the 85% target was met for seven of the 18 mandatory training modules for which qualified nursing staff were eligible. The overall mandatory training rate at Trust level was 70%.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 at trust level for medical staff in urgent and emergency care is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Resuscitation L1	116	166	69.9%	85%	No
BPAT	114	166	68.7%	85%	No
Infection Control L1	103	166	62.0%	85%	No
Health & Safety Awareness	102	166	61.4%	85%	No
WRAP	28	46	60.9%	85%	No
Fire Safety	100	166	60.2%	85%	No
Basic Radiation Safety	98	166	59.0%	85%	No
Fraud & Security	94	166	56.6%	85%	No
Equality, Diversity & Human Rights	93	166	56.0%	85%	No
Emergency Planning	92	166	55.4%	85%	No
Moving and Handling	86	166	51.8%	85%	No
Waste Management	84	166	50.6%	85%	No
Blood Transfusion	78	166	47.0%	85%	No
Resuscitation L2	78	166	47.0%	85%	No
Information Governance	75	166	45.2%	85%	No
Conflict Resolution	74	166	44.6%	85%	No
Infection Control L2	69	166	41.6%	85%	No
RTT L1	68	166	41.0%	85%	No

At Trust level in urgent and emergency care the 85% target was not met for any of the 18 mandatory training modules for which medical staff were eligible. The overall rate for medical staff mandatory training was 55%.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the urgent and emergency care department at Barnet Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	87	87	100%	85%	Yes
Resuscitation L1	86	87	98.9%	85%	Yes
Infection Control L1	85	87	97.7%	85%	Yes
Basic Radiation Safety	80	87	92.0%	85%	Yes
Health & Safety Awareness	80	87	92.0%	85%	Yes

Fraud & Security	79	87	90.8%	85%	Yes
WRAP	78	87	89.7%	85%	Yes
Emergency Planning	76	87	87.4%	85%	Yes
Waste Management	74	87	85.1%	85%	Yes
Equality, Diversity & Human Rights	74	87	85.1%	85%	Yes
Moving and Handling	74	87	85.1%	85%	Yes
RTT L1	36	43	83.7%	85%	No
Information Governance	68	87	78.2%	85%	No
Resuscitation L2	67	87	77.0%	85%	No
Fire Safety	64	87	73.6%	85%	No
Infection Control L2	64	87	73.6%	85%	No
Blood Transfusion	58	87	66.7%	85%	No
Conflict Resolution	56	87	64.4%	85%	No

At Barnet Hospital urgent and emergency care department the 85% target was met for 11 of the 18 mandatory training modules for which qualified nursing staff were eligible. The overall mandatory training rate for nursing staff at Barnet Hospital was 80%. This was better than the Trust's average rate of 70%.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the urgent and emergency care department at Barnet Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Resuscitation L1	91	129	70.5%	85%	No
BPAT	89	129	69.0%	85%	No
Health & Safety Awareness	81	129	62.8%	85%	No
Infection Control L1	78	129	60.5%	85%	No
WRAP	15	25	60.0%	85%	No
Basic Radiation Safety	75	129	58.1%	85%	No
Equality, Diversity & Human Rights	75	129	58.1%	85%	No
Fire Safety	73	129	56.6%	85%	No
Fraud & Security	72	129	55.8%	85%	No
Emergency Planning	70	129	54.3%	85%	No
Moving and Handling	69	129	53.5%	85%	No
Waste Management	63	129	48.8%	85%	No
Blood Transfusion	60	129	46.5%	85%	No
Resuscitation L2	57	129	44.2%	85%	No
Conflict Resolution	56	129	43.4%	85%	No
Information Governance	56	129	43.4%	85%	No
Infection Control L2	54	129	41.9%	85%	No
RTT L1	52	129	40.3%	85%	No

At Barnet Hospital urgent and emergency care department the 85% target was not met for any of the 18 mandatory training modules for which medical staff were eligible. The overall mandatory training rate for medical staff at Barnet Hospital was 55%. This was slightly worse than the Trust's average rate of 59%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We reviewed the A&E training spreadsheet dated December 2018. We found medical staff were still not meeting the Trust's 85% target for any mandatory training modules.

Staff told us there were issues with the hospital's e-learning mandatory training record, as it did not always update staff records with mandatory training they had completed. In response practice educators had asked staff to screen shot confirmations that training had been completed and send it to the e-learning team to update their staff records.

The practice learning team told us the mandatory training spreadsheet did not give a full picture of staff learning. This was due to a number of staff on maternity leave being included in the overall training figures. Staff told us staff on maternity leave would have to update mandatory training on their return to work prior to taking up their duties.

The Trust set a target of 85% for completion of mandatory training. We reviewed the A&E mandatory training spreadsheet dated December 2018. We found nursing staff were meeting or exceeding the Trust's 85% target for most mandatory training modules with the exception of: blood transfusion (73%); conflict resolution (77%); fire safety (65%); infection control level two (72%); information governance (76%); resuscitation level two (73%).

Staff told us there were issues booking urgent and emergency care (A&E) staff onto advanced life support (ALS) training. This was due to the Trust offering Barnet Hospital A&E staff seven places on the course a year. Staff said this was insufficient to cover all staff that needed to update ALS training every four years.

Practice educators told us there was an incentive for staff to complete mandatory training, as gaining access to non-mandatory training was dependent upon completion of mandatory training. Staff could access mandatory training whilst on shift or could complete mandatory training at home. Staff were paid an hourly rate for completing mandatory training off-site.

Mental health awareness training was not mandatory. However, the practice education team told us this was covered during junior doctors' inductions. Staff also told us there were regular mental health awareness training days for nurses and security officers

Safeguarding

We found staff completion rates for some safeguarding training modules were not meeting the Trust's 85% target.

The Trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018 for qualified nursing staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	179	181	98.9%	85%	Yes

Safeguarding Children L2	179	181	98.9%	85%	Yes
Safeguarding Adults L1	155	181	85.6%	85%	Yes
Safeguarding Adults L2	150	181	82.9%	85%	No
Safeguarding Children L3	123	181	68.0%	85%	No

Trust wide, the urgent and emergency care department 85% target was met for three of the five safeguarding training modules for which nursing staff were eligible. In December 2018 we found compliance rates for safeguarding adults level 2 had improved at 91% and compliance with safeguarding children level 3 had declined at 52%. However, all staff we spoke with were aware of reporting processes.

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018 for medical/dental staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L3	31	49	63.3%	85%	No
Safeguarding Children L1	103	166	62.0%	85%	No
Safeguarding Children L2	98	166	59.0%	85%	No
Safeguarding Adults L1	94	166	56.6%	85%	No
Safeguarding Adults L2	90	166	54.2%	85%	No

Trust wide, the Trust's 85% target was not met for any of the five safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018 for qualified nursing staff in urgent and emergency care (A&E) is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	87	87	100%	85%	Yes
Safeguarding Children L2	87	87	100%	85%	Yes
Safeguarding Adults L1	82	87	94.3%	85%	Yes
Safeguarding Adults L2	82	87	94.3%	85%	Yes
Safeguarding Children L3	57	87	65.5%	85%	No

At Barnet Hospital urgent and emergency care department the 85% target was met for four of the five safeguarding training modules for which nursing staff were eligible.

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018 for medical/dental staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	21	37	56.8%	85%	No

Safeguarding Children L3	13	24	54.2%	85%	No
Safeguarding Children L2	20	37	54.1%	85%	No
Safeguarding Adults L1	17	37	45.9%	85%	No
Safeguarding Adults L2	17	37	45.9%	85%	No

At Barnet Hospital urgent and emergency care department the 85% target was not met for any of the five safeguarding training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

In December 2018 we found rates at Barnet Hospital had improved slightly but were still not meeting the Trust's 85% target. For example, level 3 children's safeguarding training completion rate was 65%, level 2 and level 1 were both 70%. This meant that some medical staff were still not achieving the Trusts 85% compliance rate for safeguarding training.

The urgent and emergency care (A&E) department had systems to safeguard adult patients identified as at risk of abuse. Safeguarding policies and procedures were available to staff on the Trust's intranet and reflected best practice guidance.

The chief nurse was the designated executive lead for safeguarding. The Trust employed a team of nurses to support staff with safeguarding issues upon request. Safeguarding specialist nurses were available 24 hours a day, seven days a week.

The staff we talked with were able to tell us about how they recognised actual or potential abuse and staff knew how to report abuse. This included the identification and reporting of patients subjected to female genital mutilation (FGM), child sexual exploitation (CSE) and modern slavery. This meant staff had the knowledge necessary to safeguard adults and children in vulnerable circumstances.

The hospital followed pan-London child protection procedures and worked closely with multidisciplinary colleagues. The hospital's safeguarding team participated in local safeguarding children boards.

The Trust's electronic patient record (EPR) had a flagging system for children subject to child protection plan. This meant staff would be aware if a vulnerable child or young person visited the A&E.

The safeguarding team produced written updates for all hospital staff on safeguarding procedures and safeguarding issues.

The Trust had a policy on restraint, which was under review at the time of the inspection. During the inspection it appeared a patient in Barnet Hospital A&E had been restrained for intramuscular medicine to be administered. There was no record the patient had received physical observations at the frequency required following rapid tranquilisation. The exact circumstances of the event were unknown due to poor record keeping. It appeared that this practice did not follow best practice guidance, 'Violence and aggression: short-term management in mental health, health and community settings', National Institute for Health and Care Excellence (NICE), 2015.

Cleanliness, infection control and hygiene

The A&E controlled infection risks well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The hospital had up to date infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice. For example, communicable diseases and isolation.

During this inspection we observed all areas of the urgent and emergency care (A&E) to be visibly clean. We checked the A&E for high and low level dust and found all areas to be dust free. There were procedures in place for patients requiring isolation, including laminated isolation signage.

Staff followed IPC guidelines for routine disinfection. This included the cleaning of medical devices between each patient. We saw staff cleaning equipment following each use. We checked three commodes and saw disinfection of the equipment had taken place. Equipment that was clean and ready for use was labelled with 'I am clean' high visibility stickers. However, when we asked housekeeping staff for the A&E cleaning schedule for patient equipment they were unable to locate it.

Both the main A&E and paediatric sluice rooms were suitably maintained. We saw that national colour coded cleaning equipment was in use. We also saw staff completing a deep clean in the A&E 'resus' area.

IPC training was part of the hospital's corporate induction. Staff received annual refresher training. For example, from April to August 2018 the compliance rate with IPC training was 97.7%.

Staff were bare below the elbow and had access to a supply of personal protective equipment (PPE), including gloves and aprons. We saw staff using PPE appropriately.

All the patients we spoke with were positive about the cleanliness of the A&E and the actions of the staff with regards to IPC. All the staff we observed demonstrated compliance with good hand hygiene technique in washing their hands and using hand gel when appropriate. Staff had access to hand washing facilities. Throughout the inspection we found all staff were compliant with best practice regarding hand hygiene.

Hand hygiene audits were completed to measure staff compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients. Results for the reporting period January 2018 to December 2018 showed a compliance rate of between 98% and 100% in all months in the period.

Housekeeping staff attended monthly IPC meetings and communicated messages from the meetings to staff via email and nursing handover meetings.

A private contractor provided cleaning services at the hospital. IPC audits were completed weekly by the private provider of cleaning services. Results for the 12 months preceding this inspection demonstrated that the A&E regularly achieved between 95% and 99% compliance. Results of audits were displayed in the housekeeping room with improvement action plans.

Waste was handled and disposed of in a way that kept people safe. Waste was labelled appropriately and staff followed correct procedures to handle and sort different types of waste.

Environment and equipment

The ED had suitable premises and equipment and looked after them well.

Staff told us equipment was usually available when required. However, staff said issues with patient flow through the A&E meant there was a need for more beds in A&E.

The layout of the A&E was compatible with health and building notification (HBN15-01) guidance. Access was via A&E main entrance. There was a separate ambulance handover reception. Treatment areas were accessible by key fob from both the A&E main reception and ambulance handover reception. There was a patients waiting area in the main A&E reception which was visible to staff working at the main A&E reception. There was also a triage area in the main A&E reception which was screened.

The main A&E reception area provided toilet facilities for patients and visitors. We found toilet facilities for patients were clean and well maintained. The paediatric A&E waiting area was accessible via a key fob door from the A&E main reception. This also provided drinking water and toilet facilities for children and visitors.

There was a system of staff medical device passports to ensure staff knew how to operate equipment. The passports were signed off by a senior member of the team when staff were assessed as competent in the use of specific pieces of equipment. For example, staff told us about a team away day where all staff had received training on new continuous positive airway pressure (CPAP) machines and a high flow respiratory system. These are ventilator systems to keep airways continuously open in patients who are not able to breathe spontaneously on their own.

Resuscitation equipment was readily available All resuscitation trollies were sealed with a tag. Records we viewed confirmed staff had checked resuscitation equipment in accordance with the Trust's safety checks policy.

Failures in equipment and medical devices were reported to the Trust's estates team. Equipment breakdown was logged on the hospital's incidents log to enable managers in monitoring the reliability of equipment.

There were systems in place to ensure repairs to machines or equipment were timely. These ensured patients would not experience prolonged delays to their care and treatment due to equipment being broken and out of use. Housekeeping staff followed up any equipment that had gone for servicing or repair to ensure its prompt return. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme by the hospital's estates department. Housekeeping staff had been trained to monitor servicing dates on equipment.

During our inspection we checked the service dates on some items of equipment, including three infusion pumps, two defibrillators, two suction units, and two blood pressure monitors. All the equipment we checked was clean and within the service date. We also checked six sharps bins and found these were correctly assembled, labelled and not over filled.

All equipment conformed to relevant safety standards and was regularly serviced. All non-medical electrical equipment was safety tested as part of regular servicing schedules by the hospital's estates team.

Resuscitation equipment was readily available and staff sealed all crash trolleys with a tag.

Trolleys were checked at regular intervals and trolley checks recorded in accordance with the

Trust's policy.

The A&E had a specific room in majors for mental health assessments. The room had two outward-opening doors, a window and wall alarms. However, a hospital review of the environment identified some ligature risks in the room which required removal. Plans were in place to remove the ligature points. Patients requiring a mental health assessment were accommodated in one of three bays in majors. This ensured nursing staff could observe them closely, and reduced any potential risks patients could present to themselves or others.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Since our last inspection, Barnet Hospital had introduced a new electronic patient record (EPR). These included various risk assessments that were needed to manage individual needs. Examples included, safeguarding management tool, vital signs, national early warning score (NEWS), paediatric early warning score (PEWS) and fluid management.

Initial assessment was by a single clerking process which had a positive effect on the patient journey and medical staff resources. Clerking involves staff in documenting a comprehensive history and full examination of a patient when a patient is admitted to hospital. Single clerking means bringing together all the specialty on-call doctors with A&E doctors as one acute team. The main aim of this process was to ensure the care delivered was efficient and provided access to a senior decision maker at the earliest opportunity.

The department used adult (NEWS) and paediatric (PEWS) early warning scoring systems to monitor deteriorating patients. These are guides used by medical services to quickly determine the degree of illness of a patient. The escalation pathway for an elevated score was readily available on the observation records for staff to easily refer to. There were processes to ensure that staff reported elevated early warning scores to a medical practitioner, and patients had access to necessary medical reviews. We saw NEWS and PEWS being performed and concerns escalated through appropriate channels.

We saw falls risk assessments, venous thromboembolism (VTE) assessments, sepsis screening tools, safeguarding assessments and mental health needs risk assessments were completed. Work was in progress as part of the new EPR on a sepsis bundle which would be rolled out in January 2019. Paediatric staff had a paediatric sepsis screening tool that provided guidance to staff on actions to take if a child or young person displayed particular symptoms.

The A&E had sepsis champions, these were members of staff that promoted staff knowledge of sepsis and worked with staff on initial assessments and the identification of sepsis and its treatment within one hour. The hospital informed us that in December 2018 90% of nursing staff and 100% of medical staff had been trained in the management of sepsis.

The EPR had an icon which staff could activate to alert staff viewing a patient's record that the record belonged to a patient with suspected sepsis.

A wide range of checks were expected to be undertaken within the four hour wait time, these included: pain assessment and analgesia, communication, early warning score, bloods, cannula, electrocardiogram (ECG). We saw this in use and found the checks fully completed for all patients during the inspection

All paediatric A&E nurses were trained in advanced paediatric life support (APLS).

The escalation policy in A&E followed the Red, Amber, Green, Black, (BRAG) system of risk. The escalation policy was displayed in the A&E. The policy clearly described what actions needed to be taken at each stage and the individual tasks and responsibilities of staff, by grade. This meant that staff had a clear pathway to escalate safety concerns. We observed staff using the A&E escalation procedures during our inspection and found they worked well.

The department held safety huddles throughout the day. We observed two of these meetings during our inspection and found these to be effective.

There was a non-documented policy within A&E of not placing patients in corridors.

Staff referred patients who were considered as a mental health risk to the psychiatric liaison team for review and support. At Barnet Hospital, the psychiatric liaison team operated a ‘core 24’ service. This meant that there were always psychiatric liaison staff available to assess patients. This followed best practice guidance (Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2, NHS England). All emergency department clinical staff could make referrals to the psychiatric liaison team who had a response time of one hour from referral.

When the psychiatric liaison team identified a patient as at high risk of harm they used pre-printed coloured stickers to attach to the patient’s paper records. This highlighted to staff possible high risks. Psychiatric liaison staff also informed the A&E flow co-ordinator. When a patient had been assessed as at high risk of harm staff would request a mental health nurse from a bank or agency to support the patient. Until the nurse arrived, a security officer would observe the patient. There were clear procedures in place for 1:1 observations.

The Trust scored worse than other Trusts for one of the five Emergency Department Survey questions relevant to safety. The Trust scored “about the same” as other Trusts for the remaining four questions.

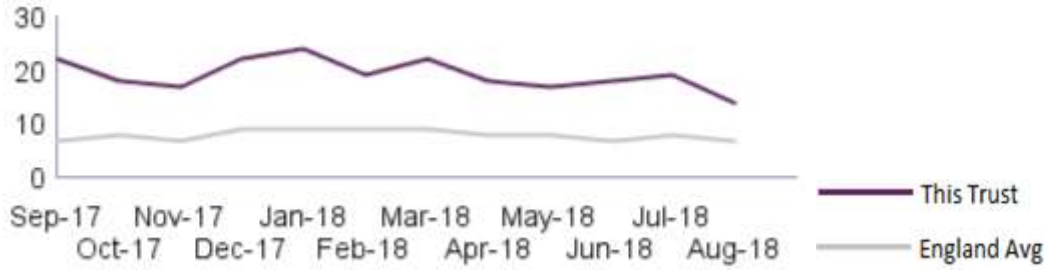
Question	Score	RAG
Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	7.3	About the same as other Trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	5.4	About the same as other Trusts
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	5.6	About the same as other Trusts
Q33. In your opinion, how clean was the emergency department?	7.9	Worse than other Trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.3	About the same as other Trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

The median time from arrival to initial assessment (emergency ambulance cases only) was consistently worse than the overall England median over the 12-month period from September 2017 to August 2018.

In the latest period, August 2018 the median time to initial assessment was 14 minutes compared to the England average of 7 minutes.

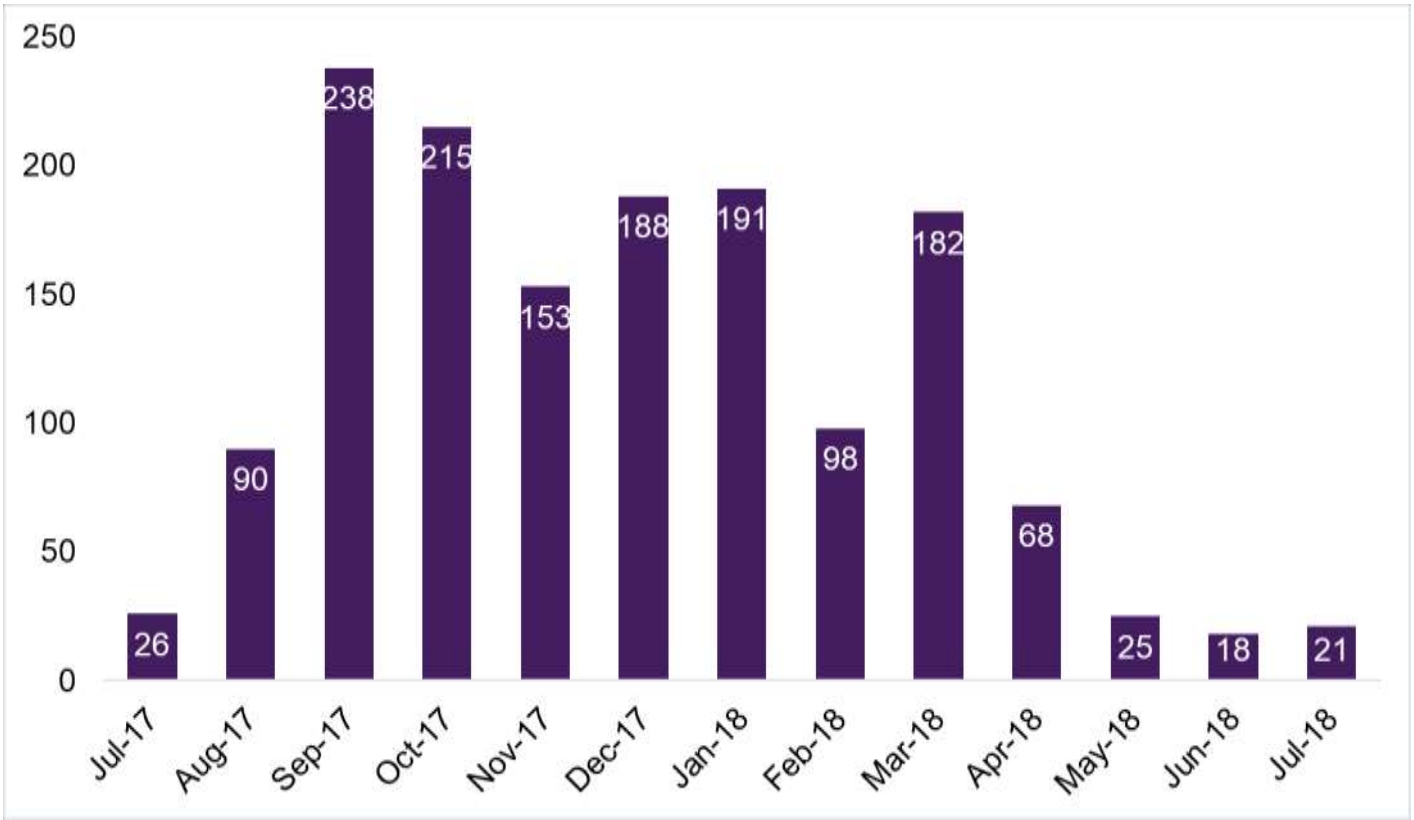
Ambulance – Time to initial assessment from September 2017 to August 2018 at Royal Free London NHS Foundation Trust



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

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

From July 2017 to July 2018 the Trust reported 1,513 “black breaches”, with a downward trend over the period.



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Between November 2017 and October 2018 Barnet Hospital 'black breaches' reached a peak in January 2018 with 101. There was an improvement between February and October 2018, with the lowest rate being five 'black breaches' in August 2018. Staff told us the A&E had being doing well with black breaches until October 2018 when the trend was upwards with 16 breaches. Staff told us winter pressures had an impact on the A&E performance in regards to 'black breaches.'

Nurse staffing

At the time of inspection, the A&E had eight nurses on maternity leave and a vacancy rate of 21%. Staff told us staffing was a challenge, but A&E staff were prepared to work bank shifts and staffing was supplemented by regular agency nurses.

Registered nurses were being trained in paediatric competencies. This was due to a shortage of paediatric A&E nurses. The paediatric A&E establishment was three registered paediatric nurses during the day and at night. A paediatric nurse told us, "There has been an increase in attendances, three nurses on shift when there are a number of patients waiting is difficult to manage." The paediatric A&E did not have emergency care assistants (ECA). Although staff told us there was a plan to introduce ECA to paediatric A&E, but there was no timescale for when ECA would be introduced.

We viewed paediatric A&E rotas for staff trained in advance paediatric life support (APLS) from 28 May 2018 to 2 December 2018. There were 378 shifts in the period with 374 of these having an APLS nurse on shift. Four shifts in the period did not have an APLS trained nurse on shift. The hospital informed us there had been four shifts in the period which the A&E had been unable to staff with paediatric nurses.

Nurses worked a variety of shift patterns including long days from 7.30am to 8pm; mid-long days 9.30am to 10pm; nights 7.30pm to 8am; twilight 6pm to 2am; and long twilight 6pm to 6am. One nurse was responsible for four cubicles and answered to the nurse in charge.

Three senior nurses were training to be advanced nurse practitioners (ANP). Staff told us the intention was that once qualified these nurses could support the registrars' rota and assist in future proofing staffing in the A&E. Furthermore, two emergency care assistants (ECA) were on a Trust sponsored course to convert to qualified nurses.

The clinical decision unit (CDU) was staffed by two registered nurses (RGN) and two emergency care assistants (ECA) 24 hours a day. Staff told us the CDU used to have a band 7 nurse, but, they were reallocated. As a result two band 6 nurses had taken over co-ordination of the CDU. However, staff said the band 6 nurses were included in the actual numbers of staff on shift. Staff said it was difficult for the band 6 nurses to co-ordinate the CDU and provide nursing care. Although staff said this had not resulted in an increase in incidents or complaints.

The Trust has reported the following qualified nursing staff numbers in urgent and emergency care from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate

Barnet Hospital	122.7	100.5	81.9%	125.2	88.8	70.9%
Chase Farm Hospital	19.0	11.8	62.1%	18.3	12.4	67.5%
Royal Free Hospital	110.9	84.0	75.7%	120.7	81.0	67.1%
Total	**252.6**	**196.3**	**77.7%**	**264.1**	**182.1**	**69.0%**

From April 2017 to March 2018, the Trust reported a staffing level of 77.7% for qualified nursing staff in urgent and emergency care. This had decreased to 69.0% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Staff we spoke with told us that although nurses felt supported by matrons and managers, staff retention was a challenge at the hospital. In response to staffing vacancies the hospital had organised A&E recruitment days which were attended by the Trust's human resources (HR) team to enable prospective new employees to apply for job, including 'on the day' interviews and maths and literacy tests. For example, we saw flyers for a band 5 and band 6 nurses A&E recruitment day on 6 October 2018. The recruitment day included free training for all attendees from the A&E practice educators which provided credits that attendees could use towards their revalidation. Staff told us the hospital provided free training opportunities to encourage prospective staff to attend and "get a flavour of the learning opportunities available at the hospital." The day had resulted in the A&E successfully recruiting eight new nurses.

A band 7 senior nurse had been part of a Trust team that had travelled to India to recruit new nurses. This resulted in the Trust recruiting 30 new nurses. Staff told us two of these nurses would be joining Barnet Hospital A&E once they had completed their nursing conversion to practice in the UK.

From September 2017 to August 2018, the Trust reported a vacancy rate of 23.9% for qualified nursing staff in A&E. This was higher than the Trust target of 12%. However, the 20.3% vacancy rate at Barnet Hospital A&E in the same period was better than the Trust average

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Nursing vacancy rates at the time of inspection at Barnet Hospital were: 0% band 7; 38.9% band 6; 26.6% band 5. Paediatric nursing vacancy rates were: 28.8% band 6.

From September 2017 to August 2018, the Trust reported a turnover rate of 27.1% for qualified nursing staff in A&E. This was higher than the Trust target of 13%. However, the 20.6% turnover rate at Barnet Hospital ED in the same period was better than the Trust average

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the Trust reported a sickness rate of 3.3% for qualified nursing staff in urgent and emergency care. This was lower than the Trust target of 3.5%. The 4.1% sickness rate at Barnet Hospital A&E in the same period was worse than the Trust average

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the Trust reported that 20% of all staff shifts in A&E were filled by bank staff and 6% of shifts were filled by agency staff. In addition, 1% of shifts were over-filled by bank and agency staff to cover staff absence.

The breakdown by site is shown in the table below.

Site	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Barnet	282,484	61,876	22 %	12,281	4%	Over-filled by 19,139	Over-filled by 7%
Chase Farm	41,363	4,979	12 %	11,316	27%	2,576	6%
Royal Free	254,980	51,447	22 %	8,301	4%	11,041	4%
Total	**578,827**	**118,301**	**20 %**	**31,898**	**6%**	**Over-filled by 5,522**	**Over-filled by 1%**

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

This indicates that shifts at Barnet Hospital were overstaffed, but, this was based on the use of bank and agency staff.

Medical staffing

The department was not meeting the Royal College of Emergency Medicine (RCEM) workforce recommendations, 2018. The RCEM recommendations highlight, “The value of having enough consultants on duty at busy times of the day (depth of cover) and over a 16 or 24 hour period (breadth of cover). Case mix and demand will dictate the model that is right for a system to be safe and sustainable”. There was a consultant on site from 8am to 11pm Monday to Friday. The consultant was on-site for eight hours on Saturday and Sunday. Outside of these hours there was a consultant on-call from home that was within 30 minutes travelling time to the hospital. When the consultant was not on-site there was a doctor on-site that was a minimum of ST4 grade.

Staff told us the A&E was funded for 11 WTE consultants. At the time of the inspection the actual number of A&E consultants employed was seven. Staff told us the A&E consultants were very supportive and would work bank to cover shifts. Staff told us the hospital had a rolling programme of recruitment to try to attract new medical staff.

A paediatric consultant covered the paediatric assessment unit (PAU) from 9am to 6pm, out of hours there was cover from an A&E registrar and paediatric registrar

Nurses and doctors handovers had been introduced in January 2018. We observed a paediatric doctors handover on the 13 December 2018. The handover included all doctors coming on to shift receiving a briefing from a doctor that was going off shift. Patients state of health, test results and images were individually discussed and reviewed by all the doctors, and actions or treatment plans were discussed and formulated.

The Trust has reported the following medical staff numbers in urgent and emergency care from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	118.5	124.4	Over-established by 5.0%	140.9	132.4	93.9%
Chase Farm Hospital	5.6	2.7	48.2%	7.8	3.0	38.7%
Royal Free Hospital	45.7	34.0	74.4%	46.0	34.3	74.5%
Total	**169.8**	**161.1**	**94.9%**	**194.7**	**169.7**	**87.2%**

From April 2017 to March 2018, the Trust reported a staffing level of 94.9% for medical staff in urgent and emergency care. This had decreased to 87.2% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From September 2017 to August 2018, the Trust reported a vacancy rate of 10.8% for medical staff in urgent and emergency care. This was lower than the Trust target of 12%. Barnet Hospital had a vacancy rate of 2% in the period. This was much better than the Trust's target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

In December 2018 the whole time equivalent (WTE) medical vacancy rates at Barnet Hospital were: consultants 30.9%, specialty doctors 17%; higher trainees 20%; acute care common stem (ACCS) and GP 66%; foundation year two doctors 15.3%. The total medical vacancy rate was 24.7%.

From September 2017 to August 2018, the Trust reported a turnover rate of 7.8% for medical staff in urgent and emergency care. This was lower than the Trust target of 13%. The rate at Barnet Hospital was 6.7%. This was better than the Trust average.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the Trust reported a sickness rate of 0.7% for medical staff in urgent and emergency care. This was lower than the Trust target of 3.5%. Barnet Hospital had a rate of 0.9%. This was similar to the Trust average and lower than the Trust target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the Trust reported that 10% of medical shifts in urgent and emergency care were filled by bank staff and 5% of shifts were filled by locum staff.

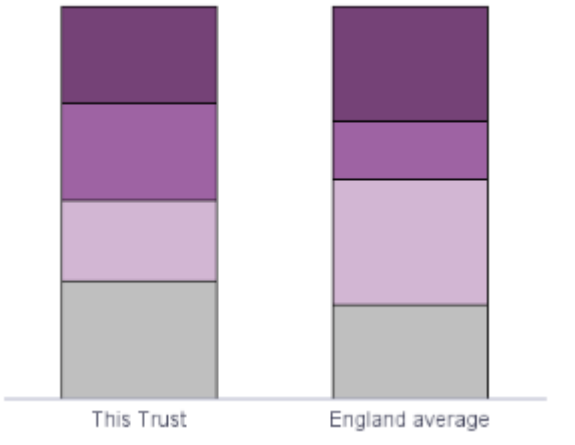
The breakdown by site is shown in the table below:

Site	Total hours available	Bank Usage		Locum Usage		NOT filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Barnet	250,029	15,603	6%	3,030	1.2%	Over-filled by 1,301	Over-filled by 1%
Chase Farm	12,996	5,107	39 %	0	0%	3,127	24%
Royal Free	89,577	13,452	15 %	13,457	15%	Over-filled by 1,181	Over-filled by 1%
Total	**352,602**	**34,162**	**10 %**	**16,486**	**5%**	**646**	**0%**

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In July 2018, the proportion of consultant staff and the proportion of registrar group reported to be working at the Trust were both lower than the England average. The proportion of junior (foundation year 1-2) staff and middle career were both higher.

Staffing skill mix for the 77 whole time equivalent staff working in urgent and emergency care at Royal Free London NHS Foundation Trust.



	This Trust	England average
Consultant	25%	29%
Middle career^	25%	15%
Registrar group~	21%	32%
Junior*	30%	24%

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

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The Trust were in the process of rolling out a new records system. The A&E were using a 'paper light' system at the time of our inspection. Staff told us the hospital record systems would be fully integrated and paperless by November 2019.

Staff told us there had been some issues with the EPR roll out. However, the Trust had 'floor walkers' in the department. These were staff from the Trust's IT department that A&E staff could ask for assistance with the new records system.

The Trust was in the process of reviewing and standardising nursing documentation with the implementation of the new EPR. Records were stored securely and kept confidential. Patient records were well organised and easy to navigate. The majority of patient records we viewed had appropriate risk management records and audit trails. Since our last inspection, assessment tools had been reviewed and improved to reflect best practice guidance. Patients risk assessments and early warning scores were complete and easy to navigate.

Care records clearly recorded patients with mental health needs. The psychiatric liaison team assisted A&E staff with obtaining information concerning patient's mental health history. A&E staff had access to the local mental health Trust's patient records system. However, staff said there were delays in obtaining patient information when patients lived in an area operated by another mental health Trust. The psychiatric liaison team had arranged to have an additional IT terminal installed. This would allow staff to access these patients' records.

Medicines

The A&E followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Staff handled and stored medicines in accordance with current regulations.

We reviewed the controlled drug (CD) register and found entries had two signatures to demonstrate staff had witnessed the use of CD as outlined in the 'Safe and Secure Handling of Medicines: A Team Approach (the revised Duthie report)', March 2005. Although we also found an entry in the CD register that had been crossed out. This was not in accordance with 'The Misuse of Drugs, Regulation 20 (c)', which states that registers should not have entries cancelled or altered.

Drugs in the A&E were stored in locked cupboards, with the exception of the 'resus' area. We found drug trollies next to each bed space were open to aid staff in accessing drugs quickly in an emergency. Staff told us there was a two to one patient ratio in the 'resus' and all visitors were chaperoned. However, staff were unaware if there was a risk assessment for the drug trollies.

Housekeeping staff had been given training and responsibility for checking and recording fridge temperatures. We looked at temperature records in both the A&E and paediatric A&E and found a consistent approach to medicine fridge temperature checks. All the records we viewed were up to date. This meant that medications were stored at the required temperature range to maintain their efficacy and safety.

Oxygen cylinders were stored safely and in accordance with national guidance from the Health and Safety Executive.

We found a folder with out of date guidelines in the paediatric A&E. We drew this to the attention of the lead nurse who removed the folder and told us staff used the Trust's intranet for medicines guidelines.
The clinical decisions unit (CDU) had a pharmacist that worked exclusively with the CDU.

Incidents

The service managed patient safety incidents well. Managers monitored data from incident reporting to identify trends and themes, which were shared with all members of the urgent and emergency care (A&E) team. We found investigations were undertaken when necessary. These promoted staff involvement as well as learning from incidents.

Between December 2017 and December 2018 there had been 1149 incidents reported in A&E; of these 1072 were found to have resulted in no harm to patients; 69 resulted in low harm meaning patients required extra observation or minor treatment; three resulted in moderate harm and patients requiring a change to their care plan or short term harm; five resulted in severe harm resulting in life threatening or permanent harm to patients.

We reviewed three root cause analysis (RCA) investigations. RCA is a problem solving and quality improvement approach used to identify, understand, and resolve the root causes of an incident. The RCA reports we viewed contained an appropriate level of detail. However, we noted a lack of specific learning actions in response to incidents. For example, an incident involving a patient had a detailed action plan in place for nurses learning, including additional training as a result of the incident. But the action plan for doctors was not detailed and robust, as it required doctors to be reflective and consider how they would ensure compliance with management plans in the future.

Nursing handovers were used as an opportunity to communicate learning from incidents to the ED team. Staff told us they also received emails from the matron to convey learning from incidents. Staff we spoke with told us they received consistent feedback from incidents.

Staff told us Mortality and Morbidity (M&M) meetings were held monthly. The aim of an M&M meeting is to improve patient care by developing a culture of awareness of quality and encouraging front line staff to identify harm, report problems and share lessons to prevent reoccurrence. We reviewed minutes of the most recent three M&M meetings. We found the M&M meetings were focused on staff learning. The hospital also had learning from death reviews from serious incident investigations. We saw a review that had been presented to staff in 2018.

All the staff we talked with were aware of the duty of candour regulations. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Staff we spoke with were able to provide examples of the duty of candour being applied in practice. We also reviewed written evidence that demonstrated appropriate responses from the hospital in regards to implementing the duty of candour.

Incidents involving patients with known or suspected mental health problems were discussed at the monthly multi-agency mental health meeting. Actions to be taken arising from incidents focussed on how to minimise the risk of repetition. For example, following a serious incident in the A&E, the A&E were obtaining ligature cutters. There was a plan to store the ligature cutters with the resuscitation equipment.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

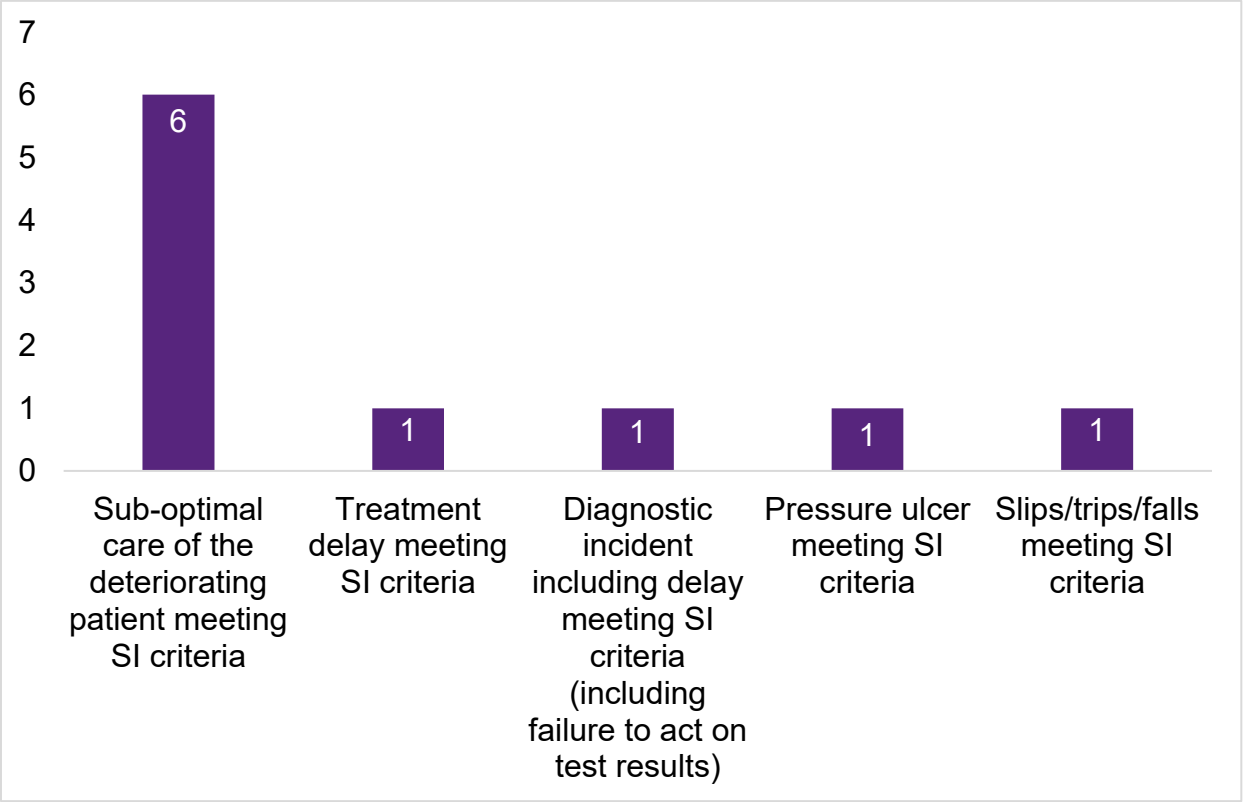
From September 2017 to August 2018, the Trust reported no incidents classified as never events for A&E.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the Trust reported 10 serious incidents (SIs) in urgent and emergency care (A&E) which met the reporting criteria set by NHS England from August 2017 to September 2018.

These were:

- Sub-optimal care of the deteriorating patient meeting SI criteria with six (60% of total incidents)
- Treatment delay meeting SI criteria with one (10% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (10% of total incidents)
- Pressure ulcer meeting SI criteria with one (10% of total incidents)
- Slips, trips and falls with one (10% of total incidents)



(Source: Strategic Executive Information System (STEIS))

The service used safety monitoring results well. Staff collected safety information and shared it with other staff.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the Trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from September 2017 to September 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

The hospital had introduced a smart phone 'app' to enable staff in monitoring the prevalence of patient harms in urgent and emergency care (A&E). The 'app' technology captured indicators such as the processes used to spot and treat sepsis infections or pressure ulcers**.** The 'app' helped staff to quickly complete a set of questions that monitored key indicators of patient care.

Is the service effective?

Evidence-based care and treatment

The Emergency Department (A&E) provided care and treatment based on national guidance and evidence of its effectiveness.

Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines.

Staff could demonstrate how they would access pathways, policies and procedures on the Trust's intranet. We viewed a range of clinical pathways on the Trust's intranet, these included: referrals to ambulatory care, sepsis six, asthma, fractured neck of femur, and diabetes. All policies and procedures we viewed were up to date.

Our review of patients' medical records demonstrated that staff delivered care in accordance with national and best practice guidance.

Patients with potential mental health problems were identified by the A&E triage nurse. When patients had physical health needs and possible mental health needs, they were referred to the psychiatric liaison team. Patients' had a mental health assessment alongside their physical health assessment or treatment. This reduced delays for patients and improved patient experience and safety. It also followed best practice guidance, 'Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2', 2016, NHS England and 'Mental Health in Emergency Departments', The Royal College of Emergency Medicine (RCEM), 2017.

All patients attending the A&E who had self-harmed had a holistic assessment by the psychiatric liaison team. This followed best practice. 'Self-harm in over 8's: short-term management and prevention of reoccurrence', National Institute for Health and Care Excellence (NICE), 2004.

The A&E had a delirium pathway which was well understood by staff. This followed best practice guidance, 'Guidelines for the Management of Excited Delirium/Acute Behavioural Disturbance',

RCEM, 2016. There was also a published dementia pathway to ensure patients had their own specific needs assessed.

There was a clear referral pathway for children and young people with mental health needs to the child and adolescent mental health service (CAMHS). The referral pathway was well understood by paediatric nursing and medical staff.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff ensured patients had appropriate access to food and fluids, and therefore protected them from risk of poor nutrition and dehydration. We saw there were regular nutrition and hydration rounds. This involved a member of staff regularly carrying out checks to ensure patients in the department were provided with food and fluids.

Staff prescribed and recorded intravenous fluids appropriately. We viewed six patients fluid balance charts and found these were complete.

Although there were vending machines in the main reception area, a hot drinks machine had a notice at the time of our inspection saying it was awaiting repair. Patients had access to free drinking water from a machine in the waiting area.

Patients we spoke with told us they had access to adequate food and drink whilst in urgent and emergency care (A&E). We saw regular comfort rounds in the A&E where patients were offered food and drinks.

In the CQC Emergency Department Survey, the Trust scored 6.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other Trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. Staff supported patients by using suitable assessment tools and gave additional pain relief to ease pain.

Patients were asked about pain when booking in at the main reception and at triage to ensure analgesia could be provided in a timely way. Most patients we asked told us they had their pain relief adequately met.

The department used a recognised pain assessment tool to measure patients’ pain levels. Staff appropriately documented pain scores and acted promptly to administer pain relief. Inspectors saw patients’ pain being addressed in a very prompt manner and we saw staff using the pain tool to measure and record pain levels.

In the CQC Emergency Department Survey, the Trust scored 5.6 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other Trusts.

The Trust scored 7.2 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other Trusts.

Question – Effective	Score	RAG
Q31. How many minutes after you requested pain relief medication did it take before you got it?	5.6	About the same as other Trusts
Q32. Do you think the hospital staff did everything they could to help control your pain?	7.2	About the same as other Trusts
Q35. Were you able to get suitable food or drinks when you were in the emergency department?	6.1	About the same as other Trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

There was a clinical audit lead with oversight of the local and national audit programme. The department had a schedule of national audits which ran annually from August to January. Audit results were shared with the urgent and emergency care (ED) as part of governance meetings.

We reviewed the A&E audit schedule which demonstrated a wide range of audit activity was in progress in the department.

We viewed a report benchmarking Barnet Hospital with the Royal College of Emergency Medicine (RCEM) audits 2017/18. We found the A&E were not meeting RCEM fundamental standards for an audit of ‘adult patients who presented to A&E and required procedural sedation’, a ‘pain in children’ audit, and a fractured neck of femur audit. This was not dissimilar to other Trusts in England. However, we found Barnet Hospital had produced comprehensive action plans in response to the RCEM audits, including the modification of the procedural sedation checklist, a new children’s paediatric pathway including the documentation of pre-hospital administration of analgesia to prevent medication errors, and the introduction of a medical hip fracture lead in ED.

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Barnet Hospital’s A&E failed to meet any of the national standards.

The department was in the upper UK quartile for three standards:

- Standard 1a (fundamental): O_2 should be given on arrival to maintain saturation of 94-98%. This department: 65.4%; UK: 19%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 87.0%; UK: 77%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed according to guidelines. This department: 72.7%; UK: 52%.

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

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: X%; UK: X%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
- Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
- Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
- Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 0%; UK: 19%.
  - Standard 5b (fundamental): within 4 hours (moderate). This department: 0%; UK: 28%.

The department's result for the remaining standard was within the middle 50% of results.

In response to the audit the Trust had introduced a folder on the shared drive which contained all asthma guidelines. The folder was accessible to all staff. The Trust were also using a 'wheezy child' pathway to aid staff with the management of children presenting at the A&E with wheeze symptoms.

In the 2016/17 Consultant sign-off audit, Barnet Hospital's ED failed to meet any of the national standards.

The department was in the lower UK quartile for one standard:

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 0%; UK: 8%.

The department's results for the remaining three standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

The A&E had seven consultants, but, all registrars were involved in audits as part of specialist training. Registrars of grade Sp4 and above could sign off audits in accordance with RCEM recommendations. All staff received feedback on the outcomes of audits and were advised to read audit reports. The A&E was performing better than the national average for audits signed off by registrars.

In the 2016/17 Severe sepsis and septic shock audit, Barnet Hospital's A&E failed to meet any of the national standards.

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

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 68.3%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 57.4%; UK: 43.2%.

The department was in the lower UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 45.5%; UK: 64.6%.

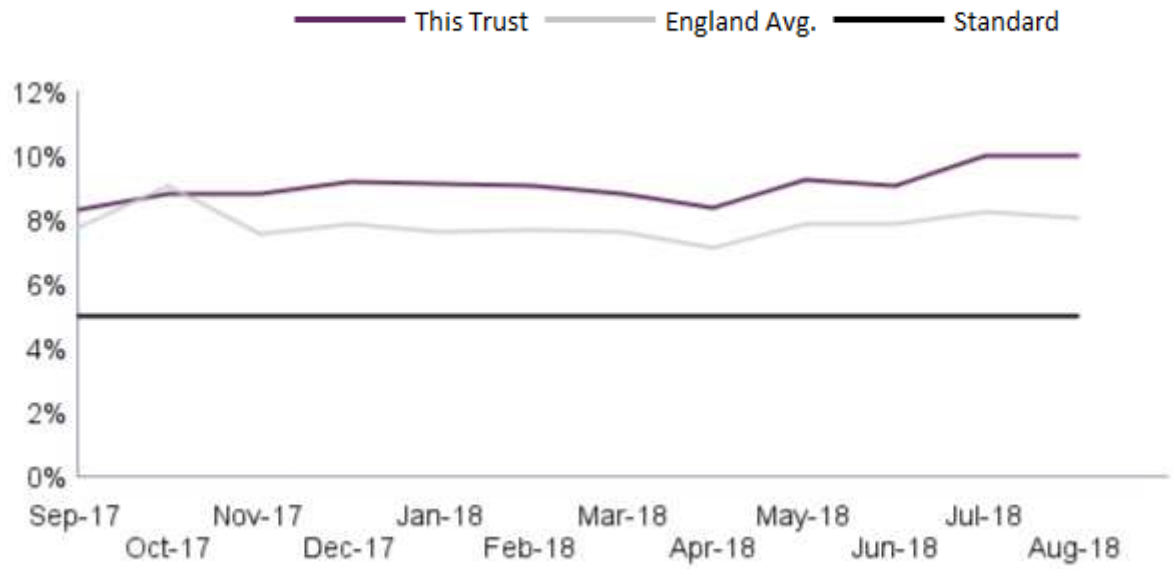
The department's results for the remaining five standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

In response the A&E were working with the Trust's IT department on a Sepsis pathway on the electronic patient record (EPR). The Trust had introduced a Sepsis lead and lead for Sepsis in A&E. The Trust had also introduced a guide to antibiotics on the Trust intranet and an application (App) for handheld devices that provided guidance for staff on Sepsis and antibiotics. All medical staff had received training on the 'Sepsis 6' bundle as part of their induction. The training had also been incorporated into the Trust's induction for medical staff.

From September 2017 to August 2018, the Trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average with the exception of October 2017 where performance was similar to the England average. In the latest period, August 2018, Trust performance was 10.0% compared to an England average of 8.1%.

Unplanned re-attendance rate within seven days - Royal Free London NHS Foundation Trust



(Source: NHS Digital - A&E quality)

Barnet Hospital unplanned re-attendance rate was close to the Trust average. For example, between November 2017 and October 2018 the lowest rate was 8.9% in June 2018, this was the same as the Trust average. The highest rate in the same period was 10.4% in July 2018, this was slightly worse than the Trust average in July 2018 of 9.10%. The hospital had a monthly frequent attenders meeting. This was a multidisciplinary meeting that reviewed patients who had re-attended the hospital within seven days of attending the A&E. Staff told us the meeting provided an opportunity to monitor themes and trends in patients' re-attendance. Information from the meeting was shared with individual patients GP.

The hospital had a ‘failed discharge system’. This meant patients returning to A&E within seven days of discharge would be directly referred back to the specialty.

Competent staff

The A&E made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

There was an education strategy as an aspect of the divisional clinical strategy. For example, the strategy included the introduction of a range of new learning opportunities including an induction and support programme, an increase in staff skills base by providing ad hoc training sessions, and a practice development nurse with a remit for staff supervision.

The strategy also included the development of a new workforce model; as a result five advanced nurse practitioners (ANP) were planned over the next two years, although staff told us there was a need for nine. An emergency nurse practitioner (ENP) training programme to master’s degree level was being developed for band 5 nurses.

The ED had a professional development team to provide support in the development and education of staff. The team had established their own database to monitor staff training, appraisals and competencies. For example, we viewed staff appraisal records during the inspection and found 86% of staff had received an annual appraisal.

New nurses undertook a four-week supernumerary induction period with an allocated professional development nurse (PDN), during which they received training and clinical supervision in all areas of the A&E including triage, NEWS, incident reporting and safeguarding. All new nurses completed a ‘clinical skills competency record book’ and had to meet all performance criteria before they were allowed to work independently. Competence was assessed and signed off by an assessor that was a band 6 nurse or above.

Agency staff received a ‘New starter welcome pack’ and also undertook an induction before working in the A&E.

We saw there was an extensive induction and preceptorship programme for newly qualified nurses and each nurse was allocated a mentor. The training programme lasted for a period of 12 months and included six taught sessions and two study days. The preceptorship programme was comprehensive and covered areas including: action learning sets around safe practice, discharge plans, patient safety including incident reporting and sepsis recognition and treatment, recognising the deteriorating patient, medicines management, maintaining professional records, nutrition, mental health awareness and enhanced care.

Emergency care assistants (ECA) had opportunities to develop their careers and become qualified nurses. For example, six ECAs were completing the nurse associate programme. Practice educators told us on completion of the programme nurse associates could complete further study and training to become band 5 qualified nurses.

Staff received regular clinical supervision from the practice development team. The department assessed the learning needs of staff by means of appraisal. Staff we spoke with told us the

appraisal process was meaningful. Staff appraisals were aligned with the Trust's values, identified staff learning needs and included objectives individual staff members had met in the previous 12 months, as well as their objectives for the next 12 months.

Junior doctors were positive about the learning and teaching opportunities within the department. Junior doctors had access to protected time scheduled teaching sessions. For example, junior doctors received training sessions from middle grade doctors from other specialities across the hospital to increase their skills and knowledge.

Staff were supported with renewal of their professional registrations, such as with the nursing and midwifery council (NMC). The professional development team recorded nurse competencies on a spreadsheet to enable them in monitoring staff competence and ensuring staff were up to date with current best practice based on national benchmark standards. The human resources department and the consultant lead oversaw medical staff revalidation.
Staff in the children's emergency department completed children's clinical competencies which were signed off by the professional development team. This included the completion of the Trust's workbooks on medication administration, intravenous (IV) fluids. Staff competencies were assesses in a wide range of skills and knowledge, including paediatric triage, the use of patient group directives (PGD), patient transfer internally and externally, recognising the sick and injured child, paediatric resuscitation, trauma and massive haemorrhage, child bereavement, supporting parents, and communication.

The speech and language therapy lead at Barnet Hospital was providing A&E nursing staff with training to carry out a basic swallow assessment. This was planned to be completed by January 2019 with the support of the A&E practice educators.

The A&E had commissioned 120 places on breakaway training for staff in response to an increase in the number of incidents involving staff being assaulted by members of the public.

From April to September 2018, 73.7% of staff within urgent and emergency care at the trust received an appraisal compared to a Trust target of 85%. Nursing staff had a 78.8% completion rate and medical/dental staff had a 75.3% completion rate.

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/ No
Estates and Ancillary	1	1	85%	100%	Yes
Nursing Registered	146	115	85%	78.8%	No
Medical and Dental	73	55	85%	75.3%	No
Healthcare Assistants	40	23	85%	57.5%	No
Administrative and Clerical	10	5	85%	50.0%	No

Total	**270**	**199**	**85%**	**73.7%**	No

Barnet Hospital

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Nursing Registered	72	62	85%	86.1%	Yes
Medical and Dental	62	50	85%	80.6%	No
Healthcare Assistants	21	15	85%	71.4%	No
Administrative and Clerical	3	2	85%	66.7%	No
Total	**158**	**129**	**85%**	**81.6%**	**No**

Nursing staff at Barnet Hospital had a completion rate of 86.1% and medical/dental staff had a completion rate of 80.6%, compared to the 85% Trust target. However, we viewed appraisal rates for medical staff at the time of our inspection and found these had improved with medical staff having an 82% completion rate. The rate for consultants was 100%.

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

Mental health awareness training was not mandatory. Although staff told us the A&E was planning shared multidisciplinary mental health training for A&E staff in collaborations with mental health services and the Police.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

The hospital had introduced some measures to address demand pressures on urgent and emergency care (A&E). For example, A&E worked closely with the triage and rapid elderly assessment team (TREAT), this was a multidisciplinary team with a remit to reduce the number of older people unnecessarily admitted to hospital. The TREAT team consisted of a consultant, doctors, nurses, health care assistants, physiotherapists and occupational therapists (OT). The team saw patients over the age of 80 years of age that required extra support. The team could arrange extra social care support as part of a community care package and community healthcare following discharge from the A&E.

To address demands on the service A&E had introduced ‘sitrep’ meetings. These were operational update meetings which reviewed pressures on the hospital system and delayed transfers in patient care. The meetings also reviewed the A&E escalation plan. ‘Sitreps’ were attended by the clinical site manager.

The hospital had also introduced bed meetings; these were attended by the A&E matron and senior staff from specialties. The bed meetings had the objective of establishing and continuously updating discharge plans and forecasts that would create capacity to meet both the scheduled and the anticipated unscheduled demand on the hospital for the day. However, some staff told us the measures the hospital had taken to mitigate risks to patients in A&E had addressed some demand and capacity issues but that some issues remained. Following our inspection, the Trust informed us that the Trust had worked with NHS Improvement for a year assessing and testing

improvement ideas in A&E and had trialled a number of change ideas with varying degrees of success such as, ‘care in a chair’ and ‘streaming nurses.’

A&E staff told us they had positive working relationships with London Ambulance Service (LAS) and the East of England Ambulance Service (EEAS). Staff told us LAS in particular provided much needed support during busy times when managing capacity became a challenge.

The rapid response team was a multidisciplinary team of allied health professionals (AHP), such as occupational therapists (OT) and physiotherapists. The team worked closely with staff on the A&E, clinical decisions unit (CDU) and acute admissions unit (AAU). The rapid response team had provided additional training to OT and physiotherapists to enable staff in assessing patients’ activities of daily living (ADL) needs. Staff had also been trained by nursing staff and had annual competency assessments in cannulation, urine analysis and the removal of intravenous (IV) fluids.

A&E staff could refer patients that were up to 24 weeks of pregnancy directly to the early pregnancy unit (EPU), between 9.30 and 4pm.

The A&E team worked with the emergency gynaecology unit (EGU) this was a nurse-led, consultant-directed specialist unit for women that required emergency care for problems in the first 16 weeks of pregnancy. The service prioritized urgent GP referrals with abdominal pain on the same day and non-urgent referrals the same or the next day. The service operated Monday to Friday from 9am to 5pm and on Sunday from 9am to 5pm. Women could be referred directly to the EGU providing their condition was stable.

The ambulatory emergency care centre (AEC) provided a service to patients that were able to mobilise and did not require any further assistance. The AEC specialised in deep vein thrombosis (DVT) and had scanning facilities available. Patients with possible DVT would be referred to the AEC during the AEC opening times Monday to Friday from 9am to 5pm.

The paediatric A&E and paediatric assessment unit (PAU) worked closely together to identify and treat children requiring further management or treatment. The PAU worked alongside Pluto day unit; this was a nurse led unit that saw children and young people by appointment. The Pluto day unit was open Tuesday, Thursday and Friday.

A&E staff held monthly multi-agency meetings with the psychiatric liaison team to discuss patients in the A&E with mental health needs. These meetings were attended by the police, ambulance service and local authority approved mental health professional (AMHP) service. These meetings served a number of functions including joint working between the police and the ED, frequent attenders to the A&E, and new policies and guidance.

Barnet Hospital was affiliated to the North East London and Essex Trauma Network (NELETN). The trauma director was commended by NELETN for their engagement with network in 2018.

Seven-day services

The A&E provided a twenty-four hour, service seven days a week. There was support provided from other hospital services in the provision of specialist care.
The hospital provided a dedicated 24 hours a day, seven days a week children’s A&E.
Pharmacy services were available seven days a week. A duty pharmacist was available via switchboard outside of pharmacy opening hours.
The diagnostic imaging department provided a seven day, 24 hour on call service. This was in accordance with the NHS services, seven days a week, priority clinical standard 5, 2016. This requires hospital inpatients to have seven-day access to diagnostic services such as x-ray and

computerised tomography (CT). Magnetic resonance imaging (MRI) was available, seven days a week from 9am to 6pm.

The clinical decision unit (CDU) was open twenty four hours a day, seven days a week.

The rapid response team took referrals from 8am to 8pm, seven days a week.

Mental health support services were available twenty-four hours a day, seven days a week.

Results from the 'seven day services audit', dated April 2018 found an improvement from the 2017 audit. For example, the overall proportion of Barnet Hospital patients seen and assessed by a suitable consultant within 14 hours of admission was 88%.

Health promotion

There was a range of information leaflets available to patient in the A&E main waiting area. This included information on smoking cessation and drug and alcohol dependency.

The hospital had an alcohol liaison team (ALT). Staff could refer patients to the ALT for support and advice on external agencies that could provide information and support for both alcohol and drugs. The contact details for the service were also available on the Trust's website.
There was a range of printed information available in the paediatric A&E.

We observed a doctors' handover in the paediatric A&E. Children and young people's risk factors were identified and changes to children and young people's care or treatment was discussed by medical staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.

Staff reported there had been an increase in the number of patients being brought to A&E by police. These patients had suspected mental health needs and had voluntarily agreed to go to the hospital. The increase had followed a change in mental health law. Staff were aware of what to do if they had concerns about a patient and their ability to consent to care or treatment. Staff were familiar with processes such as best interest decisions. Where a patient lacked the mental capacity to give consent, guidance was available to staff through the Trust's consent policy. However, when patients had harmed themselves, or had thoughts of doing so, A&E staff did not always undertake a mental capacity assessment concerning treatment for their physical health needs. Emergency department staff recognised this was an area where improvement was required.

Most staff we spoke with had understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

A consent policy written in line with national guidance was available to all staff. We reviewed patient electronic records and saw all patient records included a consent to treatment record. We saw staff obtaining verbal consent patients during their treatment.

Paediatric staff we asked could explain Gillick competence which is used in medical law in England to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff were also aware of the Fraser guidelines; these specifically relate to contraception and sexual health and address the specific issue of giving contraceptive advice and treatment to those under 16 without parental consent.

Mental Capacity Act 2005 awareness training was a mandatory training requirement for all staff. The Trust reported that from April 2018 to August 2018 Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training was completed by 50% of staff in urgent and emergency care compared to the Trust target of 85%. Barnet Hospital performed slightly better than the Trust average at 54%, but this was much worse than the Trust target of 85%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

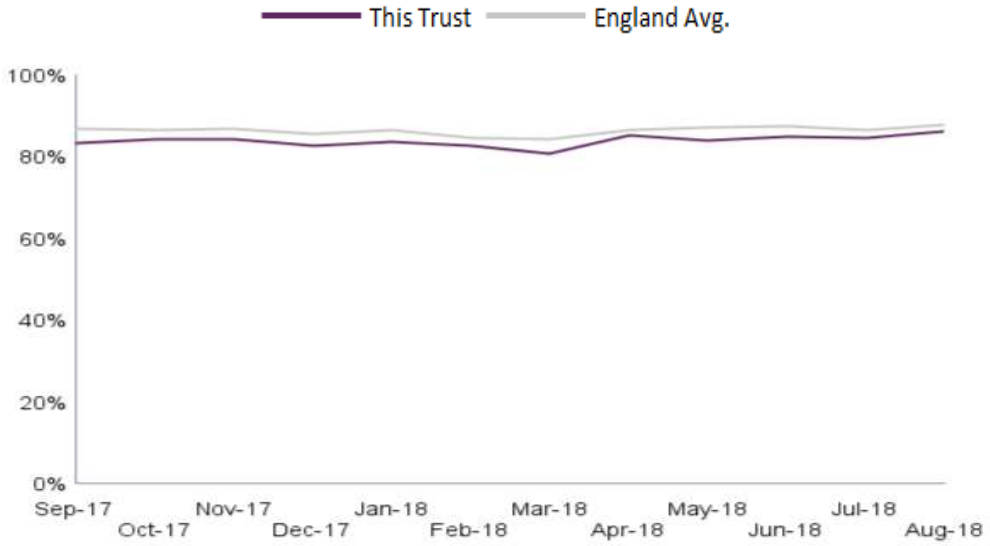
Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
Most patients were complimentary about the care they received. For example, a patient told us, "The staff have been kind." We viewed a range of comments from patients' feedback collected by urgent and emergency care (A&E) in June and July 2018. Comments included, "Staff were very kind. Everything I asked they answered. They did extra tests to put my mind at rest." Another comment was, "Staff were very kind and pleasant."

The interactions we observed between staff and patients were professional and compassionate. Patients were triaged by a streaming nurse in the main A&E waiting area. This was in a screened off corridor separate from the main A&E and at a far enough distance that conversations with the nurse could not be overheard. There was also signage on the A&E wall informing patients that they could ask at reception if they wished to speak with the streaming nurse privately. This meant consideration was given to patients' privacy and dignity during the streaming process.

Staff told us, "We are always reminded about the fundamentals of care at meetings," this is a framework to guide staff in the provision of care for people at the end of life.

From September 2017 to August 2018, the Trust's A&E friends and family test (FFT) performance (% recommended) was slightly worse than the England average. In the latest period, August 2018 performance was 86.3% compared to the England average of 87.7%. NHS England recommends that FFT results should not be used to compare Trusts.

A&E Friends and Family Test performance - Royal Free London NHS Foundation Trust



(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress.

We saw staff providing emotional support to patients, as well as their friends and families. This included reassurance from nursing, ancillary, and medical staff.

We observed paediatric staff allaying the anxieties of a parent in regards to their child having tests. Staff were supportive of the parent and explained why the tests were required and what would happen during the tests.

Staff told us they could access clinical nurse specialists and specialist teams in the hospital that could provide emotional support for patients and their relatives. This included but was not limited to end of life care and mental health.

The service had introduced, “Quiet Days,” these were days when staff were actively encouraged to make a conscious effort to reduce noise in the A&E department and make the department a less stressful environment for patients, relatives and staff.

Patients could access support from the Trust’s multi-faith chaplaincy service. The service offered spiritual, religious and pastoral support, as well as signposting to local bereavement services and services to meet the spiritual and religious needs of patients, families and carers.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients’ we spoke with told us they were provided with enough information and access to clinicians to ensure they were able to make informed choices about their care and treatment.

The urgent and emergency care (A&E) had a relatives’ room where relatives and carers could wait while their relatives were being cared for or the room could be used for breaking bad news to relatives and carers. There was a separate viewing room where people could spend time with a member of their family that had passed away in the A&E.

All staff wore name badges and introduced themselves by name. Staff routinely asked patients how they would like to be addressed.

Staff wore different coloured uniforms, which made identifying different disciplines and grades of staff easier. There was a poster that identified what discipline and grade of staff each colour uniform related to.

The Trust’s ‘seven day services audit’ results dated April 2018 found: The overall proportion of patients made aware of diagnosis, management plan and prognosis within 48 hours of admission was 97% on the weekend and 91% on a weekday.

Some patients told us there was a lack of information on waiting times in the A&E waiting area. The waiting area had a visual display screen that was out of order. The screen had signage to inform patients and visitors that the A&E were working with the Trust’s IT department to rectify

this. However, patients said in the absence of the screen staff were not timely in verbally updating patients on waiting times.

The Trust scored worse than other Trusts for three of the 24 Emergency Department Survey questions relevant to the caring domain. The Trust scored about the same as other Trusts for the remaining 21 questions.

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	4.4	About the same as other Trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.1	About the same as other Trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.2	About the same as other Trusts
Q14. Did the doctors and nurses listen to what you had to say?	8.8	About the same as other Trusts
Q16. Did you have confidence and Trust in the doctors and nurses examining and treating you?	8.8	About the same as other Trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	8.4	Worse than other Trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	7.5	About the same as other Trusts
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?	8.3	About the same as other Trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	7.4	About the same as other Trusts
Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?	8.8	About the same as other Trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.5	About the same as other Trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	8.8	About the same as other Trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.1	About the same as other Trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	5.5	About the same as other Trusts

Question	Trust 2016	2016 RAG
Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.4	About the same as other Trusts
Q27. Before you left the emergency department, did you get the results of your tests?	8.5	About the same as other Trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	8.8	About the same as other Trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.4	About the same as other Trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	4.6	About the same as other Trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	4.5	About the same as other Trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	2.9	Worse than other Trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	4.3	Worse than other Trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	6.5	About the same as other Trusts
Q45. Overall	7.7	About the same as other Trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

Is the service responsive?

Service delivery to meet the needs of local people

The A&E was not meeting the needs of local people at all times due to demand pressures on urgent and emergency care services.

The Trust's 10 year urgent and emergency care (A&E) strategy, dated October 2016, acknowledged that Barnet Hospital was built for a capacity of 85,000 patients a year; but was seeing 118,000 patients a year. Staff told us the hospital were working with the local clinical commissioning group (CCG) on streaming patients, and were discussing the potential to redirect patients to other hospitals or community providers of health and social care. The work with the CCG had also included nursing staff building relationships between the hospital and community services to identify services that were available in the community and could potentially assist

patients, rather than patients attending A&E with minor ailments. Staff told us they were waiting for a report on patient streams, which was being compiled by the CCG at the time of our inspection.

The acute admissions unit (AAU) at the hospital was subject to building works at the time of our inspection. Staff told us that capacity in the AAU was an issue across the hospital as wards could not step patients down to create extra capacity. Staff told us it was expected that the AAU expansion would provide additional capacity to cope with the increased demand in patients attending A&E.

Staff told us the physical space in A&E was a challenge. Staff said overcrowding in the waiting room was a regular occurrence due to the size of the waiting room. The hospital had plans to convert a store room and two offices in the A&E into clinical rooms to increase capacity in the A&E. There were also plans to remove a wall to improve the streaming of patients in the department.

Patients were received from both the East of England Ambulance Service Trust (EEAST) and London Ambulance Service (LAS). Staff told us they met monthly with ambulance services that served the hospital's local population. Staff told us the hospital received a lot of older patients due to the high number of care homes in its locality. Staff said the ambulance services had done a lot of work with care homes on alternative pathways to avoid the need for older patients to attend ED.

Ambulance handover was staffed by two nurses and two emergency department assistants (EDA). Handovers were taken from ambulance staff and paramedics for patients that were transferred to hospital via the 999 service. Following handover the A&E nurse would make a plan of care for the patient and the EDA would provide assistance in implementing the plan.

The hospital had introduced a 'care in a chair' initiative to decrease the time ambulances spent handing over patients to A&E. This was due to trolley availability being identified as a contributory factor in slowing down the process of ambulance handover and staff identifying that some patients were well enough to sit in a chair. Patients were assessed for suitability to sit in a chair in partnership with the ambulance conveyance team. The 'care in a chair' initiative had resulted in an improvement in the numbers of patients being handed over in 15 minutes from 43.35% in March 2018 to 72.5% in November 2018.

Triage was located in the urgent care (minors) area. The area had nine cubicles for the assessment of minor injuries and illnesses. Cubicle one and two housed a second triage nurse and ECA who completed blood test and ECGs. The triage also had an emergency nurse practitioner (ENP) who saw, treated and discharged patients with minor ailments. The urgent care centre had a GP service from 8am to 2pm every day. The GP would assess patients that did not require emergency treatment. Maxillofacial and ear, nose and throat (ENT) doctors assessed patients in treatment room seven which was adapted for specialist equipment.

The urgent care area had nine cubicles that were used for the assessment of minor injuries and illnesses. Patients were streamed by the streaming nurse who made a decision whether the patient should been seen by and A&E doctor or an Urgent Care Centre (UCC) practitioner.

The UCC had a GP service that could see patients that were assessed as not requiring emergency treatment and emergency nurse practitioners' (ENP) that would assess, treat and discharge patients with minor ailments.

Patients transferred to the ‘majors’ area were generally patients that had been transferred to the emergency department (A&E) by ambulance or patients that had arrived in the department and were too unwell to wait in the waiting area and needed a trolley and monitoring. The ‘majors’ consisted of 18 cubicles, one of which was dedicated to gynaecology, one for mental health and two for infection control. All cubicles had monitoring equipment and cupboards for items such as linen and personal care.

Cubicle 6 was a waiting area within the A&E which was staffed by a nurse. The cubicle accommodated patients that were potentially too unwell to wait in the main waiting area, but did not require a trolley.

The ‘resus’ area had six bays with one bay adapted for paediatrics. There was a bay allocated for the most critically ill patients with life-threatening conditions. Three nurses worked in ‘resus’ and received patients via ambulance and a pre-alert red telephone. The ‘resus’ also cared for patients whose condition had changed and deteriorated in the A&E. Each bay was equipped with a resuscitation trolley and two monitoring systems that were linked to a central monitor.

Paediatric A&E had a triage room and five cubicles. Paediatric A&E had a separate waiting area from the main A&E waiting area. Children under the age of 6 months old were automatically referred to the paediatric team. Staff told us there were issues with restricted space in the paediatric waiting area. We saw the waiting area was very crowded on the afternoon of 11 December 2018. Staff told us the paediatric A&E footprint was small and this made the waiting area look crowded. Staff said there was an issue if a number of children required isolation, as finding space in the three isolation rooms in the department was a challenge.

The paediatric assessment unit (PAU) was a short-stay area that worked with the paediatric A&E and provided care for children requiring further management or treatment. The PAU had four beds and two side rooms. The PAU also had its own team of nurses.

The clinical decisions unit (CDU) was a short-stay area that worked with A&E staff for patients awaiting results of investigations or for further review by an A&E or specialist doctor before a decision was made to discharge or admit a patient. The CDU had seven female and seven male beds, two side rooms, and four chairs. Staff told us that the CDU was being used for patients with a decision to admit (DTA) at the time of the inspection. Staff said they would not usually use the CDU for DTA patients, but, winter pressures meant the CDU could provide extra capacity for patients waiting for a bed on a ward. However, staff said patients on the CDU overnight caused blocking on the CDU in the morning.

There was an ambulatory care walk in unit in A&E. Patients could be discharged home from the unit at night and return to the unit the following day for ultrasound scans.

The hospital had a discharge lounge where ambulatory patients awaiting transport home could be relocated from the A&E. Patients referred to the discharge lounge had a form that highlighted their reasons for attendance and diagnosis, any to take away medicines, and detailed whether they were in possession of keys to their home to gain access.

There was a mental health assessment room in the A&E. This provided a quiet area for people awaiting a mental health assessment or bed. Staff told us there was a shortage of mental health beds which meant some patients with mental health needs spent more than 12 hours in the A&E waiting a mental health bed. However, the hospital was in discussion with the local mental health Trust in regards to the possibility of ‘spot purchasing’ private mental health beds.

Meeting people’s individual needs

Throughout our inspection of the A&E we saw staff answering call bells promptly and being attentive to patients' needs.

The needs of people living with dementia were being met. There were three dedicated bays within the 'majors' area that were allocated as dementia friendly. There were dementia friendly clocks within the department. Patients with dementia were flagged on the electronic patient record (EPR) to alert staff that the patient may have additional needs. In November 2018 46% of staff had completed dementia awareness training.

Staff told us that the hospital's learning disability team would support staff in caring for patients with learning disabilities (LD). Staff told us specialist LD nurses were supportive and responsive when asked to advise A&E staff on caring for patients with LD. The specialist nurse for LD knew the local learning disability services and was able to obtain information about patient's needs and the most effective ways to communicate with them. However, the specialist nurse was only available during weekdays from 9am to 5pm.

The hospital had an alcohol liaison team (ALT) based with. Staff worked closely with the alcohol liaison specialist nurse, to identify and assess patients for whom alcohol was a contributory factor in their attendance at A&E.

Staff had 24 hour access to a telephone interpreting service for patients, families and carers that did not speak English. Staff said the A&E had a number of staff that spoke other languages and could act as interpreters. Staff told us all of the Trust's printed information was available in most languages via a request from the A&E to the Trust's accessible communications team.

The environment of children's A&E was child-friendly. Children had access to clean toys and children's books.

The hospital had a play team. Staff told us the play team were very responsive in attending A&E to support a child, especially where a child may have social care needs rather than medical needs. Staff also had access to the contact details for local authority social work teams.

Staff in paediatric A&E had access to the contact details for the child and adolescent mental health service (CAMHS) for a child or young person that may have mental health needs.

When patients with mental health problems required additional support A&E staff booked registered mental health nurses (RMN) to support them. The A&E had also commissioned 60 training places for staff to attend mental health awareness training.

The Trust scored about the same as other Trusts for all three Emergency Department Survey questions relevant to the responsive domain.

Question – Responsive	**Score**	**RAG**
Q7. Were you given enough privacy when discussing your condition with the receptionist?	6.9	About the same as other Trusts
Q11. Overall, how long did your visit to the emergency department last?	6.2	About the same as other Trusts
Q20. Were you given enough privacy when being examined or treated?	8.9	About the same as other Trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

Access and flow

People did not always have prompt access to the service when they needed it. Waiting times from referral to treatment and decisions to admit patients were not always in accordance with best practice recommendations. There was insufficient seating in the A&E patient waiting area to accommodate all patients and visitors.

Most medical and nursing staff in the A&E identified concerns with patient access and flow in the department. Staff told us both the adults A&E and paediatric A&E often struggled to meet the demands placed upon it, because of a lack of capacity elsewhere in the hospital. Staff told us ED being blocked due to unplaced patients was a daily occurrence. However, this did not result in the A&E using inappropriate areas such as corridors. Staff said this was due to the A&E 'care in a chair' initiative.

The A&E had a flow co-ordinator that was a senior nurse. The flow co-ordinator attended daily nursing huddles to gain updates on patients and to monitor the flow situation in the A&E.

Patients were streamed in the waiting area by a senior nurse or GP after they were booked in at the main reception. The streaming nurse or GP would assess which team or department the patient should be referred to.

A senior nurse was stationed in the triage room to assess patients with more complex needs or patients requiring further investigation.

The A&E had a main waiting area. There was a section of the main waiting area which was screened for patient triage. Staff told us there had been an increasing demand on the A&E for three weeks preceding our inspection, which built up during the day. For example, at 1.15pm on the afternoon of 12 December 2018 the seating in the waiting area was full and seven people were standing. Demand pressure on the A&E grew during the afternoon. By 15.44pm the waiting area was very crowded. There were 45 patients in the waiting area; ten of these patients were in the queue for streaming. The rapid assessment team (RAT) was not being implemented due to staffing pressure. Waiting times were being updated on a whiteboard in the main waiting area, as the electronic screen which usually informed patients of waiting times was not working. Waiting times recorded on the whiteboard were: three hours 15 minutes for A&E, two hours for the UCC and 1 hour 45 minutes for paediatric A&E. Staff told us there had been unprecedented demand on the A&E for three weeks prior to our inspection. In response the hospital had allocated extra staff from other areas of the hospital to assist. However, waiting times remained over 40 minutes. This meant unwell patients that may need interventions or pain relief may not receive prompt assessment and triage.

A senior band 7 nurse accepted handovers from ambulance teams. The senior nurse would make a plan of care for the patient. The ambulance triage area was also staffed with a band 6 nurse and an emergency care assistant (ECA). Doctors attended patients in the ambulance triage area when required to assist the rapid assessment team (RAT), such as bloods, electrocardiograms (ECG) or X rays.

We observed three ambulance handovers during our inspection and saw that these handovers were completed within 15 minutes of the patient arriving at the A&E. However, on 12 December 2018 at 12.19 the longest ambulance wait was 39 minutes and the average handover time was 18 minutes. At 3pm the initial assessment wait had been over the 15 minute target for five hours. Staff told us that the 12 December 2018 was much busier than usual and the wait was usually less than 15 minutes.

Between November 2017 and October 2018 the lowest percentage of patients seen within 15 minutes was in January 2018 when the rate was 15.9%, this was better than the Trust average of 38% in the same month. The highest percentage of patients seen within 15 minutes was in August 2018 when the rate was 32.8%, this was better than the Trust average of 56%.

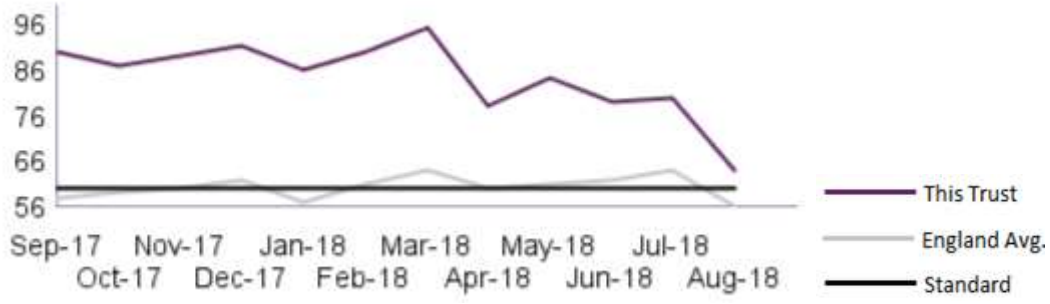
Staff in the paediatric A&E told us patients had their initial assessment within 15 minutes, but sometimes then had a two or three hour wait to be seen by a doctor. Staff told us there was sometimes difficulty with flow at the hospital. Staff told us the paediatric ward, Galaxy, was sometimes full at night. Staff said they would not transfer children or young people to the ward if staffing levels on the ward were unsafe. Staff told us this sometimes left the paediatric ED short of space for children arriving in A&E. Staff told us the hospital was aware that staffing on Galaxy ward was an issue and was trying to address this via recruitment initiatives.

Department of Health clinical indicators suggest that patients arriving by ambulance or self-presentation should be triaged within 15 minutes of arrival at A&E and given analgesia within 20 minutes if required. The A&E had a colour coordinated board which informed staff of patients that were on their way to hospital and expected time of arrival; when an ambulance arrived; patients that had not met the 15 minute handover target; patients waiting 30 minutes or more for ambulance handover; and patients that had waited over one hour, this would be recorded as a serious incident. At the time of our inspection we did not see any patients that had waited over 30 minutes for ambulance handover.

The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The Trust did not meet this standard over a 12-month period from September 2017 to August 2018.

From September 2017 to August 2018 performance against this standard was worse than the England average although performance showed an improving trend. In the latest period, August 2018, the median time to treatment was 64 minutes compared to the England average of 56 minutes.

Median time from arrival to treatment from September 2017 to August 2018 at Royal Free London NHS Foundation Trust

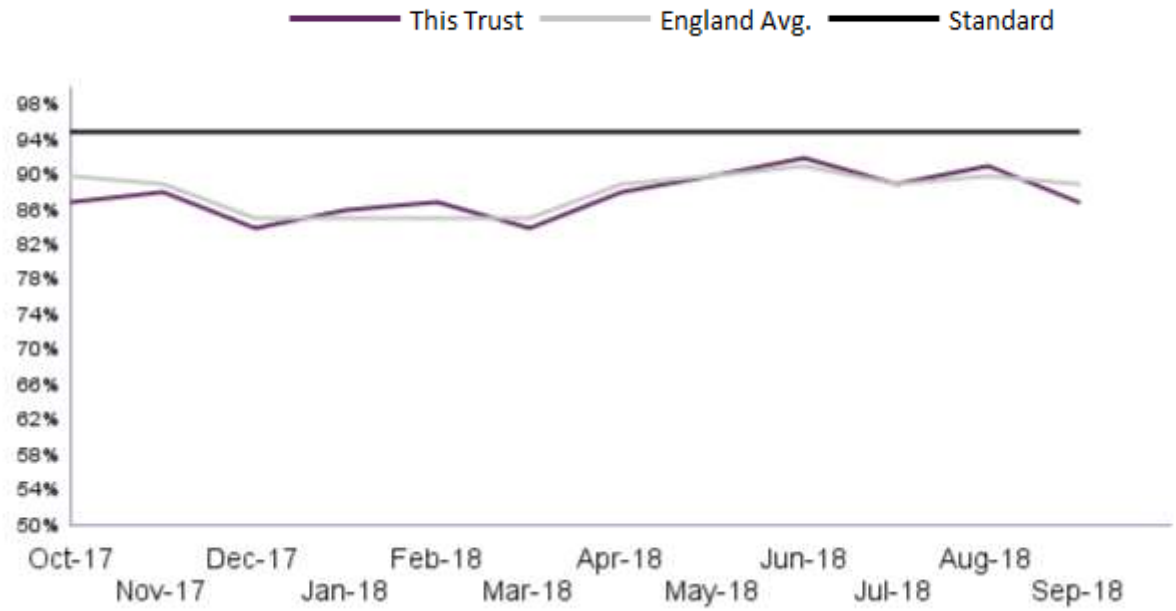


(Source: NHS Digital - A&E quality indicators)

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From October 2017 to September 2018 the Trust failed to meet the standard and performed about the same as the England average. Over the same period, performance against this metric showed a similar pattern to the England average.

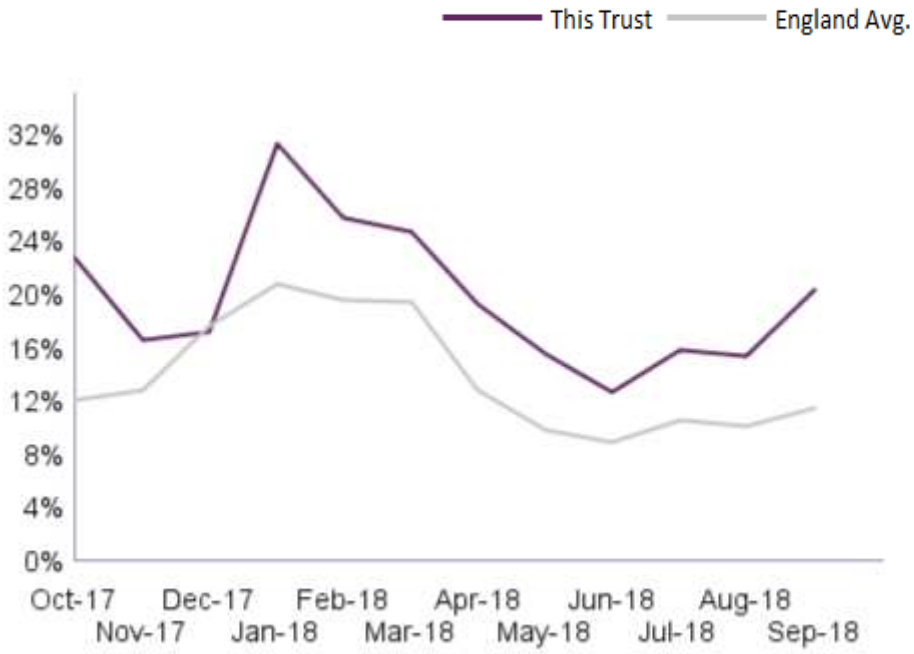
Four-hour target performance - Royal Free London NHS Foundation Trust



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

From October 2017 to September 2018 the Trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average, with the exception of December 2017 where performance was similar.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Royal Free London NHS Foundation Trust



A breakdown by month of patients waiting more than four hours to admission is below:

Month	**Number of patients waiting more than four hours to admission**
October 2017	935
November 2017	742
December 2017	742

January 2018	1,190
February 2018	962
March 2018	1,060
April 2018	786
May 2018	690
June 2018	567
July 2018	718
August 2018	663
September 2018	840

(Source: NHS England - A&E SitReps)

The number of patients waiting on trolleys from November 2017 to October 2018 of between four and 12 hours following a decision to admit (DTA) reflected seasonal variations in demand. However, Barnet Hospital was better than the Trust average and closer to the England average. For example, in December 2017 the rate was 17.5%. The rate continued to rise to 20% in February 2018. In March the rate began to decline and was 1.8% in June 2018. The rate began to increase to 10% September 2018 and 12% in October 2018.

Once a patient had been seen by an ED doctor they may be referred to a specialist doctor who would make the decision to admit (DTA) the patient, the doctor would inform the flow coordinator of what type of bed the patient would need. The flow coordinator would book the bed providing one was available and the bed manager would allocate the bed.

Patients approaching the four hour target with no plan in place or no ward or bed allocated might be sent to the AAU or PAU.

Over the 12 months from October 2017 to September 2018, no patients waited more than 12 hours from the decision to admit until being admitted.

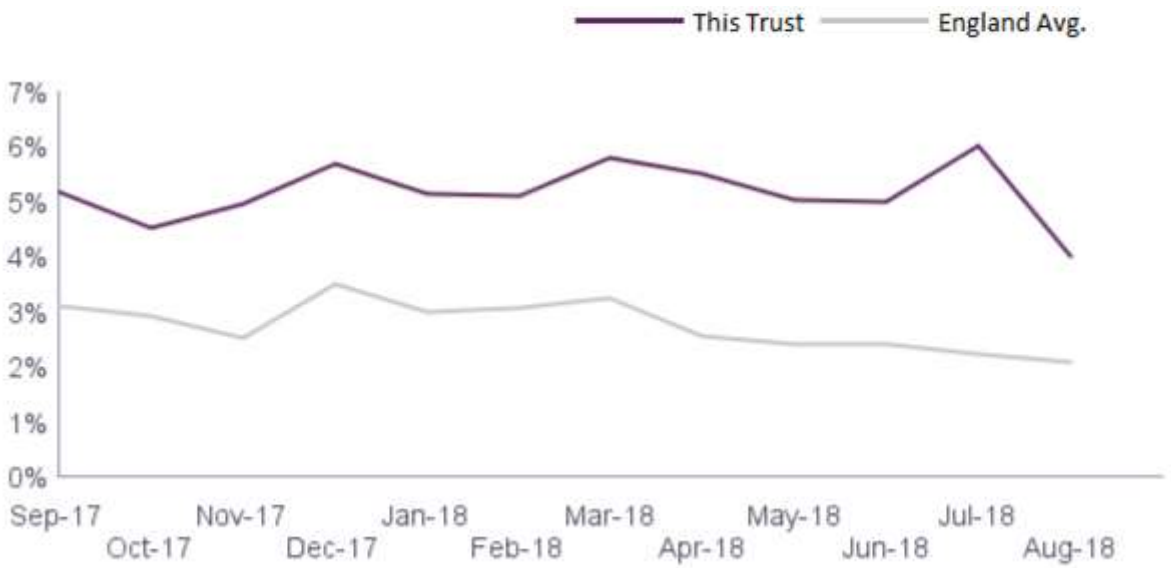
(Source: NHS England - A&E Waiting times)

From September 2017 to August 2018 the monthly percentage of patients that left the Trust's urgent and emergency care services before being seen for treatment was worse than the England average with performance ranging from 4 to 6%.

Over the same period, performance against this metric showed a stable trend until July 2018 where performance worsened, with 6% of patients leaving the Trust's urgent and emergency care services before being seen for treatment, compared to the England average which was 2.2%.

Performance showed an improvement in the latest period, August 2018 where the percentage of patients that left the Trust's urgent and emergency care services before being seen for treatment was 4.0%, compared to the England average which was 2.1%.

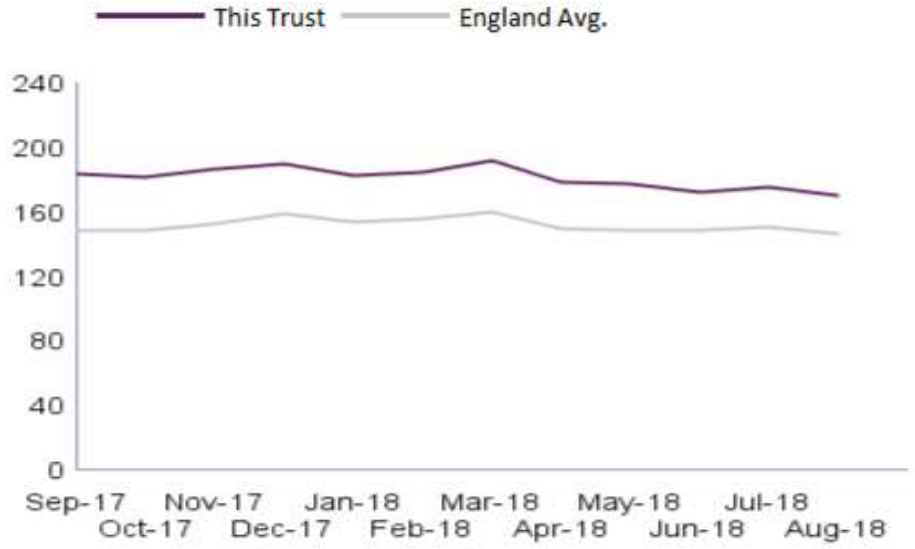
Percentage of patient that left the Trust's urgent and emergency care services without being seen - Royal Free London NHS Foundation Trust



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

The rate of patients that left the A&E at Barnet Hospital between November 2017 and October 2018 was worse than the Trust average in all months in the period. The lowest rate at Barnet Hospital was 5% in August 2017 and the highest rate was in July 2018 at 8%.
From October 2017 to September 2018 the Trust's monthly median total time in A&E for all patients was higher than the England average. In the latest period, August 2018 the Trust's monthly median total time in A&E for all patients was 170 minutes compared to the England average of 146 minutes.
From October 2017 to September 2018, performance against this metric ranged between 172-192 minutes, compared to the England average of 146-160 minutes.
The median total time spent in ED at Barnet Hospital between November 2018 and October 2018 was worse than the Trust average in all months. The lowest rate was 193 minutes in June 2018, compared to a Trust average in this month of 156 minutes. The highest rate was 217 minutes in October 2018, compared to a Trust average of 163 minutes.

Median total time in A&E per patient - Royal Free London NHS Foundation Trust



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

In December 2018 the A&E had 97% compliance with patients GPs being sent electronic discharge summaries within 24 hours of presenting at A&E.

Patients with possible mental health needs arriving at the A&E were assessed by A&E staff. This assessment included a brief mental health assessment to determine the possible level of risk to the patient. Staff could then make a referral directly to the psychiatric liaison team, in accordance with best practice guidance, 'Mental Health in Emergency Departments', The Royal College of Emergency Medicine (RCEM), 2017. The psychiatric liaison team assessed over 95% of patients within one hour of referral. The referral system was well understood by emergency department staff.

Patients with mental health and complex needs had clear discharge plans, including liaison with psychiatric services where patients were already under the care of mental health services.

Learning from complaints and concerns

The A&E treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

There were effective systems and processes to manage and learn from complaints.

The Trust's complaints policy was available to patients and visitors in the urgent and emergency care (A&E) main waiting room. The complaints policy included the contact details for the hospital's patient advice and liaison service (PALS). Staff told us if a patient made a complaint they would do their best to resolve it on the spot. However, if patients wished to escalate a complaint staff would signpost them to the PALS service.

Complaints were monitored for themes and trends at A&E governance meetings. Staff told us most complaints in the Barnet Hospital A&E related to waiting times. Staff said the unreliability of the visual display screen in A&E, since the service had introduced electronic patient records (EPR), had increased patients' dissatisfaction with waiting times in the waiting area.

A consultant and the matron had overall responsibility to review and respond to complaints. Staff monitored complaints for trends and themes to aid learning and make improvements in the department. For example, staff received feedback from complaints at the daily handovers, via emails, or in person where the complaint related to them. The A&E staff newsletter also shared learning across the department from complaints.

We reviewed the A&E response to three formal complaints. All responses contained an apology when appropriate. The responses were detailed and fair.

The Trust website provided relevant information on how to raise a complaint with the Trust. This included advice to patients encouraging them to raise concerns directly with staff, advice on making a complaint in writing, and the contact details for PALS.

From September 2017 and August 2018 there were 156 complaints about A&E services. The Trust took an average of 34 working days to investigate and close complaints. This was in accordance with their complaints policy, which states complaints should be completed and closed with 35 days.

The three most common subjects of complaints are shown in the table below:

Subject	Number of Complaint
All aspects of clinical treatment	84 (53.9%)
Attitude of staff	32 (20.5%)
Communication/information to patients (written and oral)	14 (9.0%)

From September 2017 to August 2018 there were 101 compliments made to the Trust in regards to urgent and emergency care with 59 of these relating to Barnet Hospital.

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

Is the service well-led?

Leadership

The trust had introduced a localised executive team at Barnet Hospital and staff said this had improved leadership at the hospital. However, staff told us they would like support at trust board level in managing issues with access and flow through the A&E department and in improving capacity on the Barnet Hospital site.

The urgent and emergency care (A&E) sat in the Trust's medicines and urgent care division. The Trust had introduced a localised executive team at Barnet Hospital. Staff told us this had improved staff access to the senior leadership team. For example, senior leaders had attended 'sitrep' meetings and had visited the A&E when pressures on the A&E were building. Staff told us the hospital's executive were visible. However, some staff told us the Trust board did not fully support A&E when staff tried to raise issues in regards to access and flow in A&E.

The local leadership fed into the Trust divisional structure. A clinical director, an operations manager and two matrons led the A&E at Barnet Hospital. The local leadership team demonstrated a cohesive and effective approach to managing the department during our interactions and interviews. They told us they were very proud of the team they led. They also recognised and praised the A&E team's ability to embrace and effectively manage change.

Staff told us there had been improvements in leadership at the hospital. Staff told us this included having a, "hands on", operations manager. The hospital had six weekly senior leaders' events which were led by the hospital's executive team on the Barnet Hospital site. Staff told us these events were used to provide a strategic overview of the hospital. Staff said the move to localised leadership forums had assisted Barnet Hospital in creating its own identity. Staff told us the hospital was a district general hospital and the localised meetings meant the leadership team were better able to focus on the specific needs of the hospital.

Throughout our inspection we found the A&E was well led locally. The A&E leadership team told us the team was emotionally supportive. For example, there was a social media group where managers and senior clinical staff could offer each other support. A&E staff told us local leaders were supportive and "hands on."

We asked the A&E leadership team what would make the biggest difference to their ability to deliver changes to improve the service. They told us they would like support at board level in managing access and flow and improved capacity on the Barnet Hospital site which would provide a larger and more appropriate care environment.

Following our inspection the Trust informed us the Trust had invested to increase the footprint of the A&E, with the building of an acute admissions unit (AAU). Furthermore, the Trust informed us that the group chief executive chaired a monthly A&E delivery board, which involved local partners and was focused on improving flow through the A&E. The Trust also informed us that the Trust board had received presentations directly from the A&E senior staff on improvement projects.

Monthly meetings between senior A&E clinicians and senior staff from the local mental health Trust's psychiatric liaison team supported partnership working. This ensured that patients' physical and mental health needs were assessed in an integrated way.

Staff with leadership responsibilities had access to a 'leading the leaders' course. Team leaders were also mentored by experienced managers. All the nurses and doctors we spoke with were clear about their lines of accountability.

Vision and strategy

The urgent and emergency care (A&E) had tried a number of initiatives to cope with demand pressures. However, both nursing and medical staff told us the A&E had struggled in the month preceding the inspection to meet demand. Staff told us there were capacity issues across the hospital. Staff said the hospital sometimes struggled to cope with the volume of patients requiring care and treatment.

Staff in both A&E and paediatric A&E told us some specialties did not consider the "front door" of the hospital to be their concern. Staff said sometimes wards would refuse patients without having seen the patient, and A&E staff could not make a decision to admit (DTA) a patient without the patient having been seen by the specialty. Staff said wards would sometimes refuse to take patients due to staffing levels on the wards or staff being busy with other patients.

There was a 10-year strategy for Barnet Hospital. Staff said they had received the strategy four months prior to our inspection. Staff said they were in the process of developing and aligning the A&E strategy to the hospital's strategy. Staff told us there was recognition from the Trust that the A&E footprint at Barnet Hospital needed to increase to cope with increasing demands on the service. However, some staff also told us they felt the Trust prioritised the needs of the Royal Free Hospital and felt that Barnet Hospital's strategic planning was secondary to the needs of the Royal Free Hospital.

The 'care in a chair' initiative was a Trust initiative introduced in March 2018. Staff told us the hospital were monitoring incidents relating to the initiative to identify if there was an increased risk to patients or if there were any themes relating to patients experience of care when they were in a chair as opposed to a trolley.

Culture

Managers in A&E promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff we spoke with told us that even though there were demand and capacity pressures on the urgent and emergency care (A&E) there was high staff morale. Most staff we spoke with told us they felt supported by managers and matrons. Staff told us there was a culture of 'team working' in the A&E. For example, some staff told us the matron would take telephone calls at home to support staff and some staff told us the management style in A&E was non-hierarchical.

The staff survey dated September 2018 had 52 nurse respondents and 11 medical staff respondents. To the question, 'I look forward to coming to work,' 49 nurses had responded either "always" or "often", three had responded "rarely." All medical staff had responded positively to the same question as either "always" or "often," and none of the medical staff responders had responded "rarely."

Most staff told us there was a focus on staff learning and development in A&E. Staff told us they liked the opportunities the A&E provided in regards to their professional development.

Barnet hospital A&E had introduced 'Mindfulness' meditation sessions for staff to increase staff resilience. Mindfulness was offered to all staff at handover, with staff having the option to participate. We observed a mindfulness session during nursing handover on 13 December 2018 and saw that all staff chose to participate. Staff we spoke with were positive about the sessions. The A&E had also displayed positive, motivating and inspirational quotes in the A&E to prompt staff to be positive and reflective whilst on shift. As a result of the success of the sessions at Barnet hospital the A&E leadership team had been invited to set up similar sessions by other Trusts. A staff member told us, "ED is really good at looking after itself and looking after its staff."

Staff told us that the culture in A&E was one that reflected positivity and progression. Comments we received suggested there was an open and blame free culture. Staff felt empowered to report their own errors as incidents and raise concerns about the service they worked in.

Governance

The A&E used a systematic approach to improving the quality of its services and safeguarding standards of care.

The A&E had a dedicated governance lead consultant. However, some staff told us that new governance processes had been introduced by the hospital without consideration of the time staff needed to implement the processes.

There were monthly A&E 'Quality and Operations' meetings. We viewed minutes from these meetings from July, August and October 2018. The meetings had a standard agenda and complaints, incidents and departmental risks were discussed and monitored at every meeting. Actions resulting from the meetings had an allocated member of staff to lead on the action, and actions were followed up at subsequent meetings.
The medicine and urgent care division had monthly divisional governance meetings and were led by the interim divisional director of operations. The meetings were attended by the A&E operations manager and A&E matron. The meetings had a standard agenda including a review of the divisional performance dashboard. The meetings also looked at divisional responsiveness in regards to complaints and incidents. For example, minutes dated 16 October 2018 recorded that it had been noted that A&E incidents took longer to review and close than the Trust's targets. Actions were that divisional leads were going to speak to governance teams to improve on this. Action plans were followed up at subsequent divisional governance meetings.

Management of risk, issues and performance

The A&E had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There were weekly urgent and emergency care (A&E) performance meetings which reviewed NHS response and waiting time quality indicators. The 'sitrep' meetings were used to review the 'real time' situation in A&E at the time of the meeting. For example, we attended a 'sitrep' meeting at

11.45am on the 13 December 2018. The meeting informed staff there were 43 patients in the A&E and nine paediatric patients. One patient was waiting for transfer to the CDU and was potentially a 12 hour breach. However, at the time of the meeting no patients were in the A&E for over 12 hours. There was one ambulance at the ambulance handover reception waiting to handover a patient and two patients' en-route to the A&E. There were three patients in 'resus' with one waiting for a bed.

There was a department level risk register to monitor A&E risks. Risks could be escalated from the A&E risk register to the Trust's risk register at the local governance meeting. The A&E leadership team were aware of risks on the risk register and told us they were encouraged to identify and escalate risks.

The risk register was reviewed monthly at 'Quality and Operations' meetings. Risks on the risk register were regularly updated and were regularly reviewed by the risk lead.

The A&E risk register contained 10 risks in December 2018. The risk register contained three risks which had been assessed as "extreme." These risks were: underperformance against the four hour wait target. The risk register identified high vacancy levels as a contributory factor to the risk. In mitigation the hospital had a rolling programme of recruitment and use of urgent care and admission avoidance measures. An "extreme" risk was a shortage of A&E junior doctors and consultants. Action in mitigation included the training of nursing staff as advanced nurse practitioners (ANP). A further "extreme" risk was overcrowding and lack of capacity in ED. In mitigation the hospital had developed an A&E escalation plan and work was on-going with external partners at executive level to address A&E capacity. The department had also introduced a 'care in a chair' initiative to create further capacity in the A&E.

Minutes from monthly morbidity and mortality (M&M) meetings provided evidence that data on patients' deaths was collected and reviewed at a departmental level and used to drive service improvements.

The A&E had a dashboard to monitor key performance indicators (KPI) in regards to the hospital's transformation programme. These included outcomes, such as patients discharged from A&E within four hours. We found the performance for the four hour target was stable between 29 August 2018 and 5 November 2018. The dashboard also included performance 'drivers', such as reducing attendances in A&E. However, performance data on the dashboard we were sent by the Trust had most 'drivers' indicators themes reading as 'to be confirmed.' We could not therefore comment on the A&E performance in regards to the transformation programme 'drivers.'

Information management

The A&E collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.

The hospital had introduced a new electronic patient record system (EPR). The record combined the patients' healthcare information in one record, which reduced the risk of patients waiting for test results or medicines as patients records were available to staff online. Staff had computers to input patient information directly at the bedside which meant patients' records were up to date and accessible to other clinical staff caring for the patient. Staff had a smart card and pin to access patients' records and could only see parts of the record they were authorised to access.

Some staff told us the introduction of the new EPR system had been a contributory factor to delays in the A&E in the previous month. Staff told us there had been staff from the Trust's IT

department on hand in A&E to provide staff with support, but, that staff were learning to use a new system and new ways of working. Most staff told us they could see that the EPR would be beneficial to both patients and staff in the longer term. Although some staff questioned the timing of the introduction of the system as it coincided with an increase in demand on the A&E due to winter pressures.

A peer review in 2018 raised concerns about Barnet Hospital's compliance with the trauma audit and research network (TARN) data entry timescales. The hospital had an action plan that meant the hospital would be compliant by April 2019.

Engagement

The A&E engaged with patients, staff, and local organisations to plan and manage services. There were monthly meetings where staff had the opportunity to raise issues with the divisional lead and senior clinical staff.

The staff survey results for the September 2018 survey recorded the response rate as: 16 administrative staff, 51 nursing staff and 11 medical staff. The results of the survey were mixed. For example, to the question, "I am satisfied with the extent that the organisation values my work": The majority of administrative staff (13) had responded to the question with an answer of "No." Nurses' responses to the same question were better. However, 27 of the nursing staff had responded "No" to the same survey question and 24 had responded "Yes." Medical staff responses to the same survey question were better, with seven of the medical staff responding "Yes" and four staff responding "No." There was an action plan in place to address issues raised in the staff survey. For example, this included staff being involved in the compilation of the A&E staff newsletter.

The A&E held an A&E 'super week' in May 2018. This involved all staff in raising ideas for more efficient and effective working in A&E. As a result the A&E introduced a tracker for patient blood test results to aid doctors in locating them on the Trust's system and doctors having a 30 minute sign off of plans for patients to ensure nurses could implement plans in a timely way. The A&E had also introduced 'sitrep' meetings in minors and a work bench to improve staffs working environment.

There was a new starter forum every Wednesday at noon. All staff across the hospital could attend the forum for the first 12 months of employment. The forum provided support for new staff where they could discuss wellbeing as well as practical aspects for working at the hospital.

A&E had social media group for all staff to exchange information and offer support.

Staff received a monthly A&E newsletter from the matron which disseminated information on new policies and learning from incidents and complaints. For example, the December 2018 newsletter had information on the EPR and learning from past incidents.

The hospital had a 'Hidden Heroes' award scheme. Four members of the A&E support team had been invited to a tea party in December 2018 as part of the scheme.

The A&E had a staff choir which provided concerts across the hospital.

The department had various ways to connect with and capture the voice of the public. This included using social media, friends and family test (FFT) surveys, and the NHS choices website.

The A&E had a 'You said, we did' noticeboard in the major's area. This carried information on improvements the A&E had made in response to issues raised by patients and visitors. For example, a patient had fed back that the metal chairs in the main waiting area were too small and

uncomfortable. In response the A&E had replaced the seats for more comfortable seating and was consulting with patients on further improvements to the waiting area.

Staff told us the hospital charity were supportive of the A&E. For example, the charity provided Christmas trees for the hospital and had also provided a massage chair for the A&E to offer massages to prospective new staff on a recruitment day.

Learning, continuous improvement and innovation

The A&E was committed to improving services by promoting training, and innovation.

A matron had recently written an article on the use of mindfulness for a professional journal. There was a clear focus on staff members' mental health and acknowledgement of the impact of stressful events on staff wellbeing. Staff were encouraged in the practice of mindfulness to reduce stress and build resilience.

The hospital had introduced a 'care in a chair' initiative to decrease the time ambulances spent handing over patients to A&E. This had resulted in an improvement in the numbers of patients being handed over in 15 minutes from 43.35% in March 2018 to 72.5% in November 2018.

A&E staff held monthly multi-agency meetings with the psychiatric liaison team to discuss patients in the ED with mental health needs. These meetings were attended by the police, ambulance service and local authority approved mental health professional (AMHP) service.

Medical care (including older people's care)

Facts and data about this service

Barnet Hospital is an acute hospital with 249 inpatient beds providing a range of medical care services. These services include cardiology, respiratory medicine, general medicine, stroke and older person medicine located across 11 wards and the medical day treatment unit and the TREAT (triage and rapid elderly assessment) frailty hub.

(Source: Routine Provider Information Request AC1 - Acute context)

Across the trust there were 66,461 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 24,946 (37.5%), 2,647 (4.0%) were elective, and the remaining 38,868 (58.5%) were day case. Admissions for the top three medical specialties were:

- General medicine - 16,323 admissions
- Gastroenterology - 13,648 admissions
- Dermatology - 5,987 admissions

(Source: Hospital Episode Statistics)

During the inspection we visited the following wards and services: acute assessment unit (AAU), TREAT, medical short stay unit (MSSU), Mulberry, Palm, Juniper, Larch, Spruce, Rowan wards, the CCU and the discharge lounge.

During this inspection we spoke with 49 staff including health care assistants, doctors, nurses, allied health professionals and ancillary staff. We also spoke with the leadership team. We spoke with nine patients and relatives. We reviewed eight patient records and two medication administration records. Attended two multi-disciplinary board meetings and a bed management meeting. We made observations and looked at documentary information accessible within the department and provided by the trust.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff, but compliance for nursing and medical staff was below the trust target of 85%.

The trust set a target of 85% for completion of mandatory training.

Mandatory training for nursing staff was 80% as of September 2018. Staff told us they could access their annual and mandatory training on line and they received a reminder before it was due to expire to complete their training. However, some staff told us they did not always get time to

complete their mandatory training and completed their training on their days off or came in earlier which was difficult as they worked 12-hour shifts.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the medicine department at Barnet Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
IRR17	7	7	100%	85%	Yes
BPAT	183	192	95.3%	85%	Yes
Infection Control L1	181	192	94.3%	85%	Yes
Resuscitation L1	179	192	93.2%	85%	Yes
Basic Radiation Safety	173	192	90.1%	85%	Yes
Fraud & Security	173	192	90.1%	85%	Yes
Health & Safety Awareness	168	192	87.5%	85%	Yes
Emergency Planning	162	192	84.4%	85%	No
Waste Management	158	192	82.3%	85%	No
Moving and Handling	156	192	81.3%	85%	No
Information Governance	156	192	81.3%	85%	No
Infection Control L2	152	192	79.2%	85%	No
WRAP	10	13	76.9%	85%	No
RTT L1	55	74	74.3%	85%	No
Blood Transfusion	141	192	73.4%	85%	No
Fire Safety	139	192	72.4%	85%	No
Conflict Resolution	138	192	71.9%	85%	No
Equality, Diversity & Human Rights	137	192	71.4%	85%	No
Resuscitation L2	121	192	63.0%	85%	No

At Barnet Hospital medicine department, the 85% target was met for seven of the 19 mandatory training modules for which qualified nursing staff were eligible.
Mandatory training for medical staff was 43% as of September 2018. Medical staff told us they would ensure that their training was completed prior to their annual appraisal. Medical staff told us the electronic training record system did not always record when they have completed a module so they take photos of the screen to show the training has been completed. Medical staff also told us they had difficulty in attending face to face training sessions the training was provided often at the Royal Free Hospital and the traveling took too much time. Medical staff training felt could be better harmonised across the trust sites with training time allocated.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the medicine department at Barnet Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
IRR17	8	9	88.9%	85%	Yes
Resuscitation L1	71	115	61.7%	85%	No
BPAT	68	115	59.1%	85%	No
Emergency Planning	65	115	56.5%	85%	No
Infection Control L1	65	115	56.5%	85%	No
Basic Radiation Safety	64	115	55.7%	85%	No

Health & Safety Awareness	64	115	55.7%	85%	No
Fraud & Security	60	115	52.2%	85%	No
Waste Management	55	115	47.8%	85%	No
Resuscitation L2	54	115	47.0%	85%	No
Equality, Diversity & Human Rights	52	115	45.2%	85%	No
Information Governance	50	115	43.5%	85%	No
Moving and Handling	49	115	42.6%	85%	No
RTT L1	49	115	42.6%	85%	No
Infection Control L2	46	115	40.0%	85%	No
Blood Transfusion	43	115	37.4%	85%	No
Fire Safety	43	115	37.4%	85%	No
Conflict Resolution	35	115	30.4%	85%	No

At Barnet Hospital medicine department, the 85% target was met for one of the 18 mandatory training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse, but compliance for safeguarding training for medical staff was below the trust target of 85%. However, staff we spoke with were aware of their responsibility to protect vulnerable children and adults.
The hospital had a designated safeguarding team which included a learning and development lead and two acute liaison nurses for patients with a learning disability.

Staff we spoke with were aware of their responsibility to protect vulnerable children and adults. Staff told us that they had received safeguarding adults and children level 2 training and demonstrated a good understanding and knowledge of the types of abuse patients may experience. On one ward staff told us they had additional face to face safeguarding training to increase their knowledge and awareness and that safeguarding is discussed as part of their weekly team meetings. Staff were able to give us an example of a recent safeguarding concern, they were knowledgeable about what happened after a referral was made. The staff received feedback and knew how a particular safeguarding concern was resolved.

The trust had a policy for female genital mutilation (FGM) that set out the staff's responsibility for identifying and reporting to known or suspected cases of FGM. This was available on the trusts intranet and was accessible for all staff. FGM was included in the trusts safeguarding training.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for qualified nursing staff in the medicine department at Barnet Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	180	192	93.8%	85%	Yes
Safeguarding Children L1	176	192	91.7%	85%	Yes
Safeguarding Adults L2	175	192	91.1%	85%	Yes
Safeguarding Children L2	162	192	84.4%	85%	No
feguarding Children L3	9	13	69.2%	85%	No

At Barnet Hospital medicine department, the 85% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for medical staff in the medicine department at Barnet Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	63	115	54.8%	85%	No
Safeguarding Adults L1	60	115	52.2%	85%	No
Safeguarding Adults L2	57	115	49.6%	85%	No
Safeguarding Children L2	57	115	49.6%	85%	No

At Barnet Hospital medicine department, the 85% target was not met for any of the four safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Following the inspection, the trust provided a breakdown of compliance for safeguarding training as of March 2019. This showed that consultants met the trust target of 85% in safeguarding adults level 1 (85%) and safeguarding children level 1 (87%), but did not meet the target in either safeguarding adults and safeguarding children level 2 (83% and 81%). Foundation year one and two medical staff were below the trust target of 85% in all four safeguarding modules with a completion rate of 33% for each module.

Cleanliness, infection control and hygiene

Although the service generally controlled infection risk well, hand hygiene compliance was variable across the wards. Action plans had been put in place when compliance was low.
The IPC team that worked closely across the wards to reduce the risk of infection in the hospital. Hand hygiene audits were undertaken weekly. Between September and the first week of December 2018 hand hygiene audits for the medicine wards showed the scores varied. For example, on the 26th November 2018 the scores ranged from 100% (cardiac care unit) and 45% (Spruce ward). Staff told us that they did various weekly infection prevention and control (IPC) audits, including hand hygiene. The hospital had recently introduced the perfect ward software application (app) which included infection control audits which were in the process of being moved to being completed on line to enable closer oversite and identify areas of concern. Following the inspection, the trust provided evidence to demonstrate action taken when compliance scores were low.

We observed doctors and nursing staff washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. Visitors were asked to use sanitising gel when arriving on the wards and this was freely available and clearly visible at the entrance to wards. All staff were bare below the elbow and used personal protective equipment (PPE). At bedsides we observed there were hand gels and side rooms had sinks and soap and gels.

The IPC lead told us to reduce the risk of hospital acquired infections they had recently introduced stronger antiseptic wipes which will be in place for three months, and hand hygiene audits had been increased to weekly as part of an enhanced programme of infection control.

During inspection, we found wards appeared clean, tidy and well maintained. Housekeeping staff were observed cleaning on the wards. 'I am clean' stickers had been dated and were visible on all the wards to indicate the equipment had been cleaned and was ready for use. However, we found that cleaning schedules were not displayed on the wards. Cleaning audits for November showed that the wards scored between 95% and 98% for cleanliness. Following the inspection, the trust advised cleaning schedules are displayed inside the cleaner's cupboard which can be accessed by all members of staff.

Disposable items of equipment were disposed of appropriately, either in clinical waste bins or sharps instrument containers. Wards had designated bins and colour coded bags for clinical waste. Most of the sharps bins were not over filled, however one sharps container was above the fill line which meant sharps could be removed from the bin. This meant sharps management did not always comply with Health and Safety (sharps instruments in healthcare) regulation 2013.

All patients were screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) on admission or transfer from another hospital. If patients had diarrhoea, stools were sent for testing for Clostridium Difficile (C Diff) and results were received very quickly. Staff told us that patients were isolated in a side room. We observed patients who were in isolation in side rooms had their doors closed and signage was in use which identified patients in isolation. The signage also included instructions to staff and public on use of PPE. The wards we visited reported no incidents of MRSA or C Diff in the last 3 months.

Environment and equipment

The service had suitable premises and equipment and looked after them well, but we observed potential trip hazards on the care of the elderly wards. However, there had not been any identifiable increase in falls on the wards.

On the wards we inspected we found ward bays and corridors were generally kept clear of equipment accept on Palm and Juniper wards where we found that corridors were cluttered with wheel chairs and walking aids, which could cause a trip hazard for elderly patients or visitors. Following the inspection, the trust provided data of the number of falls across the medical wards during the period March 2018 to February 2019 which indicated that there was a total of 375 falls during this period. A review of Datix incidents for a 12 months period indicated had been no serious incidents resulting in actual or potential harm to either patients or staff relating to this issue.

During this inspection we looked at four resuscitation trolleys. Resuscitation trolleys were located on each ward and we saw they were checked daily and the contents of drawers were checked weekly. Trolleys were within easy access for staff. The seal was changed when medicines and stock were checked. On three of the wards (acute assessment unit (AAU), Mulberry, and Spruce)) we observed a few gaps when checks were missed.

Electrical medical equipment (EME) had a registration label affixed. Portable Appliance Testing (PAT) labels were attached to medical equipment such as feeding pumps, electrocardiogram (ECG) machines and hoists showing they had been inspected and were safe to use.

Barnet Hospital had an external provider responsible for maintenance of equipment. The provider maintained the medical device inventories and labels on the equipment ensured staff were informed them when equipment needed to be serviced.

Assessing and responding to patient risk

Risk assessments were complete and most mitigation of risk was carried out in accordance with the care plan. However, we noted that for two patients there were no records that provided assurance that staff had undertaken the necessary checks to be undertaken when mittens were worn by patients.

When patients, who had a stroke, removed intravenous infusions or other medical equipment the use of mittens to prevent patients from doing so was discussed at multidisciplinary team (MDT) meetings. The trust restraint policy acknowledged this was mechanical restraint. However, the policy did not follow the latest guidance regarding mechanical restraint (Positive and Proactive Care, DH, 2015; Violence and aggression: short-term management in mental health, health and community settings: NICE, 2015). But in the care records of patients with mittens there was no record that an MDT discussion had taken place to reach the decision. There was also no record of what alternatives had been explored so that the use of mittens was exceptional. There was no record that staff monitored the use of mittens at regular intervals. Staff told us the use of mittens was reviewed daily. This did not meet the frequency described in best practice guidance (Positive and Proactive Care, DH, 2015)

All patient records we looked at showed people were admitted through the emergency department (ED) and were assessed using the National Early Warning System (NEWS). Each chart recorded the necessary observations such as pulse, temperature and respirations. Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the patient to be seen by medical staff or the critical care outreach team. Staff responded appropriately to the changing risks of people. Patients who triggered the NEWS were seen by a member of the patient at risk team (PARRT) who would physically assess the patient. The trust advised that most referrals from the medical wards came from the medical short stay unit (MSSU) and Walnut ward which was a respiratory ward.

Staff assessed patients in key safety areas such as falls, skin integrity, venous thromboembolism (VTE), sepsis and nutrition using national risk assessment tools. White boards were used at patient's bedsides to indicate for example if they were at risk of falls, if they were on a special diet or fluids, needed assistance with moving, or needed pressure ulcer care. This ensured all staff were aware of key risks for patients.

Staff told us comprehensive assessments were carried out on patients. For example, patients who were at risk with swallowing would be referred to speech and language therapists (SALT). Patients with wounds were referred to the tissue viability nurse. Patients were assessed using the malnutrition universal screening tool (MUST), and if required patients were referred to a dietitian. If patients came in with a skin tear or were at risk of a pressure ulcer they were given a pressure relieving mattresses and had turning charts.

The staff on the wards also used a risk assessment for guiding the level of enhanced supervision patients may need who were vulnerable due to falls, mental health, confusion and challenging behaviour or mental health. This was used to determine the skills level of the staff required to provided 1:1 supervision such as such as a health care assistant (HCA), nursing assistant or registered mental health nurse (RMN). Most wards also operated a bay tagging system which meant that a nurse was allocated to a bay and could not leave the bay unless another member of staff covered. This ensured that patient who were most vulnerable were not left unsupervised.

Handover meetings were scheduled on the wards each morning and evening. Staff had printed handover notes, which they updated during the handover. Different topics were also discussed as

part of these meeting to ensure key information was handed over, we saw these were documented in wards diaries or communication books.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people and to provide the right care and treatment.

The trust used a safer staffing tool to plan the numbers of staff needed on each ward in relation to the needs of the patients on each ward. If wards had concerns these would be escalated to the matron. The daily bed meetings allowed for staff to be moved to different wards to improve safe staffing levels.

Planned and actual staff numbers for nurses and health care assistants (HCAs) were displayed on wards. There were high vacancy rates on some wards. Vacant shifts were mainly covered by bank and agency staff. Staff told us the wards used bank and agency staff and there was a rolling recruitment programme for band 5 and band 6 nurses. A band 5 nurse is a staff nurse which is the initial grade of a qualified nurse and band 6 is a senior staff nurse. Staff told us the normal staffing ratios were 1:6 but as they were over stretched they were operating at 1:8 ratios. Staff were aware the senior leadership team had plans to recruit staff from abroad and locally.

Senior staff reported they currently had 88 band 5 vacancies across the medicine and urgent care (MUC) division. This had improved from a position of 112 vacancies early in the year. The MUC division had a staff retention quality improvement project team in place that met fortnightly. The project team were introducing staff rotations across the wards, and had provided water coolers and fruit baskets for staff as part of the ongoing staff retention strategy. We found registered nursing staff recruitment had been identified on the MUC divisional risk register.

The trust reported the following qualified nursing staff numbers in medicine from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	271.7	197.8	72.8%	274.4	188.9	68.8%

From April 2017 to March 2018, the trust reported a staffing level of 72.8% for qualified nursing staff in medicine. This had decreased to 68.8% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

From September 2017 to August 2018, the trust reported a vacancy rate of 27.6 % in medicine at Barnet Hospital. This was higher than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 16.7% in medicine at Barnet Hospital. This was higher than the trust target of 13%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 2.7% in medicine at Barnet Hospital. This was lower than the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 25% of nursing staff shifts in medicine at Barnet Hospital were filled by bank staff and 5% of shifts were filled by agency staff. In addition, 2% of shifts were over filled by bank and agency staff to cover staff absence.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
Senior staff reported there were no consultant vacancies in medicine, but there were vacancies in middle career, registrar and junior doctor grades on the care of the elderly wards, the speciality wards. This was added to the MUC divisional risk register in February 2018 when the junior doctor vacancy rate was approximately 30% within health services for elderly people (HSEP). Senior staff reported that they had looked at the minimum staffing levels required and manged to maintain this. Plans were in place to address the gaps which included the introduction of a new on call rota and the recruitment of physician's associates.

Seven day wards rounds were held on the short stay wards. Consultant cover was available for the specialities including weekends. Elderly care consultants worked across the care of the elderly wards at weekends and cardiologist were available 7 days per week. There was an on call consultants rota in place for out of hours.

Handover to the hospital at night team was every evening at 9.00pm which included medical staff and site practioners. Morning handovers were daily with representative from all the wards and the consultants on call. On Friday at 4.30pm patients were handed over to the weekend teams

Junior medical staff we met had no concerns about safety or clinical care and they felt consultants were approachable and they felt supported by their consultants. Teaching sessions for junior doctors included attendance at ward rounds, board rounds, and outlier's reviews, attendance at weekly training meeting, morbidity and mortality meeting, monthly junior doctor forums and grand rounds for the whole hospital. A grand round is an educational meeting for all medical and non-medical staff. It is a chance for different disciplines to meet to discuss important cases and recent advances in treatment.

Barnet Hospital undertook an audit of the junior doctor's workload and role of the hospital at night team. The audit found most jobs requested of doctors at night were appropriate, but only 2% of handovers at night had the hospital at night team present. The outcome was a hospital at night meeting was set up and improved handover arrangements. A re-audit showed there was improved attendance.

The trust has reported the following medical staff numbers in medicine from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	137.4	120.8	87.9%	140.7	115.3	82.0%

From April 2017 to March 2018, the trust reported a staffing level of 87.9% for medical staff in medicine. This had decreased to 82% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

From September 2017 to August 2018, the trust reported an vacancy rate of 12.2% in medicine at Barnet Hospital. This was similar the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 16.7% in medicine at Barnet Hospital. This was higher than the trust target of 13%.

(*Source: Routine Provider Information Request (RPIR) – Turnover tab)*

From September 2017 to August 2018, the trust reported a sickness rate of 0.4% in medicine at Barnet Hospital. This was lower than the trust target of 3.5%.

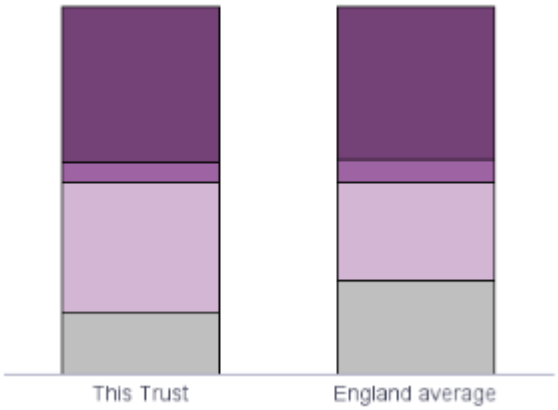
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 11% of medical shifts in medicine at Barnet Hospital were filled by bank staff and 2% of shifts were filled by locum staff. A total of 1063 hrs were not filled by bank or locum staff.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In July 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 442 whole time equivalent staff working in medicine at Royal Free London NHS Foundation Trust



	This Trust	England average
Consultant	42%	42%
Middle career^	6%	6%
Registrar group~	35%	27%
Junior*	17%	25%

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

(Source: NHS Digital - Workforce Statistics - Medical (July 2018))

Records

Staff kept records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The trust used paper and electronic patient's records (EPR) on the wards. The EPR had only recently been implemented in the hospital some staff described some teething problems with the system. For example, pharmacy was not automatically aware that a discharge summary is complete until the doctor tell them. At that point they can screen the discharge prescription and dispense the medicines. If doctors do not tell pharmacy, there are delays to the receipt of discharge medicines to the ward. Some staff also told us they had received limited training and were having difficulty accessing IT support. Senior staff acknowledged some staff still needed additional support but felt the system was settling in well.

The EPR could only be accessed by staff password so the system was protected. This meant that patient information and records were stored securely. All entries on the system records were dated timed and identified to the staff member using the doctors or nurses professional pin number who updated the records. The EPR was shared by doctors, nurses and other healthcare professionals. This meant that all professionals involved in a patient's care could access the records as required. Medical staff were also able to access results from investigations electronically.

During the implementation period the trust had identified what paper based records were to be continued for example, do not attempt cardiopulmonary resuscitation (DNRCPR) forms, and Deprivation of Liberty safeguards (DoLS) paper work. Staff stored patient records in lockable trolleys and were conscious about maintaining the privacy of patient information

We looked at eight records and found that assessments for VTE, pressure areas, nutrition, pain had been completed using national risk assessment tools. Sepsis bundles were in place where appropriate. The records also included evidence of the daily ward round review and completed care plans.

Staff also used EPR to record patients' observations which updated the NEWS. The electronic system allowed early warning scores to be automatically calculated within the EPR and push real time alerts for deteriorating patients with a known infection.

On the wards there were enough computers on trolleys were available for staff, this meant records could be updated immediately.

On the cardiac day unit (CDU) staff told us they were still using paper records whilst the wards were on EPR. They had access to patients EPR but the treatment pathways were not on the system yet they were not using it.

Medicines

Most aspects of medicines were managed safely. But some medicines were not stored in tamper evident boxes and staff did not always monitor ambient temperatures in medicine storage areas.

Medicines (including controlled drugs) were generally stored securely. Medicines and equipment for use in emergencies were readily accessible to staff and were checked regularly. On most wards emergency medicines were stored in tamper evident boxes. However, on the Cardiac Care Unit (CCU) we saw some diazepam injections for emergency use that were not stored in a tamper evident box. This meant that if any medicines were taken, staff would not necessarily be aware straight away. In addition, the medicines could have been accessed by unauthorised people as they were not locked away.

Whilst staff monitored fridge temperatures across the wards, no action was taken when the readings were out of range.

We saw controlled drugs (CD) were recorded but were not always handled appropriately with two nurses signing when controlled drugs were being administered. On Mulberry ward we noted there were three occasions when there was a discrepancy with only one staff member signing in the CD book. In the electronic patient records (EPR) we saw that CD's also were counter signed electronically. Staff told us they sign both the CD register and the EPR.

Pharmacy staff visited wards each day and conducted medicines reconciliation. (Medicines reconciliation is the process of ensuring that the list of medicines a person is taking is correct.) Staff could access medicines supplies and advice out of hours. Pharmacy had a satellite dispensary on MMSU so the staff could dispense medicines for the MSSU (and nearby wards) in a timely fashion. Pharmacists and pharmacy technicians counselled patients on their medicines.

We checked a selection of prescription charts and saw that information on patient demographics and allergy statuses were complete.

Incidents

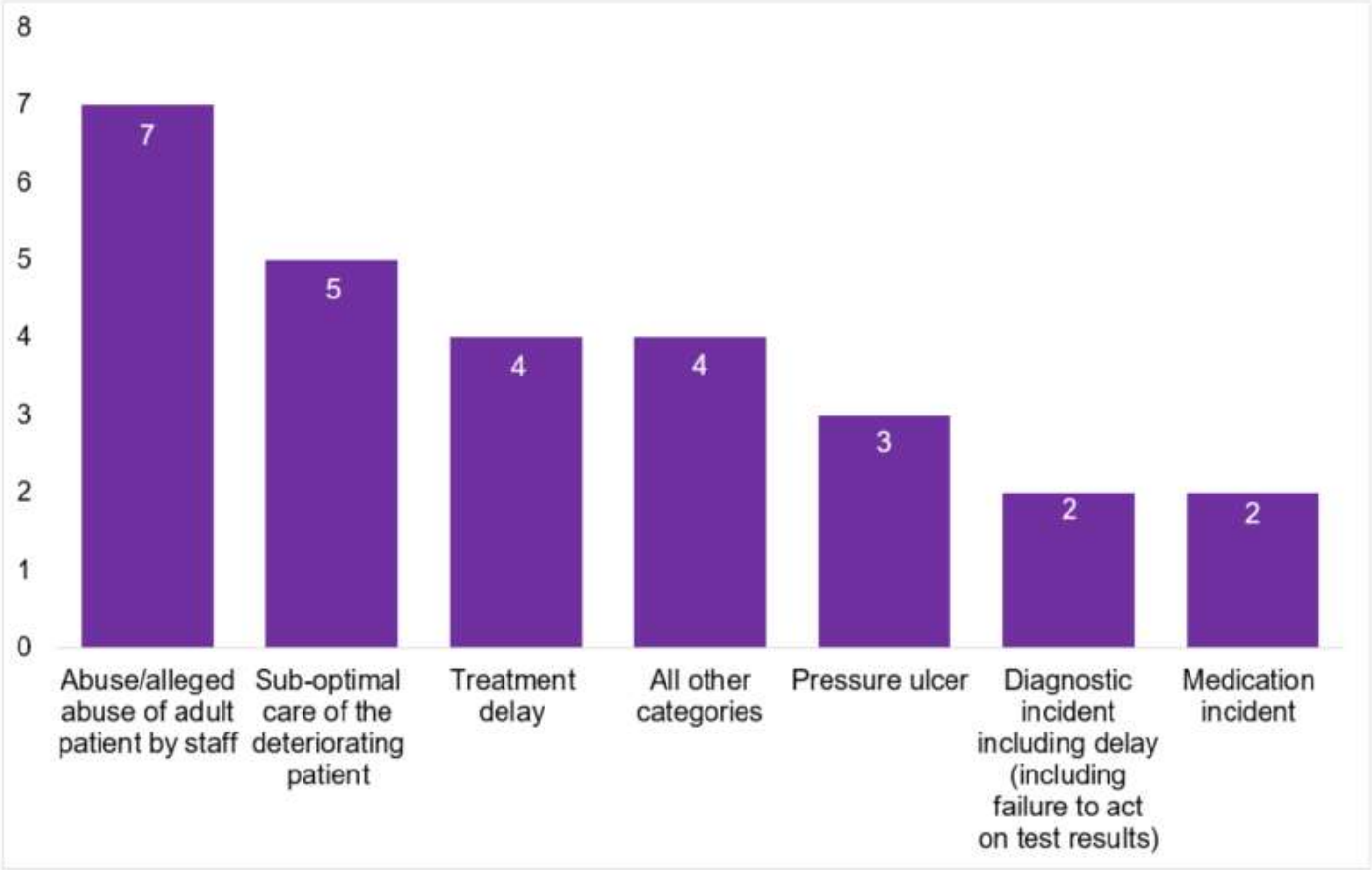
Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learned with the team and the wider service. When things went wrong, staff apologised.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The trust reported one incident classified as never event for medicine at Barnet Hospital for the period September 2017 to August 2018. This was for treatment delay meeting SI criteria (unintentional connection of a patient requiring oxygen to an air flowmeter).

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 27 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from September 2017 to August 2018.



Of these, the most common types of incident reported were:

- Abuse/alleged abuse of adult patient by staff with seven (25.9% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with five (18.5% of total incidents).
- Treatment delay meeting SI criteria with four (14.8% of total incidents).
- All other categories with four (14.8% of total incidents).
- Pressure ulcer meeting SI criteria with three (11.1% of total incidents).
- Medication incident meeting SI criteria with two (7.4% of total incidents).

During the period September 2017 to August 2018 Barnet Hospital reported 16 serious incidents.

(Source: Strategic Executive Information System (STEIS))

We reviewed three SI reports which detailed the involvement and support of patients or relatives under duty of candour. The investigations also identified the root causes, lessons learned, arrangements for shared learning and an action plan which detailed what actions the trust had taken to prevent reoccurrence.

From November 2014, NHS providers are required to comply with the duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of

candour is a regulatory duty relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were aware of their responsibility to apologise and be open and honest and share the information with the patient and their carer's.

The trust used an electronic incident reporting system widely used in the NHS to report incidents including near misses. Staff we spoke with were aware of how to report incidents and most incidents they reported related to falls, not recognising that a patient was at risk of falls, and community acquired pressure sores. Staff said they were encouraged to reported incidents and had individual feedback. Nursing staff told us learning from incidents was shared through safety huddles and during handovers. Nursing staff were also able to tell us about changes that had been implemented across the wards following a serious incident. For example, most staff we spoke with were aware of the never event. And measures that had been put in place to prevent a reoccurrence. We saw on the wards nursing staff carried out daily bay checks which included checking if the air flow meters had been removed or the air flow meter terminal plug was off. The nurse in charge also completed a checklist for the department. Medical staff told us that learning from incidents across the trust was circulated every three months from the incident reporting team via email and this was further emphasised at the weekly grand rounds.

We requested a breakdown of the incidents reported by the medical wards in the MUC division over the last 12 months recorded as no harm, minor harm, moderate harm, and major harm. But this information was not provided.

Learning from deaths mortality reviews reported on all deaths within the medical specialities Meetings were held monthly. Barnet Hospital's mortality review group met Monthly to review the learning from death reviews from across the hospital. Minutes detailed the learning from the reviews and highlighted areas of good practice.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The NHS Patient Safety Thermometer is a national tool used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering 'harm free' care. This information is intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide

All the wards we visited displayed safety thermometer results on their quality and safety boards. Wards displayed the number of falls and pressure ulcers in terms of the number of days of harm free care. Staff told us that information on patient safety is disseminated to staff at handovers, for example if a patient had a fall.

Safety thermometer scores for 'harm free' care across the trust for the period July 2017 to June 2018 varied between 89% in September 2017 and March 2018 to 97% in November 2017. There were three months (July 17, November 2017, February 2018) when the trust scored more than 95%. Ward level information was requested however trust level was provided.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Data from the patient safety thermometer showed that the trust reported 16 new pressure ulcers, seven falls with harm and 12 new urinary tract infections in patients with a catheter from September 2017 to September 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Royal Free London NHS Foundation Trust

Total Pressure ulcers (16) [1]

Total Falls (7) [2]

Total CUTIs (12) [3]

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Policies, procedures and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines. Policies, procedures and guidelines were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. Medical staff were also able to access the trust procedures and guidelines via an app on their phones.

Care pathways were based on national guidance for conditions such as sepsis, stroke and pressure ulcers. Patient assessments used by staff were based on national tools such as the Nutrition Screening Tool (NST) and the News Early Warning Scores (NEWS).

The Barnet Hospital's medicine and urgent care (MUC) divisional risk register highlighted the non-compliance or not following clinical guidelines NICE, National Service Framework (NSF) for Diabetes management of the Diabetic Foot. Actions identified the need to recruit 1.5 whole time

equivalent Band 7 podiatrists to provide inpatient and outpatient diabetes footcare. The risk had last been reviewed in July 2017. It was not clear from the risk register actions taken had minimised the risk as it the current risk level was high.

Barnet Hospital therapy quality improvement project “Keep me Mobile” was being rolled out across the care of the elderly wards. The aim of the project was to have 95% of suitable patients up and out of bed and having their lunch at the table by 12.30pm. Data showed that 92% of patients on Larch ward were sitting out by 2nd December 2018.

Barnet Hospital had an extensive audit programme and participated in a range of national and local audits, which included:

- The national lung cancer audit. The key success was identified as being above the national average for the first year of survival. The audit was on going.
- The national Chronic Obstructive Pulmonary Disease (COPD) audit, the key success was identified as being in the top quartile for the most recent reporting period. Compliance with the COPD care bundle being delivered on wards and onward referral into the community. The audit was on going.
- The national audit of dementia. The key success was identified as results from the audit placed Barnet Hospital within the top 5% in the country, however the trust needed to ensure the '8 things about me' were put in the patient notes. The audit was on going.
- Local audits for preventing inappropriate urinary catheters. The key success was identified as training which had improved the documentation of the indication for catheter insertion in the clinical record. However, the audit also found there needed to be an improvement in the percentage patients having their catheter reviewed at day two. Key actions from the audit identified further training and audit.
- Local audits looking at the appropriateness of IV fluids. Most patients had intravascular fluid volume status assessed before commencement and documented, however, the audit found documentation needed to be improved to conform to trust guidelines. Key action from the audit were to present the finding to the health services for elderly people (HSEP) clinical governance meeting June 2018.

We requested information on the Barnet Hospital performance on sepsis management. The trust advised the hospital did not collect any sepsis data.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Patients had access to dietician and speech and language therapy (SALT) services. SALTs worked closely with nursing and medical staff in assessing and supporting patients with eating, drinking and swallowing needs.

On the wards nutrition boards by patient bedsides and on the door of side rooms indicated whether patients were on normal or required support or assistance with eating. Swallowing guidance was included on the nutritional boards and indicated whether patients were on special diets such puree, soft, or had thickened fluids had red trays. We also saw this information was held in patients notes.

Drinks were left within reach and patients were given assistance to drink if required.

We saw that most wards had protected meal times from 1.00pm to 2.00pm and 6.00pm to 7.00pm with a maximum of two visitors.

Patients been seen by the TREAT (triage and rapid elderly assessment) service had access to hot drinks and sandwiches if patients had to wait a long time. On the cardiac day unit (CDU) we observed a patient being given a hot drink and sandwiches following their procedure.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Patients were prescribed pain relief to be given 'when required' and could request this when they needed it. Patient medicines were provided in line with the patients' prescriptions.

Patients we spoke with told us they were asked about their pain and were given pain relief if required. Patient notes recorded whether patients had been asked about pain. With the introduction of the electronic patient record (EPR) patients pain was assessed as part of the wards four hourly patient rounding. Patient rounding's are a structured means of promoting patient centred care which focuses upon patients pain, positioning and personal care needs.

Staff told us with the introduction of the EPR they did not have access to pain tools for patients who were non- verbal as this option was not available on the system.

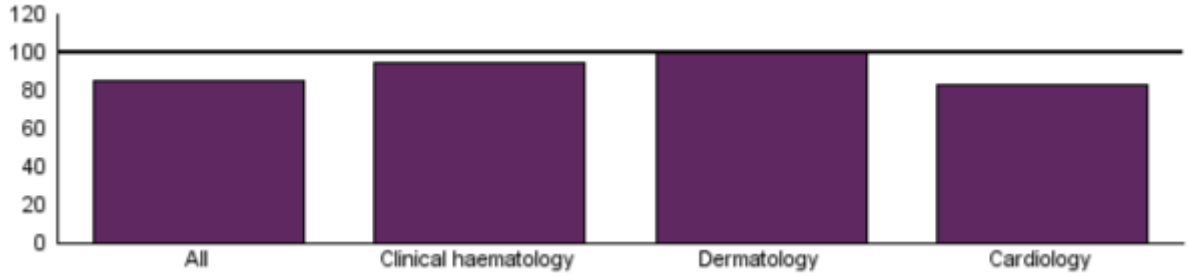
Staff told us they had access to a specialist pain team who they could refer patients too. The team was available during the week however staff found it difficult to access the service at weekends.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

From June 2017 to May 2018, patients at Barnet Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in dermatology had a similar to expected risk of readmission for elective admissions
- Patients in cardiology had a lower than expected risk of readmission for elective admissions



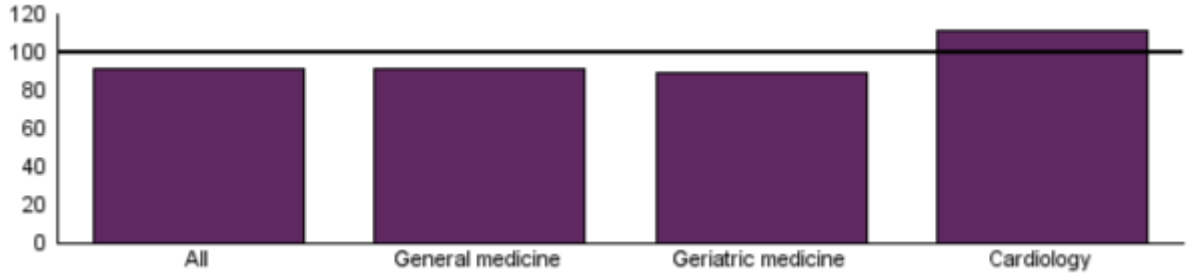
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count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

During the inspection the leadership team for medicine at Barnet Hospital advised that clinical haematology, dermatology and cardiology were managed by the Royal Free Hospital

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective

admissions

- Patients in cardiology had a higher than expected risk of readmission for non-elective admissions



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

(Source: Hospital Episode Statistics - HES - Readmissions (June 2017 – May 2018))

Barnet Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A grade in latest audit, December 2017 to March 2018.

Barnet Hospital is a non-routine patient centred unit which means that is a team which does not generally admit stroke patients directly but continue to provide care in an acute setting when patients have been transferred from place of initial treatment.

Overall Scores	Dec 16 - Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18
SSNAP level	B↓	C↓	A↑↑	A
Case ascertainment band	A	A	A	A
Audit compliance band	B↓	B	A↑	A
Combined total key indicator level	B↓	B	A↑	A

Non-routine patient centred performance	Dec 16 - Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18
Domain 1: Scanning	D↓↓↓	E↓	A↑↑↑↑	C↓↓
Domain 2: Stroke unit	E↓↓	E	C↑↑	E↓↓
Domain 3: Thrombolysis	D↓↓↓	C↑	A↑↑	A
Domain 4: Specialist assessments	E↓↓↓	E	B↑↑↑	D↓↓
Domain 5: Occupational therapy	A	A	A	A
Domain 6: Physiotherapy	A	A	A	A
Domain 7: Speech and language therapy	B↓	B	A↑	A
Domain 8: Multi-disciplinary team working	D	E↓	B↑↑↑	D↓↓
Domain 9: Standards by discharge	A	B↓	B	B
Domain 10: Discharge processes	A	A	A	B↓
Patient-centred total key indicator level	C↓↓	C	A↑↑	B↓

- Domain 1: Scanning has seen a decline from grade A to grade C in the latest audit for non-routine patient centred performance.

- Domain 2: Stroke unit has seen a decline from grade C to grade E in the latest audit for non-routine patient centred performance.
- Domain 4: Specialist assessments has seen a decline from grade B to grade D in the latest audit for non-routine patient centred performance.
- Domain 8: Multi-disciplinary team working has seen a decline in performance from grade B to grade D in the latest audit for non-routine patient centred performance.
- Domain 10: Discharge processes has seen a decline from grade A to grade B in the latest audit for non-routine patient centred performance.
- Patient and team centred total key indicator level has seen a decline from grade A to grade B in the latest audit for non-routine patient centred performance.

Non-routine team centred performance	Dec 16 - Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18
Domain 1: Scanning	**NA**	**NA**	**NA**	**NA**
Domain 2: Stroke unit	**C↓**	**D↓**	**A↑↑↑**	**B↓**
Domain 3: Thrombolysis	**NA**	**NA**	**NA**	**NA**
Domain 4: Specialist assessments	**NA**	**NA**	**NA**	**NA**
Domain 5: Occupational therapy	**A**	**A**	**A**	**A**
Domain 6: Physiotherapy	**A**	**A**	**A**	**A**
Domain 7: Speech and language therapy	**C↓**	**C**	**A↑↑**	**B↓**
Domain 8: Multi-disciplinary team working	**NA**	**NA**	**NA**	**NA**
Domain 9: Standards by discharge	**B↓**	**B**	**B**	**A↑**
Domain 10: Discharge processes	**A**	**A**	**A**	**NA**
Team-centred total key indicator level	**A**	**B↓**	**A↑**	**A**

- Domain 2: Stroke unit has seen a decline from grade A to grade B in the latest audit for non-routine team centred performance.
- Domain 7: Speech and language therapy has seen a decline from grade A to grade B in the latest audit for non-routine team centred performance.
- Domain 9: Standards by discharge has seen an improvement from grade B to grade A in the latest audit for non-routine team centred performance.

(Source: Royal College of Physicians London, SSNAP audit)

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 82.4%, which did not meet the audit minimum standard of 90%. The 2016 figure was 34.4%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 18.2%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 78.3%, which represents good practice compared to other hospitals. The 2016 figure was not significantly different to the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 82.9%, which represents good practice compared to other hospitals. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 was 43.1%, which represents good practice compared to other hospitals. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

Royal Free Hospital participated in the 2017 National Audit of Inpatient Falls and the crude proportion of patients who had a vision assessment (if applicable) was 42.4%. This did not meet the national aspirational standard of 100% and was worse compared to other hospitals.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 15.4%. This did not meet the national aspirational standard of 100% and was worse compared to other hospitals.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 17.6%. This did not meet the national aspirational standard of 100% and was worse compared to other hospitals.

The crude proportion of patients with a call bell in reach (if applicable) was 56.7%. This did not meet the national aspirational standard of 100%. Compared to other hospitals the trust performed similar, in this context 'similar' means that the result was between 50% and 79%.

(Source: Royal College of Physicians)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Most of the staff told us they had annual appraisals and had access to training. On medical wards some staff had opportunities for further development.

Agency nurses and bank staff were often used, with 30% of shift between September 2017 to August 2018 covered by bank (25%) and agency staff (5%). The trust had a local induction check list which agency and bank staff would need to complete and have signed off prior to commencing duties when working on a new ward.

Staff had access to a range of specialist nurses to provide advice and guidance on the care of specific groups of patients, such as those with diabetes and tissue viability issues. There were also lead specialist nurses for safeguarding, learning disabilities and dementia.

Wards had identified link nurses to lead on different initiatives on the wards these included for example, nutrition, slips, trips and falls, and infection control. The link nurses would access additional support to develop their skills and knowledge in these areas and they would be responsible for supporting other nurses in these areas.

Junior doctors we spoke with reported the hospital provided good teaching and regular learning opportunities and were given time for training. They also felt they had good support from consultants who also provided clinical supervision. Doctors were encouraged to attend weekly training sessions which looked at clinical cases, mortality and morbidity meetings and they participated on the 'Grand Rounds.

For the period April to September 2018, 70.7% of nursing staff and 87.5% medical staff at Barnet Hospital had an appraisal. This was lower than the trust target of 85%. Appraisals were on a rolling programme with the expectation that all staff would have an appraisal at least once a year.

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/ No
Healthcare Scientists	1	1	85%	100%	Yes
Medical and Dental	48	42	85%	87.5%	Yes
Healthcare Assistants	91	73	85%	80.2%	No
Administrative and Clerical	18	13	85%	72.2%	No
Nursing Registered	167	118	85%	70.7%	No
Allied Health Professionals	60	33	85%	55.0%	No
Additional Clinical Services	11	3	85%	27.3%	No
Add Prof Scientific and Technic	1	0	85%	0.0%	No
Total	**397**	**283**	**85%**	**71.3%**	**No**

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

There was effective multidisciplinary team (MDT) working in the ward areas. Relevant professionals were involved in the assessment, planning and delivery of patient care.

Consultant led multidisciplinary board rounds were held on a daily basis Monday to Friday on the wards and seven day ward round were in place on the medical short stay unit (MSSU) and the acute assessment unit. (AAU). Patients care and treatment were reviewed with actions being taken being taken to progress care.

We observed that multidisciplinary (MDT) working was evident on medical wards; physiotherapists and occupational therapists were part of ward rounds. There was evidence of an MDT approach to discharge planning.

Ward and specialist medical teams had access to the full range of allied health professionals such as speech and language therapists, dietitians, dementia specialist, tissue viability, and diabetic nurses. Patient flow coordinators were also on the wards to facilitate social care packages for patients on discharge.

Records we looked at confirmed involvement from health professionals of different disciplines where appropriate. For example, patient records showed the involvement of occupational therapists, speech and language therapists (SALT), physiotherapists and dieticians as well as appropriate referrals to specialist nurses or teams.

There was pharmacist support on the wards and they provided information to patients on their medications and medication usage.

The wards had access to psychiatric liaison services, staff could refer patients for psychiatric assessment where there were concerns.

Seven-day services

Patients had access to medical consultants who provided cover seven days a week across the medical wards.

Geriatricians and cardiologists provided seven day consultant cover to the care of the elderly wards and cardiology wards. The MSSU, AAU and TREAT had dedicated consultant cover seven days per week with daily ward rounds wards rounds on the short stay units. At other times there was a consultant on call who could be contacted for advice or attend the hospital in an emergency.

Diagnostic services including imaging, and laboratory facilities were available seven day a week.

Physiotherapists, occupational therapists were available seven days per week to support the MSSU, AAU, TREAT and some medical wards. The speech and language therapy service and dieticians provided a weekday only service.

Pharmacy services were available 24/7 at Barnet Hospital. The inpatient pharmacy was open from 9.00am to 6.15pm for supply of medications to patients in the trust. Ward pharmacy services were available from 9.00am to 5.30pm Monday to Friday. At weekends pharmacy services were available from 10.00 am to 5.00pm. Outside these hours there is a pharmacy on call service.

Health promotion

The medical wards displayed health promotion information relating to the specific conditions the ward specialised on. For example, on the stroke ward (Spruce) there were several leaflets about stroke, and patients were also given a patients' handbook. There was also a weekly outreach group run by therapists for patients and relatives on how to prevent stroke, signposted patients and relatives to other stroke support groups and advised on benefits they are entitled too.

The TREAT service reviewed older patients concurrent use of multiple medications and reviewed the medicines that patients had been taking for long periods. They would also refer patients to exercise classes to help prevent falls which were ran on the hospital site and in community. Patients were also referred to the classes by physio therapists. The service also provided information about smoking cessation and patient's diets, specifically how patients should be eating foods of higher calorific value as older people usually lost weight.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, but compliance for safeguarding training for medical staff was below the trust target of 85%.

The trust was not following the Department of Health guidance 'Positive and Proactive Care' (2014) and did not demonstrate that the use of mechanical restraint was exceptional, that other options had been attempted, or that it was reviewed rigorously (including by an independent clinician and that the board were sighted on it). The trust policy on restraint was out of date and did not follow current best practice guidance.

When a decision had been made that a patient required mittens, so that their treatment could continue, staff undertook a mental capacity assessment. However, when mittens were used, staff automatically made an application for the Deprivation of Liberty Safeguards (DoLS) to apply to the patient. The use of mittens, in itself, did not change the status of the patient sufficiently to warrant a DoLS application. Staff did not apply the legal test when considering if a DoLS application should be made.

The trust restraint policy, which was under review at the time of inspection, indicated it would be usual to make a DoLS application when using any kind of restraint. The updated trust DoLS policy correctly stated that the patients' status should be reviewed when using mittens. Deprivation of Liberty safeguards (DoLS) applications were authorised by the local authority. This was similar to what we found at the last inspection.

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training and deprivation of liberty (DOLS) training. The trust reported that from April 2018 to August 2018 the training rates for the medicine department at Barnet Hospital was 90.6% for nursing staff and 48.7% for medical staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff were aware of the trusts policies regarding consent, mental capacity act and deprivation of liberty safeguards and had access to them through the intranet.

Staff told us they always asked a patient before they provided any care, where patients had capacity they would seek verbal consent. Nursing staff told us if an elderly patient was undergoing a procedure they would undertake additional checks and ensure that their family was involved. Doctors would consent patients who were undergoing procedures.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

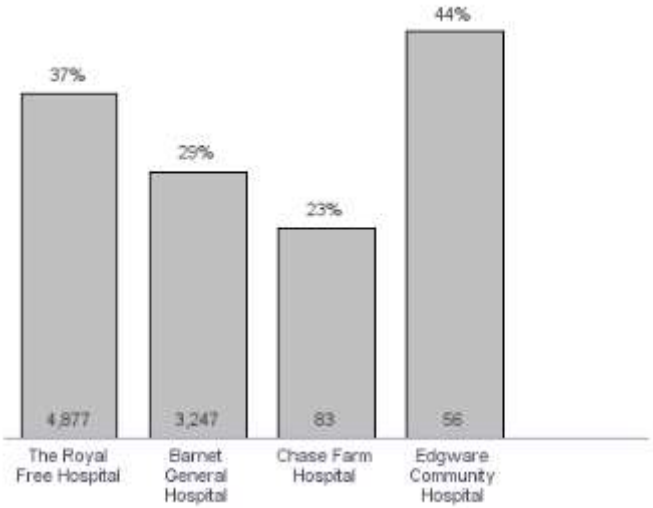
Staff were seen to be considerate and empathetic towards patients. Most of the patients we spoke with were positive about the staff who provided their care and treatment. They told us the nurses were kind, caring and listened to their concerns.

We spoke with nine patients and relatives, they were mostly positive about the care they received. A patient told us their dignity and privacy was respected, staff drew the curtains when assisting with personnel care or were giving injections. On one ward we observed that staff drew the curtains of all the patients in the bay when a patient died to maintain the deceased patient's dignity and not to worry the other patients in the bay. Patients commented, "The care has been good", "The nurses respond quickly", The nurses are kind", and "Everyone was kind". However, one patient told us the "The care is not as nice as it used to be".

On some medical wards, we observed thank you cards from patients, relatives and carers which had been displayed on the walls. There were messages thanking staff for their caring and kindness.

The Friends and Family Test response rate for medicine at the trust was 33% which was better than the England average of 25% from September 2017 to August 2018.

Friends and family Test – Response rate from September 2017 to August 2018 by site



A breakdown by ward is below:

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	
BH-CDU	791	33%	85%	89%	83%	82%	87%	86%	82%	92%	88%	91%	96%	89%	87%
BH-MSSU	739	26%	81%	92%	82%	87%	78%	83%	73%	90%	83%	91%	90%	86%	86%
10 SOUTH A	692	47%	96%	92%	93%	85%	89%	82%	77%	86%	94%	88%	88%	75%	88%
10 WEST	651	44%	100%	95%	90%	98%	98%	90%	93%	98%	97%	98%	94%	88%	95%
8 NORTH	605	35%	89%	86%	85%	91%	84%	90%	83%	87%	77%	95%	86%	83%	86%
9 NORTH	564	47%	88%	87%	91%	85%	94%	86%	88%	90%	90%	91%	87%	80%	88%
11 EAST	467	44%	98%	97%	91%	93%	97%	91%	92%	98%	98%	100%	91%	95%	95%
BH-ROWAN	340	38%	94%	84%	100%	92%	97%	96%	78%	85%	96%	83%	94%	89%	91%
11 WEST	339	35%	97%	95%	94%	85%	96%	88%	86%	93%	96%	90%	89%	100%	93%
10 EAST	325	33%	78%	93%	88%	72%	89%	85%	90%	89%	88%	90%	78%	83%	86%
8 EAST	319	34%	93%	96%	97%	91%	96%	87%	93%	87%	88%	87%	81%	95%	91%
BH-WALNUT	319	35%	68%	100%	87%	91%	85%	91%	84%	83%	82%	94%	96%	85%	87%
10 NORTH	243	24%	86%	100%	100%	62%	82%	89%	100%	80%	78%	87%	84%	93%	88%
8 WEST	236	23%	71%	90%	82%	86%	79%	72%	89%	91%	89%	85%	96%	69%	84%
BH-CCU	235	52%	88%	100%	95%	93%	94%	100%	100%	95%	100%	100%	100%	94%	97%
BH-	226	31%	91%	82%	91%	88%	91%	73%	67%	89%	86%	85%	75%	77%	84%
6 SOUTH	220	31%	90%	92%	94%	89%	82%	94%	86%	58%	93%	90%	88%	88%	88%
BH-OLIVE	184	26%	94%	94%	88%	92%	100%	94%	100%	92%	87%	100%	88%	78%	92%
6 EAST	184	27%	100%	100%	100%		80%	90%	81%	86%	96%				82%
11 SOUTH	128	44%	87%	87%	96%	88%	91%								90%
BH-JUNIPER	118	20%	86%	79%	100%	100%	58%	78%	87%	56%	88%	77%	100%		81%

Highest score to lowest score

Key 100% 50% 0%

[1] The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).

[2] Sorted by total response.

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

Note: sorted by total response

Between September 2017 and August 2018 at Barnet Hospital the coronary care unit (CCU) had the highest response rate with 52% and Juniper ward had the lowest response rates with 20%. *(Source: NHS England Friends and Family Test)*

Emotional support

Staff provided emotional support to patients to minimise their distress.

We saw staff providing emotional support to patients and relatives. Patient's individual concerns were identified and responded to in a positive and reassuring way. For example, a patient rang the ward looking for advice and reassurance regarding their dressing, the nurse suggested what the person should do whilst being supportive. One patient we spoke with told us they were awake

during their procedure and staff kept them informed of what was happening and this made them feel relaxed.

Chaplaincy services were available to patients who needed them. The chaplaincy was multi-faith and provided support 24 hours per day. Staff were aware of how to contact the chaplaincy to meet the spiritual and religious needs of patients and their families.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Most patients we spoke with said they felt involved in their care. One patient told us that medical staff explained the risks linked to their procedure and explained what it involved. A relative told us that the they were regularly speaking with the doctors and were waiting for a meeting to discuss their loved ones ongoing care. They told us “The communication from doctors was fantastic”.

Most patients knew the name of their consultant and who was in charge of their care.

Most of the wards had visiting hours which meant relatives could visit their loved ones from 2.00pm until 8.00pm daily.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Senior staff told us the acute medical service mostly cared for elderly patients. Four (36%) of the eleven medical wards were designated for care of the elderly. Consultant geriatricians worked across all the medical wards working alongside specialist consultants, 50% of consultants working on the medical wards were geriatricians to ensure that medical staff had the right skills to treat the elderly population.

Acute medical services were planned to avoid long hospital admissions. The TREAT (triage and rapid elderly assessment) service was operated seven days per week from 9.00am to 5.00pm for patients over 80 years of age with co-morbidities and frail who were mobile. The aim of the service was to provide a responsive service to avoid admission so patients could return home. The service could request such as X rays, CT scans, and ultrasound and get the results the same day or day after. Staff told us that from January 2019 there were plans to bring the TREAT, the acute assessment unit (AAU) and the ambulatory care unit together in one location.

The acute assessment unit (AAU) admitted patients for up to 12 hours, but due to bed capacity patients stayed longer. Staff told us this could be up to six or seven days for some patients. The trust had plans in place to open an additional four bays to help with patients’ flow.

The medical short stay unit (MSSU) admitted for between 24 - 72 hours. The wards held daily multidisciplinary team meetings to review patient’s treatment plans and arrange care packages and worked closely with the community based post acute care team (PACE) who monitored patient at home for up to five days.

Longer stay patients were accommodated on the wards. All the wards we visited had large signage with pictures and text for toilets and bathrooms.

On care of the elderly wards staff used ‘forget me not’ stickers on patient bed boards to indicate if a patient was confused or living with dementia. This helped improve care by making sure patients got the attention and support they needed. Staff also used the ‘This is me’ document which is a document intended to provide professionals with information about the person with dementia or confusion to enhance the care and support given while the person is in an unfamiliar

Patient passports were in place for patients with a learning disability. Staff told us that the liaison learning disability nurse would make sure that patient passports were in place.

Meeting people's individual needs

The service took account of patients' individual needs.
Although we found that call bells are not always within reach of all patients, there were processes in place to ensure patients could gain staff attention and that patients who were most vulnerable were not left unsupervised.

The trust provided three audits which demonstrated three wards were auditing call bells. Staff carried out patient rounding to ensure if a patient had misplaced their bell they can quickly gain the attention of a member of staff to help them resolve actual/potential issues. Most wards also operated a bay tagging system which meant that a nurse was allocated to a bay and could not leave the bay unless another member of staff covered. This ensured that patient who were most vulnerable were not left unsupervised.

On the care of the elderly books and games were available. The wards also offered a programme of activities which included arts and crafts, patients were encouraged to be dressed and out of bed as part of the elderly care wards keep me mobile campaign to encourage staff to assist patients out of bed to maintain mobility.

The trust advised 73% of nursing staff across the medical wards and services had completed dementia training. Health care assistants (HCA) had been trained as 'specials' to support patients who had complex needs and required 1:1 support. Nursing staff also had access to specific training on frailty, deconditioning and frailty assessment which commenced in 2018. On one ward we observed a bank HCA had been allocated to support a patient 1-2-1 with dementia and at risk of falls. The HCA was supporting the patient whilst walking and speaking in a friendly manner. They told us they did not have any specific training on dementia.

Staff were able to refer patients to the mental health liaison service. During the period April 2018 to October 2018 a total of 499 patients were seen on the acute assessment unit and wards

In the national audit of dementia round 3 2016 / 2017 52% of patients over the age of 75 admitted as emergency inpatients had an initial screening for delirium, and 90% had a clinical assessment for delirium.

A variety of meals were available for patients to choose. There were allergy aware menus and menus with healthier choice, higher energy, vegetarian, gluten free, softer / easy chew and finger food. Staff told us that if a patient was not eating they would contact their relatives or carers to see to find out what their food preferences were.

Staff told us they could access interpreters, but they would see if anyone in the team could speak the patient's language. Translation services were provided via a telephone interpreter and by face-to-face interpreters. Staff were familiar with the process for booking an interpreter and they could access documents in different languages and large print documents when required. We requested information on the number of times translation services has been used on the wards in the last 6 months, this information was not available.

The care of the elderly wards came together regularly to attend 'Josie's Café' that was ran with the support of staff and volunteers. Patients and their relatives were supported by ward staff to attend the afternoon social get together with music, tea and cake.

The trust advised there had been no mixed sex breaches on the wards in the last 12 months.

The electronic patient record (EPR) flagged patients with a learning disability.

Visiting times on most wards were from 2.00pm and 8.00pm.

Access and flow

People could access the service when they needed it, but there were a high number of patient moves at night which meant the trust was not focussed on getting patients a bed on a ward for their speciality. There was also a high number of patients being discharged at night which did not reflect best practice.

There was not enough bed capacity within the hospital to manage medical patients in the right ward. At Barnet Hospital for the period November 2017 to October 2018 at total of 5,341 patients moved wards. The largest number of moves were on the general medicine wards with 60% (3,229) of patients being moved, on the care of the elderly wars 21.5% (1152) of patients were moved and on the cardiology ward 13% (704) were moved. The trust did not provide details of the number of times patients were moved between wards.

The number of patients moving wards across the trust per admission was 23,545. The trust did not provide a date range for the below data.

Patient moves	Number of patients	% share of all patients
1	18,452	67%
2	7,524	28%
3	1,045	5%
4+	273	1%
Total	**23,545**	**100%**

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

A total of 1,161 patients were moved at night between 10.00pm and 8.00am between November 2017 and October 2018. This meant the trust was not focussed on getting patients a bed on a ward for their speciality. The largest number of moves were from general medical wards (719), the care of the elderly wards (221) and cardiology (135). The trust did not provided information which wards patients were being moved from. Following the inspection, the trust provided additional information showed of the 1161 moves at night, of these 358 were supporting a clinical pathway, 504 were admissions from the initial assessment areas which supports flow through the hospital and the remaining 299 moves include patients moved between beds within a ward.

The trust acknowledged that moving patients at night was not ideal. The data provided showed that 25% of the patients moved at night were not moved for a clinical reason or to support an admission pathway.

A total of 1,595 patients were discharged at night between 8.00pm and 8.00am between November 2017 and October 2018 from Barnet Hospital. The highest number of discharges in October 2018 (156), January 2018 (152) and November 2017 (147). The trust did not provided information on which wards patients were discharged from. Following the inspection, the trust provided additional information which showed of the 1519 patients discharged between 8 pm and 8 am, of these 663 were discharged from an assessment area which would be the expected care pathway, 430 were patients that died, 18 patients self-discharged and 514 were discharged out of hours. The trust advised that they do not advocate out of hours discharges as a standard. The data provided showed 33.8% of patients discharged out of hours were not appropriate.

The trust had a managing escalation capacity at Barnet Hospital policy. The aim of the policy was to ensure that, ‘in the interests of patient safety and well-being, specific beds in designated areas

are bought into being only when capacity in the Emergency Department is breached, there are potential 12 hour trolley waits coming up and risks to patient safety are unable to be resolved through any other avenue (treat and transfer etc.)'.

We observed one site meetings which was chaired by the clinical operation manager, in attendance was the director of operations, senior clinical staff including, matrons and ward managers from wards and areas across the hospital. Staff were updated on the hospitals current bed position, there had been 371 attendances at the hospital's emergency department (ED) in the previous 24 hours with 55 admissions and 19 patients who had not been placed in hospital beds. Across the wards the number of patient expected to be discharged during the day were recorded. Following the meeting the ward managers discussed which patients should go onto which wards, where patients had been identified to be discharged, wards would take the patients waiting for the beds so that they could be moved from the ED to assist with the patient flow across the hospital. Staff we spoke with on the wards told us they would frequently have an additional patient on the ward waiting for a bed.

Flow coordinators worked across the wards and worked in partnership with ward sister to oversee patients discharge plans.

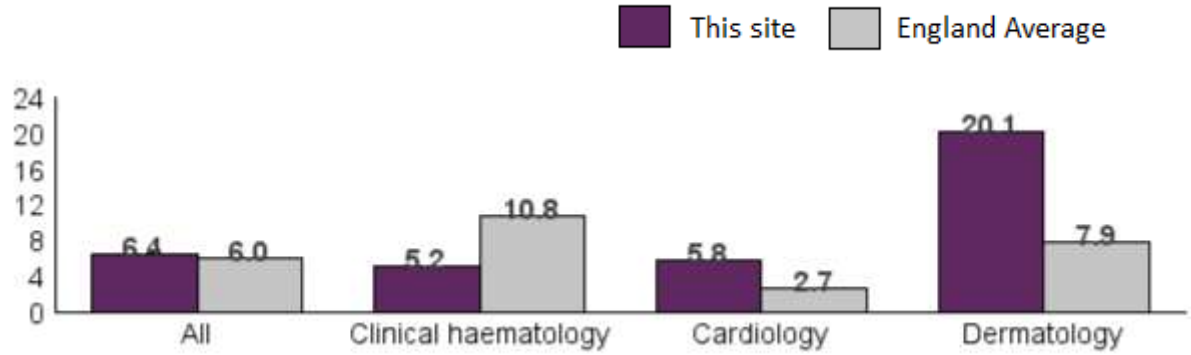
Senior staff reported the relationship with social services (SS) had improved. Barnet Hospital held multi agency discharge events (MADE) which included the Clinical Commissioning Group (CCG) and SS to look at long term patients who were waiting to be discharged but the hospital was having difficulty in accessing placements for in the community.

Medical outliers were treated on surgical wards, to ensure that patients were seen by a medical consultant each ward was linked to a medical ward so staff would know who to contact if they had a medical outlier. At bed meeting the operations team had a list of all outliers and they would visit the wards to ensure patients had been seen by the medical team. We requested information on the number of medical outliers on non-medical wards in the last six months but this was not provided. However, the hospital did advise on the 7th December there were 28 medical outliers.

The hospital had a discharge lounge. The lounge was mostly used by the care of the elderly and medical wards. The lounge opened from 9.00am to 8.00pm Monday to Friday and had capacity for 17 patients. We observed on the last day of the inspection three patients had been transferred to the discharge lounge by 10.30am. The discharge lounge target was to have 20 patients discharged through the lounge each day. The week before the inspection 81 patients had used the lounge which was less than the weekly target of 100 patients.

At Barnet Hospital for the period July 2017 to June 2018 the average length of stay for medical elective patients was 6.4 days, which is similar to the England average of 6.0 days. For medical non-elective patients, the average length of stay was 7.7 days, which is higher than the England average of 6.3 days.

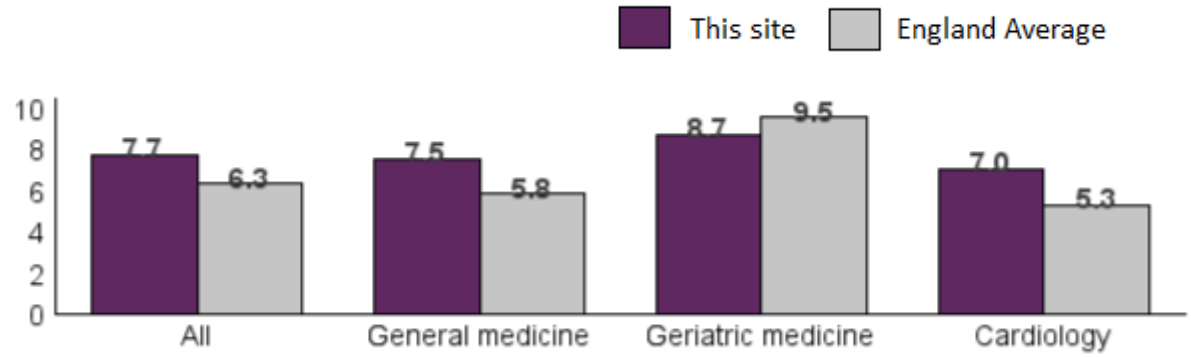
- Average length of stay for elective patients in clinical haematology is lower than the England average.
- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in dermatology is higher than the England average.



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

Non-Elective Average Length of Stay - Barnet General Hospital

- Average length of stay for non-elective patients in general medicine at Barnet Hospital is higher than the England average.
- Average length of stay for non-elective patients in geriatric medicine at Barnet Hospital is lower than the England average.
- Average length of stay for non-elective patients in cardiology at Barnet Hospital is higher than the England average.

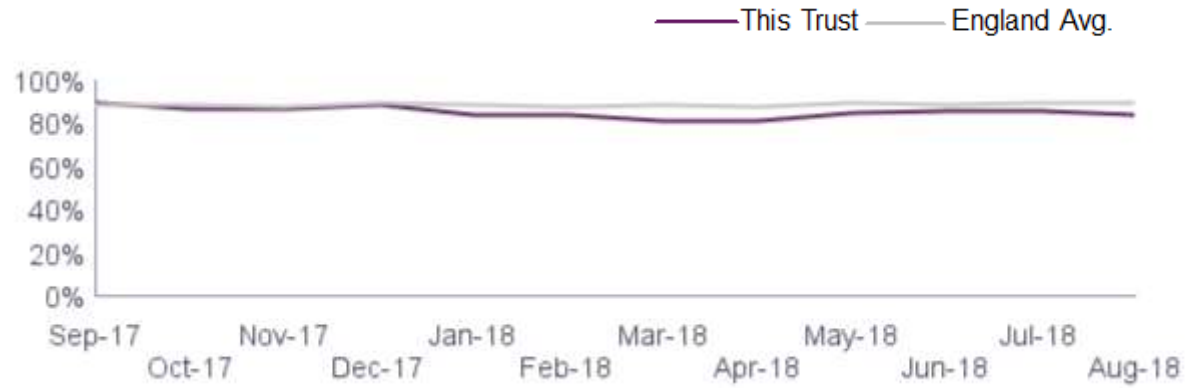


Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

During the inspection the leadership team for medicine at Barnet Hospital advised that clinical haematology, dermatology and cardiology were managed by the Royal Free Hospital.

From September 2017 to December 2017 the trust's referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average. However, from January 2018 to August 2018, performance was slightly worse. In the latest period, August 2018, the RTT rate was 84.2% compared to the England average of 90.0%.



(Source: NHS England)

Five specialties were above the England average for admitted referral to treatment (RTT) (percentage within 18 weeks) at Barnet Hospital.

Specialty grouping	Result	England average
Geriatric medicine	100%	97.0%
Thoracic medicine	98.8%	93.0%
General medicine	98.0%	96.4%
Neurology	97.1%	91.1%
Dermatology	82.9%	82.2%

Three specialities were below the England average for admitted RTT (percentage within 18 weeks) at Barnet Hospital.

Specialty grouping	Result	England average
Gastroenterology	91.3%	93.7%
Rheumatology	88.0%	94.5%
Cardiology	77.7%	82.1%

(Source: NHS England)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The trust had complaints policies and procedures in place. Information on the trust's complaints policy and procedures was available on the trust's internet website.

Information leaflets were available on the wards about the Patient Advice and Liaison Service (PALS).

Most staff were aware of the trust's complaints policy and of their responsibilities within the complaints process. Staff told us if patients complained they would try to resolve it at the time or direct them to PALS. Formal complaints were directed to the trust's complaints department.

On most wards we saw that cards were on display, thanking staff for their care and support whilst they had been an inpatient.

From September 2017 to August 2018 there were 140 complaints about medical care at Barnet Hospital. The trust took an average of 30.4 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 35 working days.

The most prevalent types of complaints across the trust were those relating to all aspects of clinical treatment (183, 45.9%), appointments, delay / cancellation (out-patient) (65, 16.3%) and communication / information to patients (written and oral) (57, 14.3%).

A breakdown of complaints by site is below:

Site/location	Number of complaints	Proportion of total complaints
Royal Free Hospital	209	52.4%
Barnet Hospital	**140**	**35.1%**
Chase Farm Hospital	39	9.8%
Edgware Hospital	3	0.8%
Mary Rankin Dialysis Unit	3	0.8%
Royal Free London Community Service	3	0.8%
Finchley Memorial Hospital	2	0.5%
Total	399	100%

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

From September 2017 to August 2018 there were 105 compliments made to the Barnet Hospital within medicine.
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in medicine and urgent care division had the right skills and abilities to run a service providing sustainable care.
There was a clear leadership structure. The medicine and urgent care (MUC) division was responsible for all the medical services across the hospital and the emergency department (ED). The division was led by the divisional director, divisional director of operations (the post was being covered by an interim at the time of the inspection), and the divisional director of nursing. At a local level they were supported by three clinical directors. One post holder was responsible for general medicine, acute and health services for elderly people (HSEP) stroke. The clinical director post responsible for gastroenterology, respiratory, general medicine and rheumatology was vacant and the clinical director for the emergency department. There were two senior matron posts, one responsible for general medicine and stroke, the other responsible for HSEP.

Ward managers were supported by matrons who worked across wards. Nursing staff told us the divisional nurse director and matrons were visible and they felt supported by their ward managers.

Staff were positive about the local leadership across the wards. Staff told us they felt supported by their line-manger to do their jobs despite challenges, especially of capacity and recruitment. Staff told us their line managers were approachable and keen they should escalate incidents to them. One staff member told us their ward manager would ask them about their further training and development. When they started on the ward they were encouraged at least one question every day to increase their knowledge.

During site meetings nursing numbers and the skills mix was reviewed by matrons and ward sisters from across the hospital and if required staffing was moved to address this.

Vision and strategy

The trust had a vision for what it wanted to achieve and plans to turn it into action.
There was a clear vison and strategy for the trust which was to ‘deliver world class expertise and local and friendly hospital care to represent the NHS at its best’ and the trust values were to be

‘welcoming, respectful, reassuring and communicative. Most staff in the medical services knew the trust values. One member of staff told us “We do it every day, we welcome patients with a smile, build trust, make them feel we care about them. This way people are less defensive. They are good values”.

The MUC divisional strategy was part of Barnet Hospitals overall strategy and included the potential to increase elderly care services by adding a 40 bed ward to the Barnet Hospital site.

The senior leadership team told us they wanted to develop staff and increase their skills by for example rotating nursing staff in care homes to help up skill care home staff and were seeking to recruit physician associates to the HSEP.

Culture

Managers across the medicine and urgent care division promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was a culture of honesty, openness and transparency. Staff were encouraged to report incidents and learning from incidents was discussed at the daily safety brief/ handovers. We saw evidence of senior staff carrying out duty of candour responsibilities which detailed the involvement and support of patients or relatives in serious incident reports.

Clinical staff felt valued, supported and spoke highly of their jobs despite the pressures. Nursing staff told us there was good team work and peer support and it was better when fully staffed, but when short staff it could be very stressful and it made their job much harder. Staff were committed to delivering a good service.

Staff were proud to work for the hospital; they were enthusiastic about the care and services they provided for patients. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work.

There were opportunities for further learning and development, nursing staff told us there were opportunities for them to progress. Junior medical staff had access to support and teaching.

On the wards we saw multidisciplinary working which involved patients, relatives, therapists and nursing staff working together to achieve good outcomes for patients.

Patients acknowledged a positive and caring ethos and were mostly happy with their care.

Governance

The trust used a systematic approach to improve the quality of its services and care. There were effective structures and process of accountability to support the services within the MUC division. Clinical governance structures were set up and used across the medical specialities and staff felt this was effective. Clinical directors for the medicine, operational managers, divisional director of nursing, matrons and the deputy chief pharmacist attended the MEC directorate management board meeting which was chaired by the divisional director. Monthly boards meetings demonstrated they reviewed complaints and compliment, infection control, finance and governance risks which included, divisional risk registers, never events, incidents. Action points were identified and areas for shared learning were highlighted. Each speciality also held monthly meetings which included clinical governance.

Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives.

We spoke with the ward managers who demonstrated a good awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, and undertaking audits.

Nursing staff had regular handovers and safety huddles to escalate and share information from incidents. Staff told us in some areas they has weekly team meeting where they discussed, safety incidents, safeguarding, development, quality improvement, in-service training.

Management of risk, issues and performance

Whilst the trust had effective systems for identifying risks and planning to reduce them, the trust could not evidence that risks were always being dealt with in a timely way.

The Barnet Hospital MUC divisional risk register had 56 risks identified of which 27 related to medicine. Some of the risks had also been identified as trust wide. The senior leadership team saw the recruitment of medical and nursing staff and lack of bed capacity across the hospital as their main risk. The risk register included all of the concerns we found during the inspection.

Some of the risks had been on the register for a number of years, there was one risk added in 2011, 2012, 2013, 2014, eight had been added in 2016, six in 2017, and nine had been added in 2018. The risk level for the four risks added in 2017 was still identified as being high. These were lack of access to neuro-psychology for stroke patients, management of non-invasive ventilation, non-compliance with Type 2 diabetes foot care. However, was not clear if the measures put in place had addressed the gaps. This meant the trust could not evidence that risks were always being dealt with in a timely way.

Activity dashboards were in place to monitor performance across the MUC division which included performance measures including referral to treatment, length of stay for non- elective patients and two week waits for gastroenterology.

Wards undertook a range of local audits these included call bell audits, pressure ulcers monitoring and privacy and dignity. The trust had recently introduced the perfect ward app which was currently used to report weekly hand hygiene performance across the wards. The nurse in charge completed daily checklists to ensure routine checks, bay checks, and weekly audits were undertaken.

Wards held daily safety huddles to discuss any concerns on the wards, for example any falls and issues with the computer system.

Information management

The trust collected, and used information to support its activities.

The trust had recently moved to electronic paper records, and were seeking to become paper light. Clinical staff had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for patients

There were service performance measures which were monitored and reported through the use of the quality dashboard or balanced scorecard.

Staff had secure access to the trust intranet which gave then access to trust news, policies and procedures and their training and personal development records.

The patient flow team and site matrons routinely collected information throughout the day to inform the management of the hospital and the flow of patients. Site meeting were held four times a day to monitor bed capacity throughout the day.

Engagement

The trust engaged with patients and staff.

Patients participated in the friends and family test to provide feedback on their experience whilst in the wards.

Volunteers assisted staff at meal times on the care of the elderly wards and also helped to run the pop up café.

The trust participated in the NHS Staff Survey 2017. To the following questions:

- The number of staff who would recommend Barnet Hospital as a good place to work was 55% which was similar to the response in 2016 which was 56%.
- The number of staff who would recommend a friend or relative if they needed treatment, as they were happy with the standard of care provided by Barnet Hospital was 69% which the same as the response in 2016.
- The number of staff who felt the trust acted on concerns raised by patients / service users was 69% which was similar to the responses in 2016 which was 68%.

The MUC division had an action plan in place to address some of the issues identified in the NHS staff survey 2017. The action plan for quarter three provided by the trust detailed three areas to be monitored. These included to review at workloads when the ward was short staffed, to review break times, to reduce the number of incidents that could hurt a patient. The timescale for completion was September 2018 but if was not clear from the information provided if actions had been completed.

The trust had ‘speak up guardians’ so staff could raise concerns around bullying and violence from staff and service users.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning, promoting training, research and innovation.

The trust had recently introduced the ‘perfect ward’ which would enable matrons to monitor performance across the wards. This would enable wards to identify what they were doing well and where they needed to improve.

Patients were able to access the TREAT (triage and rapid elderly assessment) service via their GP’s and refer patients to the to the frailty multidisciplinary team (MDT) in the community for ongoing care. The TREAT service also identified patients who required end of life care and were able to coordinate palliative care for patients in their homes if they did not want to go into hospital.

On the concourse on the third floor a pop up café with tables and chairs brought together patients from care of the elderly wards. Staff brought patients from wards, in their beds and wheel chairs as well as patients who could mobilise for a social afternoon with music tea and cake which was ran by hospital volunteers and staff. During inspection in the afternoon, we observed the café was supported by local school children who came to sing Christmas carols.

On one of the care of the elderly wards a wardrobe had been set up for clothing for patients to wear to encourage patients to get out of their night wear during the day. This helped to improve patient’s dignity especially when walking around the ward area.

Surgery

Facts and data about this service

The trust has three main sites for surgery; Royal Free Hospital (RFH), Barnet General Hospital (BGH) and Chase Farm Hospital (CFH).
Surgery and associated services at BGH include four surgical wards, Beech, Cedar, Damson, and Willow and a surgical assessment unit. The hospital currently provides emergency, trauma and elective surgery. There are five main theatres and two theatres in the labour ward. The hospital provides a variety of surgical services including colorectal, general, ear nose and throat (ENT), gynaecology, trauma and orthopaedic, and oral and maxillofacial (OMF) paediatrics. Endoscopy also has a daily emergency list.

(Source: Routine Provider Information Request (RPIR) – Acute context tab)

The trust had 49,311 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 10,751 (21.8%), 30,275 (61.4%) were day case, and the remaining 8,285 (16.8%) were elective.

(Source: Hospital Episode Statistics)

The service performed 5105 emergency and 2534 non-emergency surgical procedures from November 2017 to October 2018.

Specialty and type	
Non-emergency	**2,534**
Obstetrics	610
ENT	596
Urology	377
Colorectal Surgery	327
Maxillo-Facial Surgery	237
Gynaecology	145
(blank)	89
General Surgery	76
Paediatric Community Dentistry	43
Trauma & Orthopaedics	23
Community Dentistry	9
Cardiology	2
Emergency	**5,105**
Acute	1,909
Obstetrics	1,727
Trauma & Orthopaedics	1,469
Grand Total	**7,639**

Is the service safe?

Mandatory training

Although the service provided mandatory training in key skills they did not make sure

everyone completed it.

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory training courses from April 2017 to August 2018 for qualified nursing staff in the surgery department at Barnet General Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
IRR17	1	1	100.0%	85%	Yes
Infection Control L1	109	112	97.3%	85%	Yes
Resuscitation L1	107	112	95.5%	85%	Yes
BPAT	106	112	94.6%	85%	Yes
Basic Radiation Safety	105	112	93.8%	85%	Yes
Health & Safety Awareness	105	112	93.8%	85%	Yes
Fraud & Security	102	112	91.1%	85%	Yes
Emergency Planning	101	112	90.2%	85%	Yes
Moving and Handling	98	112	87.5%	85%	Yes
Waste Management	97	112	86.6%	85%	Yes
RTT L1	33	39	84.6%	85%	No
Equality, Diversity & Human Rights	92	112	82.1%	85%	No
Fire Safety	92	112	82.1%	85%	No
Blood Transfusion	89	111	80.2%	85%	No
Infection Control L2	88	112	78.6%	85%	No
Conflict Resolution	86	112	76.8%	85%	No
Information Governance	85	112	75.9%	85%	No
Resuscitation L2	78	112	69.6%	85%	No

At Barnet General Hospital surgery department, the 85% target was met for 10 of the 18 mandatory training modules for which qualified nursing staff were eligible. Staff was prevented to work bank shifts if their mandatory training was not up to date.

A breakdown of compliance for mandatory training courses from April 2017 to August 2018 for medical staff in the surgery department at Barnet General Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	53	77	68.8%	85%	No
Infection Control L1	48	77	62.3%	85%	No
Resuscitation L1	47	77	61.0%	85%	No
Health & Safety Awareness	46	77	59.7%	85%	No
Fire Safety	44	77	57.1%	85%	No
Fraud & Security	43	77	55.8%	85%	No
Equality, Diversity & Human Rights	42	77	54.5%	85%	No
Basic Radiation Safety	40	77	51.9%	85%	No

Waste Management	40	77	51.9%	85%	No
Moving and Handling	39	77	50.6%	85%	No
Emergency Planning	37	77	48.1%	85%	No
Information Governance	34	77	44.2%	85%	No
Infection Control L2	33	77	42.9%	85%	No
RTT L1	32	77	41.6%	85%	No
Blood Transfusion	31	77	40.3%	85%	No
Conflict Resolution	27	77	35.1%	85%	No
Resuscitation L2	22	77	28.6%	85%	No
IRR17	0	1	0.0%	85%	No

At Barnet General Hospital surgery department, the 85% target was met for none of the 18 mandatory training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Divisional leads told us that the low training rate completion amongst doctors was linked to high vacancy rates and increased workload doctors were experiencing at the time. They believed that the mandatory training compliance rates had been improving for this staff group.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.
A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for qualified nursing staff in the surgery department at Barnet General Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	102	112	91.1%	85%	Yes
Safeguarding Children L2	101	112	90.2%	85%	Yes
Safeguarding Adults L1	100	112	89.3%	85%	Yes
Safeguarding Adults L2	99	112	88.4%	85%	Yes

At Barnet General Hospital surgery department, the 85% target was met for all the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for medical staff in the surgery department at Barnet General Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	49	77	63.6%	85%	No
Safeguarding Children L1	46	77	59.7%	85%	No
Safeguarding Adults L2	44	77	57.1%	85%	No
Safeguarding Children L2	41	77	53.2%	85%	No

At Barnet General Hospital surgery department, the 85% target was not met for any of the safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff we spoke to had a good knowledge of safeguarding protocols and awareness of issues they should be concerned about when treating children and young adults. They spoke of appropriate examples were safeguarding protocols were initiated by members of staff. They were also aware of who to contact such as the safeguarding teams and safeguarding champions should they need advice in relation to safeguarding.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff kept themselves, equipment, and the premises clean. They used control measures to prevent the spread of infection.

There were housekeeping staff responsible for cleaning all areas of the department and we found all areas were maintained to a good standard of cleanliness. Patients and relatives told us they were satisfied with the level of cleanliness in the department. Areas we visited were tidy, clean, and uncluttered.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had a sufficient supply of soap and paper towels. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. We saw staff adhering to good hand hygiene practice. Personal protective equipment such as disposable gloves and aprons were readily available in all areas.

We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions.

The national guidance recommends trusts should make every effort to ensure very high levels of MRSA screening in patients from high risks groups, such as those undergoing trauma orthopaedics procedures. We were not assured that all required patients were appropriately screened to minimise the risk of infection as the trust did not audit compliance with the national guidance.

There were enough single occupancy rooms on each of the surgical wards to prevent the spread of infection for example, infectious diarrhoea, MRSA, tuberculosis (TB) and chickenpox amongst others.

We observed a consultant led surgical ward round, all staff were following the trust “bare below the elbows” policy and using hand gel appropriately. We saw staff adhering to good hand hygiene policy in all hospital areas visited.

Cleaning audits were carried out weekly by the external contractor responsible for cleaning and audit results indicated good standards of cleanness throughout the department.

There were infection prevention and control policies and procedures in place that were readily available to staff on the trust’s intranet. We found the surgical wards and theatre department to be adhering to national infection control guidance.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Overall the areas we visited were in a good state of repair. Some of the areas were cluttered with various equipment being stored in corridors on wards and in theatres. Senior leaders told us that

this was due to recent introduction new portable computer devices. Records from staff meeting indicated that this was an ongoing problem with staff complaining of cluttered environment and overall lack of storage.

Inspection and verification of theatres was undertaken by an external contractor at the beginning of 2018 to ensure compliance with health technical memorandum (HTM) 03-01 provides guidance on the design and management of heating and specialised ventilation in health sector buildings. The inspection found that theatres maintenance and compliance level was good, with an exception of theatre suite 4. This theatre was assessed as average due to the minor damage to the wall in dirty utility.

Theatres were well laid out and spacious with sufficiently large anaesthetic rooms. There was lack of storage space. Staff said it was not impacting on the working environment.

We found that theatre trollies used for transportation contained emergency airway equipment and oxygen, there was processes in place to ensure these were checked daily.

Staff told us they felt the equipment used by them was relatively modern and well maintained. Equipment we checked had servicing and electrical safety stickers on indicating it was safe to use for the designated purpose.

Resuscitation equipment stored on the resuscitation trolley was readily available and easily accessible. The trust developed a system to ensure it was checked daily, fully stocked, and ready for use.

Assessing and responding to patient risk

Although staff completed and updated most of the risk assessments for patients, they had not always followed a clear risk driven procedure to prioritise patients for surgery. They undertook suitable checks to ensure safe surgery and prevent any potential errors.

The service carried out an initial review of all patients on admission to establish if their needs would be suitable met by the department. An early warning system (NEWS 2) was used throughout the hospital for detecting the deteriorating patient, along with a sepsis care bundle (sepsis 6) for identifying and managing sepsis.

The department was supported by the hospital wide patient at risk of resuscitation team (PARRT), which was managed within the same division. The team was led by a consultant nurse specialist and worked closely with critical care consultants and trainees. The PARRT point prevalence audit of two surgical wards found that observations were documented, and staff were triggering patients with appropriate escalation and treatment plans. The team provided resuscitation and simulation training to ward staff every two months. Ward staff contacted the medical team and PARRT if a patient triggered escalation. They were supported by PARRT and critical care medical staff as needed, including visit to the ward with an ITU consultant and admission to ITU if needed.

The trust told us that the theatres utilisation rate for elective cases from November 2017 to October 2018 varied between 45% and 75% with average of 61%. The trust told us this was due to the implementation of the theatre strategy programme rationalising theatres on the Barnet site and in the process of moving services to Chase Farm Hospital. Although this meant that theatres were underused they were available to accommodate for emergency and trauma cases. The hospital was prepared for emergency and to support the ‘CEPOD’ list as guided by the National Confidential Enquiry into Patient Outcome and Death. There was a permanently staffed operating theatre that could run on a 24-hour basis. This resource was shared amongst surgical specialities that needed to conduct urgent or emergency operations.

There did not appear to be a robust system as to which cases should be on the emergency list or any process to guide patient priority. The order was not arranged according to clinical priority and specialities such as general surgery, gynaecology or maxillo-facial surgery needed to compete for places on the list. Doctors did not think it was at the expense of patient safety.

Surgical safety checks observed at three stages were conducted using prompts from the patient's admission booklet. The first stage was in the anaesthetic room when the patient was checked in. The process was thorough, and staff present signed for completion. The second stage was the 'time-out' in theatre. This was led by the scrub nurse who ensured that everybody was paying attention and not talking during the checks. All members of the team introduced themselves. The process was completed using the appropriate prompts and signed as to be being completed. It appeared to be well embedded into the theatre system and was performed correctly. The final stage was the sign-out which was completed with the whole team and again was well conducted.

We observed that in one case not all staff paid full attention during "time out" in theatre. Staff meeting record indicated that this had previously been noted as an issue and staff was reminded in October 2018 to ensure all are involved. Theatre staff told us that they were getting better with carrying out safety checks but getting people's full attention was sometimes difficult and on occasions there was no nominated lead.

The department undertook observational safety audits eight times per month to ensure all five steps to safer surgery advocated by the National Patient Safety Agency (NPSA; briefing, sign-in, timeout, sign-out and debriefing) were undertaken correctly by theatre teams. Records indicated good compliance with all steps.

Root cause analysis of hospital acquired thrombosis was undertaken and reported to the trust's thrombosis committee. Although the hospital worked with a Commissioning for Quality and Innovation (CQUIN) target to achieve VTE risk assessment completion above 95% they were unable to achieve it.

Percentage of VTE risk assessments completed on admission is shown below.

Ward	Dec-17	Jan-18	Feb-18	Mar- 18	Apr- 18	May-18	Jun-18	Jul- 18	Aug-18	Sep-18
Damson	93%	86%	85%	84%	86%	86%	92%	86%	88%	81%
Willow	82%	82%	71%	78%	74%	77%	85%	87%	77%	66%
Cedar	88%	93%	85%	81%	69%	92%	91%	87%	83%	84%
Beech	87%	88%	92%	74%	69%	88%	87%	88%	89%	74%

The table below demonstrates the VTE assessment compliance was particularly low within maxillo-facial surgery and trauma and orthopaedics specialities in September 2018.

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Oral surgery	100%	100%	100%	98%	96%	99%	93%	97%
Colorectal surgery	99%	98%	99%	95%	97%	99%	97%	92%

Maxillo-facial surgery	90%	97%	95%	97%	94%	97%	94%	34%
Trauma & orthopaedics	92%	87%	87%	89%	86%	85%	83%	38%
General surgery	76%	78%	73%	71%	77%	76%	77%	51%

Handover for patients transferred post-surgery to the recovery unit was thorough and complete. A consultant led surgical ward round observed was unhurried and a good discussion with the patients took place allowing doctors to identify any risks and listen to patients concerns.

Nurse staffing

At the time of the inspection there were enough staff on duty to meet the needs of the patients. Staff had the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, there was a high turnover rate amongst nursing staff and not all shifts were always covered. The trust has reported their staffing numbers below for August 2018. Fill rate is up from March 2018 when it was at 85%.

	August 2018			March 2018		
Site	**WTE Scheduled**	**WTE in post**	**Fill rate**	**WTE Scheduled**	**WTE in post**	**Fill rate**
Royal Free Hospital	335.4	282.6	84.0%	343.6	307.4	89.5%
Barnet General	134.8	118.2	87.7%	144.5	124.9	86.4%
Chase Farm	94.7	77.5	81.9%	86.5	81.6	94.3%
Total	**583.1**	**495.4**	**88.6%**	**589.6**	**528.8**	**85.0%**

(Source: Routine Provider Information Request (RPIR) –Total staff tab)

From September 2017 to August 2018, the trust reported a vacancy rate of 11.6% in surgery. This is lower than the trust target of 12%. The rate for Barnet General Hospital surgery department was in line with the trust average at 11.9%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 21.4% in surgery. This is higher than the trust target of 13%. The rate at the Barnet General Hospital surgery department was worse than the trust average at 24.8%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 4.7% in surgery. This is higher than the trust target of 3.5% For Barnet General Hospital surgery department the rate was slightly better than the trust average at 4.3%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported a bank usage rate of 12% and an agency usage rate of 1.4% in surgery. There were 4.2% of hours available unfilled by either bank

or agency staff.

Site breakdown can be seen below:

Site	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Barnet	278,100	26,727	10%	6,398	2%	14,674	5%
Chase Farm	198,808	11,661	6%	1,034	1%	18,280	9%
Royal Free	735,248	108,225	15%	10,179	1%	18,988	3%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The trust told us theatres did not use any agency staff for the 12 months prior our inspection and all shifts were covered with permanent or bank staff. Nurses told us that many bank staff were leaving because they liked to work on specific wards or departments they were familiar with and it could not be guaranteed. They said staff after turning up for a shift sometimes would be reallocated to work within a less familiar environment, which would not fully correlate with their competencies. This led to some bank staff refusing to work for the hospital.

To ensure patients were safe, it was expected that the patient/registered nurse ratio was not less than 1:8, which meant surgical wards should have three registered nurses (minimum) on each shift. Although all unfilled shifts were sent to bank and agency, they were not always filled and staff could also cancel last minute. There was a staffing shortage escalation procedure with an allocated person that was tasked with assessing staffing levels on all four surgical wards and ensuring safest and most appropriate staff redeployment based on the minimum ratio and skill mix.

Staff in theatres felt sometimes under unnecessary pressure and that the team lacked stability due to frequent team changes introduced on the day, after plans had been made. They felt anxious due to inadequate skill mix on night duty. They said all staff needed to be trained in all specialties to accommodate for performing the full variety of allocated tasks.

Junior nurses felt their concerns were not always taken seriously when there were staff shortages. They said nurses worked 12.5-hour shifts and supposed to take 1.45-hour break during their shift but were rarely able to take it.

Medical staffing

The service had vacancies for medical staff. This meant there was not always sufficient number of doctors with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust has reported their staffing numbers below for the period September 2017 to August 2018. Fill rate in August 2018 was 94% a slight reduction compared to the March 2018 fill rate.

	August 2018			March 2018		
Site	WTE Scheduled	WTE in post	Fill rate	WTE Scheduled	WTE in post	Fill rate
Royal Free Hospital	213.3	214.6	101.4%	208.4	214.0	103.7%
Barnet General	84.7	79.6	94%	84.7	78.4	93.0%

Chase Farm	36.0	20.3	56%	42.0	28.9	69%
Total	**333.9**	**314.4**	**94%**	**335.1**	**321.1**	**95.8%**

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

From September 2017 to August 2018, the trust reported a vacancy rate of 2.4% in surgery. This was better than the trust target of 12%. Vacancy rate for Barnet General Hospital surgery department was 8.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 9.2% in surgery. This is better than the trust target of 12%. The rate was much better at the Barnet General Hospital surgery department at 2%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 0.7% in surgery. This is better than the trust target of 3.5%. The rate at Barnet General Hospital surgery department was better than the trust average at 0.3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported a bank usage rate of 3.1% and a locum usage rage of 1% in surgery. There were 0.8% of scheduled hours which remained unfilled by bank or locum staff.

Site breakdown can be seen below:

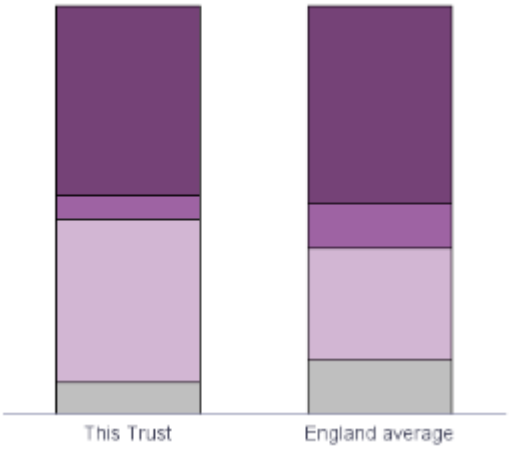
Site	Total hours available	Bank Usage		Locum Usage		NOT filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Barnet	165,647	4,415	3%	3,616	2%	12,547	8%
Royal Free	409,219	13,343	3%	2,011	0%	-8,063	-2%

The trust told us that the negative values are for areas where total hours plus agency and bank hours have exceeded the establishment (effectively unfunded hours). This will need to be investigated to understand why.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

From July 2017 to July 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at Royal Free London NHS Foundation Trust



	This Trust	England average
Consultant	46%	48%
Middle career^	6%	11%
Registrar Group~	40%	27%
Junior*	8%	13%

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

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

The trust was in the process of going 'paper free' and was in transition from the paper records to a fully electronic patient's records system which included prescribing. Trolleys containing paper records were still used by staff on the ward, these were closed and contained a folder for each patient. The folder mostly consisted of labels and patient's demographic data. There were a number of new "computers on wheels" (CoW) and there appeared to be enough of them for the staff wanting to use them. Medical staff on the ward took the CoW to the patient's bedside and wrote the notes contemporaneously. The computers also had access to the imaging system which staff said met their needs, although it was prone to occasional outages. Staff said that these problems with the system had not lasted long enough to have a significant impact on care delivery.

Prescriptions and to take out medicines' prescriptions were also generated on the electronic system. There were several IT staff 'on the floor' available to help ward staff should they had any problems with the newly introduced electronic records system. The system had only been live for two weeks and despite some occasional problems staff were happy using it. They could feedback any concerns they had about using it and suggest changes which were implemented promptly by the IT team.

Five sets of electronic records examined appeared complete and up-to-date. Risk assessments for venous thromboembolism (VTE), nutrition and pressure sores were completed accurately.

The service did not carry out routine records quality audits to monitor completeness and if best standards were met at all times. They introduced a monitoring system, but this was at initial stages of development.

Clinical staff told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for their patients.

Medicines

The service followed best practice when prescribing, administering, and recording medicines. Patients received the right medicines at the right dose at the right time. The medicines were not always stored in accordance with published guidance.

Feedback from pharmacy audit conducted in November 2018 indicated that medicines management within theatres was satisfactory, it included management of controlled drugs. Wards medicines management audit was undertaken in August 2018 and wards were found mostly compliant with the trust's policy related to medicines management.

The pharmacy department undertook 11 antibiotic use audits across the four surgical wards in 2018. They checked if a review date or duration the antibiotic was to be taken for and why were recorded on medicine administration charts. In addition, they expected to see a record of a review within 48-72 hours, if charts indicated why it was prescribed and if antibiotic use was compliant with a suitable guidance.

Two audits undertaken on the Beech ward in May 2018 indicated review within 48-72 hours was documented only in the 50% to 67% of notes. Despite poor results the audit was not repeated in the following months and it was not clear how improvements were to be achieved. Overall those audits indicated that duration the antibiotic was to be taken for, or reviewed within, was not always indicated on medicines charts (recorded in 57% of cases). Where audits were repeated on the same ward the results did not indicate improvements. For example, four audits were undertaken on Cedar ward from February to April 2018 with no improvement trends noted with an exception of improvement in review being undertaken within 48-72 hours.

Fridge temperature on surgical wards was monitored daily with thermometer recording minimum and maximum temperature. The maximum fridge temperature on Damson ward was noted on checklist as over 25 degrees centigrade, above the recommended by the trust's policy 8 degrees centigrade. Staff did not know how to reset the thermometer and were unable to verify if the correct storage temperature was maintained. The issue was noted through medication storage audit undertaken in August 2018, however, staff did not act to remedy it to ensure suitable storage environment was provided.

Medicine storage fridges in three of the anaesthetic rooms were not monitored adequately as they did not have fully completed monitoring sheets. All fridge monitoring sheets showed temperature out of recommended range lasting many days. One sheet showed temperatures exceeding 30 degrees centigrade for several days. There was no evidence of action taken in response. Staff we spoke with were not clear on the actions or procedure to follow after a fridge failure or temperature despite flow charts being available to staff in some folders and a procedure on the intranet.

Records on the Beech ward indicated that both the clean utility room door and the fridge were routinely left open or unlocked. We found the medication fridge and another cupboard unlocked within the room where medicines were stored. This posed a risk that a visitors and unauthorised persons might gain access to, or tamper with medicines intended for patients. This room also contained bags of discharge medicines for patients which had not been secured in an appropriate cupboard.

The clean utility room on Damson ward had the temperature recorder reading was 26 degrees centigrade ideally medicines should be stored at a maximum of 25 degrees. There was a fan in operation to mitigate the issues. Staff we spoke to were unclear on what to do if the temperature remained persistently high.

Controlled drugs (CD) registers were mostly well maintained. Occasionally entries were crossed out in recovery area and in theatres. It was in contravention to the Misuse of Drugs Regulations 2001 which state: no cancellation, obliteration, or alteration of any such entry shall be made, and

a correction of such an entry shall be made only by way of marginal note or footnote which shall specify the date on which the correction is made. There was a box of keys in the CD cupboard within the emergency theatre anaesthetic room. CD cupboards should only be used for the storage of medicines.

The access code to one of the theatre suite's store rooms containing a large medication stock fridge was written on the door. Staff told us that members of the public can enter the theatre suite, but they were always chaperoned including parents escorting a child or fathers attending a surgically assisted birth.

The emergency theatre anaesthetic room was untidy with used tea cups and water bottle left on the medicines preparation bench alongside medicines drawn up for the next patient. One of the syringes was not labelled and there was no evidence that there had been any check on what had been drawn up.

There was no dedicated theatres pharmacist and when staff wanted to change or amend medicines stock list they contacted the chief pharmacist. The named pharmacist visiting the recovery unit was responsible for both areas. Staff said they found it useful to be supported by a pharmacist who was familiar with the unit. Overall staff told us the pharmacy team were responsive and helped with stock issues and provided training to individual staff when needed.

Theatres staff undertook a monthly medicines stock check and checked if all medicines were in date. Stock held in the anaesthetic room cupboards was in date with short dated stock highlighted in some cases.

Staff had access to emergency medicines and the emergency trollies we inspected were regularly checked with all the drugs and oxygen cylinders in date and appropriate.

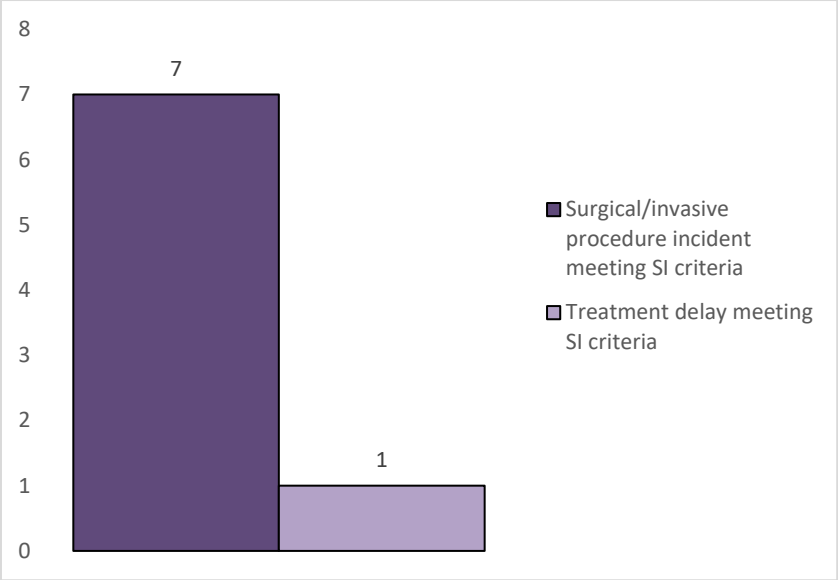
The pharmacy department undertook 11 antibiotic use audits across the four surgical wards in 2018. They checked if charts indicated why the antibiotic was prescribed and if antibiotic use was compliant with a suitable guidance. Overall those audits indicated that antibiotics were used in line with suitable guidelines guarding their use. When a potential resistance of a microorganism to an antimicrobial medicine was identified staff followed advice provided by a medical microbiologist.

Incidents

Staff recognised incidents and reported them appropriately. The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported eight incidents classified as never events for surgery. None of those incidents related to surgery services provided at Barnet Hospital.

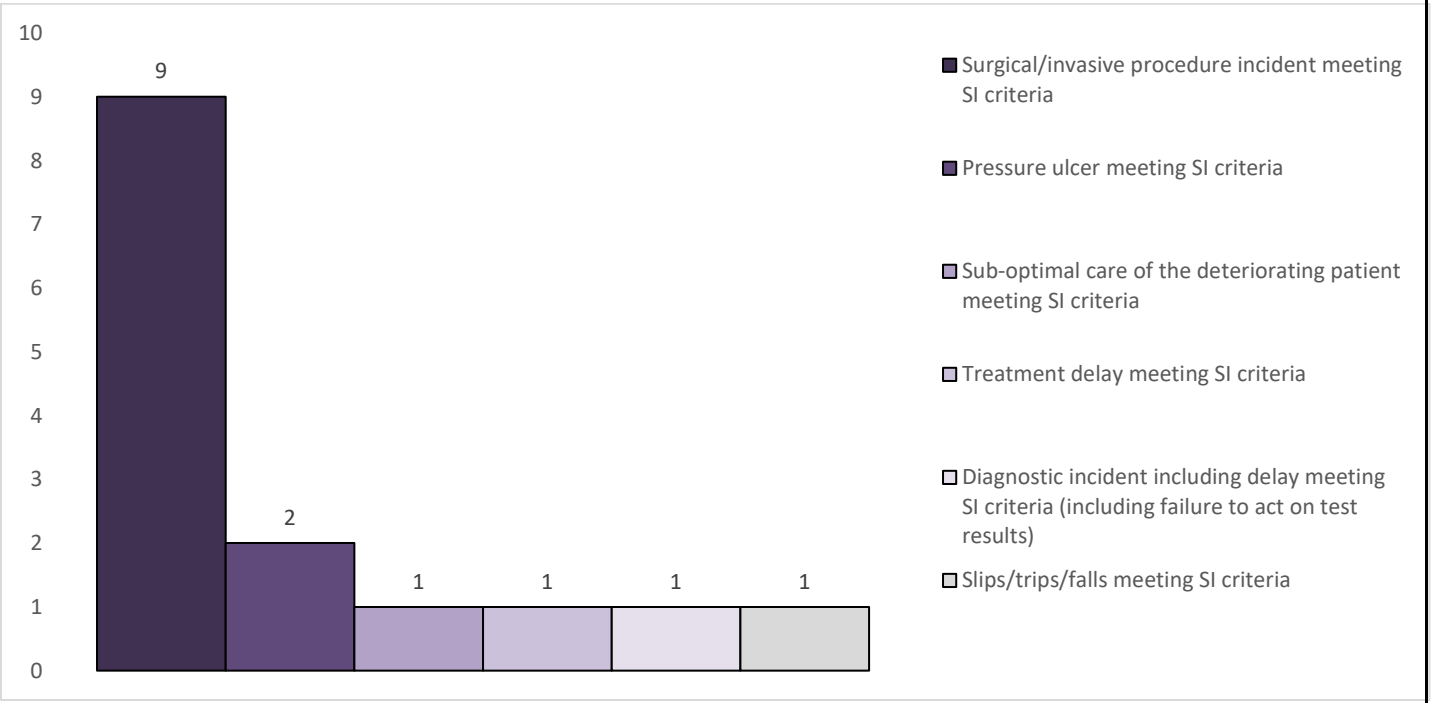


(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2017 to September 2018.

The breakdown of the different types of incident reported were

- Surgical/invasive procedure incident meeting SI criteria with nine (60% of total incidents)
- Pressure ulcer meeting SI criteria with two (13.3% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (6.7% of total incidents)
- Treatment delay meeting SI criteria with one (6.7% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (6.7% of total incidents)
- Slips/trips/falls meeting SI criteria with one (6.7% of total incidents)



(Source: Strategic Executive Information System (STEIS))

Incident reporting culture was strong, and feedback was provided to staff that reported incidents. It was possible to report anonymously if required. None of the staff we spoke to mentioned any concerns about patient's safety. Any incident report which mentioned vulnerable patient automatically triggered an alert to the safeguarding team. Feedback from serious incidents and never event investigations was widely available to staff. Significant events were also highlighted in the daily board rounds and staff huddles. Critical incidents debrief sessions were held weekly and were used to disseminate lessons from incidents, including incidents which occurred at other hospitals managed by the trust as well as across the division. Staff meetings and notice boards in staff rooms were also used to share information and learning from incidents reviews.

Staff we spoke to felt there was no "blame culture but a learning one" and they felt they could raise issues without worrying about repercussions.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients, and visitors. Managers used this to improve the service.

The safety thermometer information was available on all of the surgical wards we inspected. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 18 new pressure ulcers, two falls with harm and eight new catheter urinary tract infections from September 2017 to September 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Royal Free London NHS Foundation Trust

Total CUTIs (8) [3]

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and was able to provide evidence of its effectiveness. Managers checked to make sure staff followed guidance. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

The pharmacy department undertook antibiotic use audits. They checked if charts indicated why the antibiotic was prescribed and if antibiotic use was compliant with a suitable guidance. Overall those audits indicated that antibiotics were used in line with suitable national guidelines guarding their use.

The department contributed to national clinical audits to inform national clinical guidance development and allow for benchmarking their own clinical outcomes.

Twice a year speciality teams organised a clinical audit day. Clinical audit is a way to find out if healthcare is being provided in line with standards and lets clinicians and patients know where their service is doing well, and where there could be improvements. The day was used to update staff on changes to clinical practice and discuss outcomes of clinical audits undertaken within the department. For example, during the November 2018 meeting general surgery staff discussed findings from the national audit on closure of ileostomy, audit on paediatric appendicectomies, and they were updated on the latest developments in management of the gastroenteropancreatic neuroendocrine tumours. There were also clinical audits days organised by trauma and orthopaedics teams, anaesthetics, as well as other specialities. Notice boards in staff rooms were also used to share learning from audit and any other information related to change in clinical practice.

The department had an enhanced recovery program for colorectal surgery. Enhanced recovery is an evidence-based approach that helps people recover more quickly after having major surgery.

There was a range of clinical pathways and protocols for the management and care of various medical and surgical conditions. This had been developed in conjunction with healthcare professionals from a range of specialties and involved specialist from wider clinical network developed with other local NHS trusts.

Staff could access national and local guidelines through the trust's intranet, which was readily available to them. Staff demonstrated the ease of accessing the system to look for the current trust guidelines. The policies, care and treatment pathways, and clinical protocols we reviewed were

based upon recognised guidance, including that of NICE and other professional bodies (i.e. The Royal College of Surgeons, The Royal College of Anaesthetists). They were stored on the trust intranet.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Patients we spoke with were satisfied with the drinks they were offered, we saw fluids were available to patients and within their reach. Staff were proactive, and we observed them supporting patients with accessing beverages. Patients and their relatives could access snacks, food, or hot drinks. Meal times were protected, and staff assisted patients with feeding when necessary. Patients we spoke to said they were offered enough to eat and drink and were happy with the variety of food offered.

The malnutrition universal screening tool (MUST) was used to assess patient's risk of being under nourished. The records we reviewed had a nutrition and hydration assessment undertaken and reviewed regularly. Dietician support was available Monday to Friday and speech and language therapist was available every day. Patients were referred to a dietician if there were concerns with their weight or food intake. Staff told us dieticians and speech and language therapists were responsive and supported the team well.

Patients were assessed during pre-operation appointments, this included height and weight assessment and if low BMI was identified staff contacted patient's GP who then referred to dietitian.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using assessment tools and gave additional pain relief to ease pain.

All the patients we spoke with who had recently undergone surgery told us there were no problems in obtaining adequate pain relief. Nurses responded quickly when extra pain relief was required, and the effect of its use was monitored by them.

National cancer patient experience survey 2017 results indicated that 81% of patients felt the hospital staff "definitely did everything" to help control pain. This was within the expected range and slightly lower than the national average of 83%.

Staff on the ward had support from the trust's pain nurse specialist team who would assist with training and giving expert advice where necessary.

If patients were unable to communicate verbally, staff used a pain assessment tool based on non-verbal cues including facial expression and movement.

Staff used a trust-wide pain assessment tool which incorporated a pain score and an algorithm for prescribing pain relief. These pain tools were integrated in to the electronic patient record system. Patient's pain was scored on a 0-10 scale and was assessed at rest and on movement. These were captured as two separate scores to monitor and support the patient's recovery.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

From June 2017 to May 2018, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

Of the top three specialties based on number of admissions:

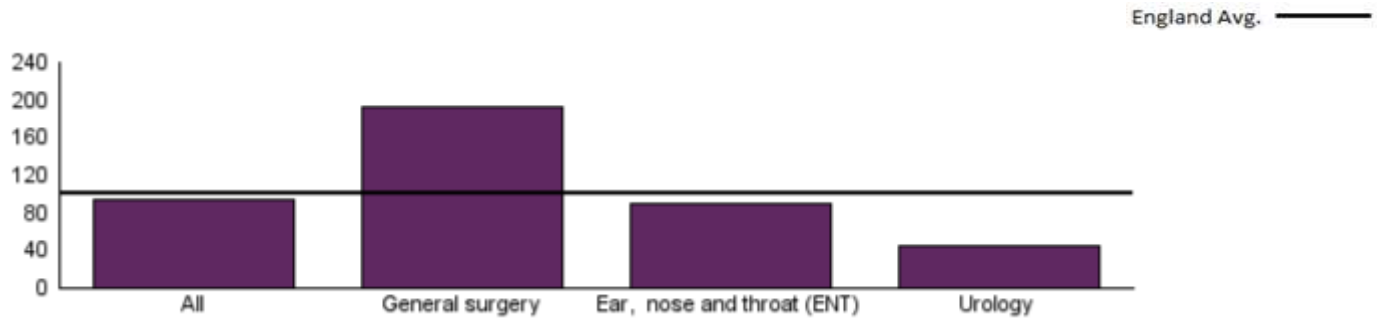
- Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- Plastic surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

From June 2017 to May 2018, all patients at Barnet General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Of the top three specialties based on number of admissions:

- General surgery patients at Barnet General Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- Ear, nose and throat (ENT) patients at Barnet General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at Barnet General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - *Barnet General Hospital*



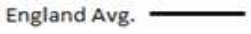
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count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

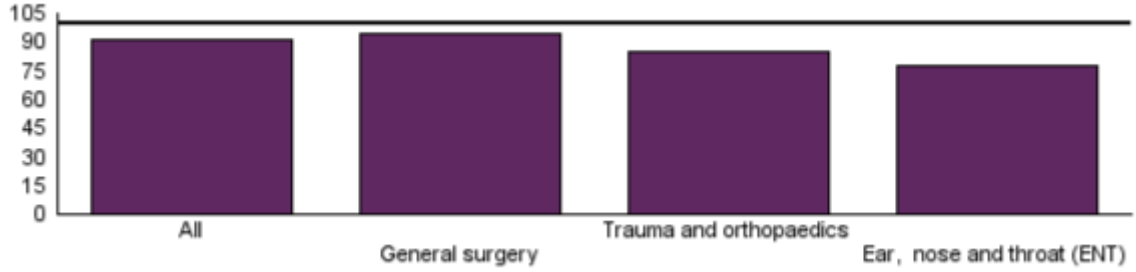
All patients at Barnet General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Of the top three specialties based on number of admissions:

- General surgery patients at Barnet General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Barnet General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Ear, nose and throat (ENT) patients at Barnet General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - *Barnet General Hospital*





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

(Source: Hospital Episode Statistics)

In the 2017 National Hip Fracture Database (NHFD), the risk-adjusted 30-day mortality rate was 7.5% which was within the expected range. The 2016 figure was 7%.

The proportion of patients having surgery on the day of or day after admission was 78.2%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 83.5%.

The perioperative medical assessment rate was 96.7%, which failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 97.6%.

The proportion of patients not developing pressure ulcers was 98%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 96%.

The length of stay was 27.6 days, which falls within the worst 25% of trusts. The 2016 figure was 21.6 days.

(Source: National Hip Fracture Database 2017)

In response to the NHFD audit the department planned to improve documentation and recording by standardising in electronic patient record. They also were looking to introduce clinical practice group for fractured neck of femur care pathway in 2019.

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), Barnet General Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 108 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 56 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 63 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical

care post-operatively. This was based on 45 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 108 cases.

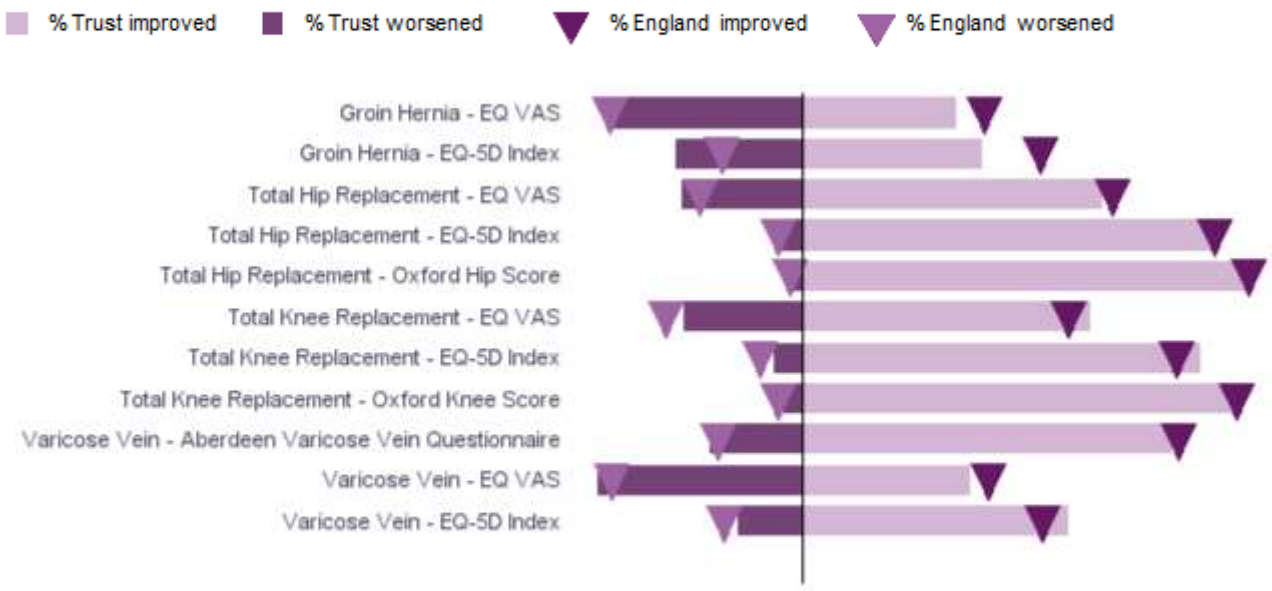
(Source: National Emergency Laparotomy Audit)

In response to the NELA audit the department planned to further improve case ascertainment rate with recently appointed NELA leads in surgery and anaesthetics. They also aimed to improve documentation of P-Possum scoring preoperatively (a tool to compare morbidity and mortality for a broad range of surgical procedures) by introducing a mandatory field in new electronic patient record. The department worked towards improving preoperative assessment offered by care of the elderly specialists. They were at initial stages of developing perioperative medicine team cross site with all involved specialties.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.



In 2016/17 performance on groin hernias was worse than the England average.
For Varicose Veins, performance was about the same as the England average. Performance in the EQVAS indicator was worse than the England average but in the EQ-5D index performance was better.
For hip replacements, performance was about the same as the England average.
For Knee replacements was better than the England average for both the EQ VAS and EQ-5D

Index indicators.
(Source: NHS Digital)

Surgical site infection (SSI) data was collected on a year-round basis in the categories of knee and hip replacement. The hospital data included patients who had their surgery at Chase Farm Hospital and were subsequently admitted to another hospital site with SSI. Information was uploaded onto a database and submitted to Public Health England each quarter. The figures for July 2017 to June 2018 indicated infection rate of 0.6% for knee replacements compared to the national rate of 0.7%. The infection rate for hip replacement was at 1.0% compared to the national rate of 0.9%.

Barnet Hospital did not have detailed information related to unplanned returns to theatre which would help to monitor effectiveness or the treatment.

Competent staff

The service made sure staff were competent for their roles. Managers appraised most of the staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

From September 2017 to August 2018, 75.8% of staff within surgery department at the trust received an appraisal compared to a trust target of 85%.

Staffing group	Appraisals required	Appraisals complete	Trust target	Completion rate	Target met?
Additional Clinical Services	9	8	85%	88.9%	Yes
Allied Health Professionals	19	16	85%	84.2%	No
Add Prof Scientific and Technic	17	14	85%	82.4%	No
Medical and Dental	151	121	85%	80.1%	No
Estates and Ancillary	14	11	85%	78.6%	No
Healthcare Assistants	144	108	85%	75.0%	No
Nursing and Midwifery Registered	478	354	85%	74.1%	No
Administrative and Clerical	26	18	85%	69.2%	No
Grand Total	**858**	**650**	**85%**	**75.8%**	No

Total completion rate by site is as follows:

- Royal Free Hospital appraisal completion rate: 72.4%
- Barnet General Hospital appraisal completion rate: 77%
- Chase Farm Hospital appraisal completion rate: 83.3%

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Trainee doctors we spoke with felt that the training they were getting was "first-class" and being a part of a large NHS trust offered a wide range of learning opportunities.

The department had a strong mentoring system and induction arrangements for new staff with individual files set up for signing off on competencies. This appeared to run well and the managers and staff were happy that no staff were being asked to do procedures they had not been certified as competent to perform.

Healthcare assistants had extensive skills and staff in other job roles, such as doctors or nurses, were very happy with the support offered by this staff group. For example, in theatres healthcare assistants supported with: team brief, equipment checks, ensured all trays were ready for the list, theatre set up to individual surgeon's requirement, assisted scrub nurse and with patient's transfer to the recovery unit.

Staff professional registration status was monitored and managers received emails prior to a staff members registration expiry.

New employees undertook both corporate and local induction with additional support and training when a need was identified. The agencies used to provide staff had been audited to ensure their staff met these standards.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses, and other healthcare professionals supported each other to provide good care.

Care planning took place at multidisciplinary team meetings where there was involvement from all members of the team including doctors, nurses and allied healthcare professionals. Staff reported good multidisciplinary working with other services within the trust and with external organisations, such as local authorities and general practitioners. We observed a good culture in multidisciplinary working and a good team ethos.

Wards were well supported by specialist services such as tissue viability and pain teams, information with details of how to access the services was easily accessible to all staff. There was good multidisciplinary working with daily physiotherapy and occupational therapist ward rounds

Ward based pharmacists and physiotherapist worked well with medical teams and were visible assisting patients.

Staff in theatres worked closely with the pre-assessment, recovery unit team and service managers to co-ordinate and prioritise the admission of patients.

Seven-day services

There was suitable provision of services at all times to ensure care and treatment delivery and supporting achievement of the best outcomes for patients.

There was suitable day and night cover within theatres to respond to emergency and allow for out of hours surgeries to take place.

Each speciality had weekend and out of hours consultant cover provided by a 'consultant of the week'. The allocated doctor was freed from other regular commitments, such as outpatients clinics, which allowed them to focus on ward rounds and providing out of hours on-call, or when required on-site, support.

There was no out of hours therapy cover. Physiotherapy and occupational therapy departments run a seven-day service based on reduced staffing at level of 25% during weekends.

There was no speech and language or dietitian weekend service provided within the department. The trust told us that those therapists provided voluntary cover service during bank holidays.

The department was supported by the hospital wide patient at risk of resuscitation team (PARRT), which was managed within surgical services. The team was led by a consultant nurse specialist and worked closely with critical care consultants and trainees. They were available everyday 7.30am to 8pm.

Health promotion

All patients of over the age of 60 who experienced a fracture of their neck of femur had a follow up phone call at 120 days to check that they were taking their bone strengthening medication. This aimed at preventing future fractures. The therapy team focused on falls prevention education prior to discharge to prevent further fractures on these at-risk patients. Bone health education information leaflets for patient in different languages were available to support education and help to understand risks.

The department organised appointments for patients at risk of osteoporosis to educate them about osteoporosis and falls prevention. They discussed factors such as use of appropriate shoes, lighting, steps, flooring, and any other factors that could contribute to a fall.

The department undertook various initiatives to highlight the risk of smoking and its impact on health, fracture healing, wound healing and how it could affect the bone strength. They also offered support with smoking cessation.

Consent, Mental Capacity Act, and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The trust reported that from April 2018 to August 2018 Mental Capacity Act (MCA) and DOLS training was completed by 81.8% of staff in surgical care compared to the trust target of 85%. The breakdown by site was as follows:

- Royal Free Hospital surgery department: 79.6%
- Barnet General Hospital surgery department: 86.3%
- Chase Farm Hospital surgery department: 90.9%

(Source: Routine Provider Information Request (RPIR) – Training tab)

All staff spoken with had a good knowledge of MCA and DOLS and were aware of how to get assistance with cases when required. Medical and nursing staff were aware of the correct consent processes to be followed. They were able to describe the legislative requirements regarding consent and confirmed that policies and procedures were available to support obtaining informed consent from patients.

Patients we spoke to told us they had been given clear information about the benefits and risks of their surgery in a way they could understand prior to signing the consent form. They were given enough time to ask questions if they were not clear about any aspect of their treatment.

Consent forms identified potential risks and complications following the procedure, they were fully completed and contained no abbreviations so that patients could easily understand them well.

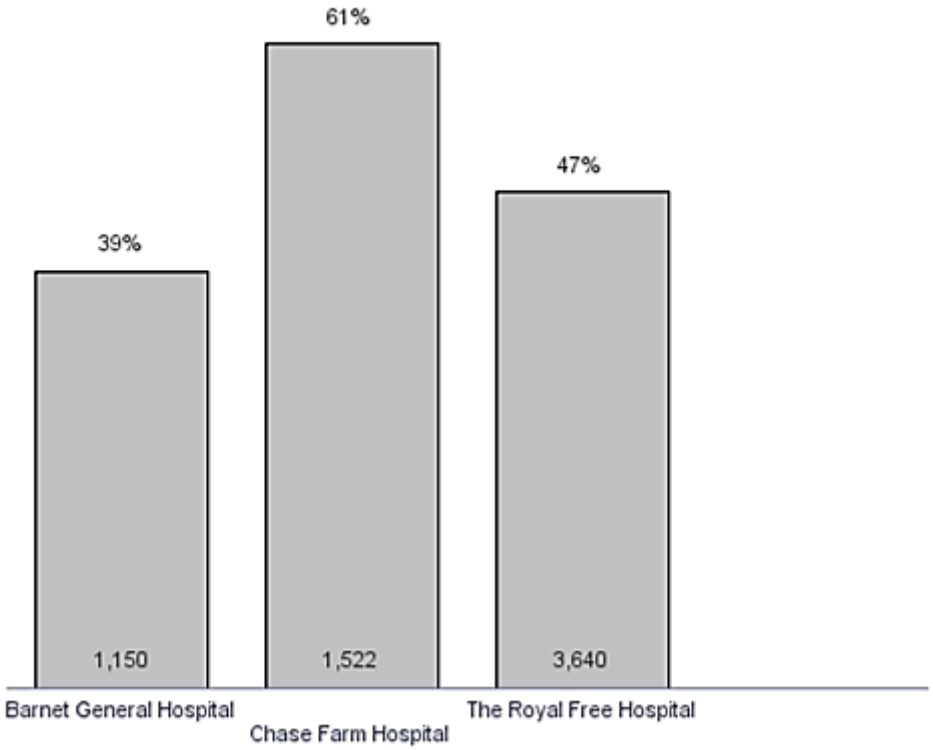
We did not identify any patients currently being treated under DoLS.

Is the service caring?

Compassionate care

Patients were treated and cared for with compassion, respect, and dignity. The Friends and Family Test response rate for surgery the trust was 45% which was better than the England average of 27% from September 2017 to August 2018.

A breakdown of response rate by site can be viewed below.



Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	
CF-WELLING	723	59%	99%	96%	96%	96%			95%		94%	96%		97%	91%
5 EAST B	708	45%	92%				84%	95%					85%	98%	89%
7 NORTH	585	53%								88%				88%	87%
CF-CANTER	576	61%	100%					98%		98%				89%	78%
9 WEST	542	52%	91%	89%		81%		73%					91%	82%	86%
BH-DAMSON	518	45%	88%	89%	84%	90%	72%	78%	94%		91%		84%	87%	86%
5 NORTH A	444	38%	97%	88%	95%	78%		90%	90%	74%	92%			80%	89%
7 WEST	405	43%	96%		88%	86%	91%	95%		87%	93%	93%	89%	81%	90%
BH-CEDAR	391	38%	84%	85%	93%	94%	97%	81%	89%	89%	76%	88%	89%	80%	87%
7 EASTB	210	62%	87%	97%	88%	88%	87%		91%	67%	100%	83%	100%		90%
BH-BEECH	196	30%	91%	100%	76%	71%	89%	95%	80%	80%	81%	95%	79%	91%	86%
7 EAST A	178	33%	80%	94%	71%	75%	100%	79%	81%	90%	88%	87%	100%		85%

Highest score to lowest score

Key 100% 50% 0%

[1] The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).

[2] Sorted by total response.

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

Note: sorted by total response

(Source: NHS England Friends and Family Test)

There was a large whiteboard used for patient details this had a folding flap over the end so that patient details were not immediately visible to passersby.

Patient's dignity was protected throughout their surgery and all theatre staff were caring in their attitudes. Patients were made to feel at ease in the anaesthetic room which was quiet and calm.

Patients we spoke to were very positive about the care they received and said nurses had time to provide compassionate care.

Throughout our inspection, we witnessed good staff interaction with patients. We observed how the nurses assisted patients, with compassion and skilled care.

In theatres we observed staff delivering care with empathy and compassion. We saw theatre staff protected patients' dignity including when they were not conscious. We saw theatre staff gave consideration to ensuring patients were not left exposed unnecessarily and that patient's dignity was preserved when opening theatre doors.

Emotional support

Staff understood the impact of patients care, treatment or condition to their wellbeing and those close to them. Patient we spoke to told us they felt staff were concerned not just about their clinical condition but also about their emotional, and social needs.

Staff provided patients and their families with compassionate care and emotional support to minimise their distress and anxiety. Staff treated and involved patients and their families as partners in assessing and meeting their emotional and social needs, which was understood as being crucial in the patient care.

Literature was available with details on a variety of support groups or services which could be accessed for example bereavement services and dementia support groups

Where it was identified that patients required additional support this was arranged and discussed with the multidisciplinary team.

There was a 24-hour chaplaincy service available at the hospital should there be a need to provide spiritual support. It consisted of a multi-faith chaplaincy team, supported by a dedicated team of chaplaincy volunteers.

Psychology service was available to discuss the emotional impact of living with physical health and appearance-related conditions, and work with patients to maximise their coping and quality of life. Staff were able to make a psychology referral should they have concerns about the psychological impact of medical conditions or injuries on patients and their families.

Understanding and involvement of patients and those close to them

Patients and those close to them were treated as active partners in the planning and delivering of their care and treatment. Patients were giving appropriate information and encouraged to make decisions about their care and treatment.

Patients told us staff were patient, very thorough and answered all their questions. We observed that patients were given information on their condition and told when they would receive their test result or what treatment to expect in the near future.

Patients relatives told us they had been involved in their relatives care and had been given regular updates.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and delivered care in a way that reflected the needs of the population of patients who accessed the service to ensure continuity of care. Patients' needs and preferences were considered and acted on to ensure services were delivered to meet those needs.

Bays were designated for men or women. The hospital did not report any single sex accommodation breaches within the department in 12 months prior the inspection.

There was a concierge service in the main lobby to help patients and visitors find their way around. There was clear signage indicating where services and individual wards were located. Staff and volunteers were readily available to help provide directions if needed.

There was a discharge lounge with staff readily available to help patients to pack their belongings on the ward and help with organising their take home medicines and arrange transport when required. On average 16 patients used the lounge each day, they had access to food and drink in case their wait had been prolonged.

Pre-assessment clinics were well organized and provided walk-in service as well as pre-booked appointments. Patients could complete pre-assessment forms electronically while awaiting seeing a member of the team. This helped to minimize the time their spent at the clinic.

Visiting times were flexible and staff could accommodate patients' needs based on their individual needs.

There were toilets that were accessible to people with mobility difficulties and nappy changing facilities for parents with children.

Meeting people's individual needs

The needs and preferences of patients were considered when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs. Care and treatment was coordinated with other services and stakeholders, to ensure the needs of patients and their families were met.

There was a learning disability liaison nurse working within the hospital and staff told us they would contact them to seek advice in relation to supporting patients with learning disabilities. General surgery speciality staff discussed best practice in managing patients with learning difficulties on surgical wards during the clinical audit day organised in November 2018. They also dedicated time to discuss the experience of frail patients on the surgical ward.

There was a large whiteboard used for patient details this had a folding flap over the end so that patient details were not immediately visible to passersby. An identifying marker was used to identify patients with special needs, for example, those living with dementia. The patients had "this is me" booklet and had special visiting arrangements. Relatives and carers were encouraged to stay with the patients as much as possible and to help at meal times. The department did not monitor dementia screening rates or carry out any audits related to dementia screening.

The department did not undertake environmental assessments to assess if the environment was responsive to needs of people with visual or hearing impairment.

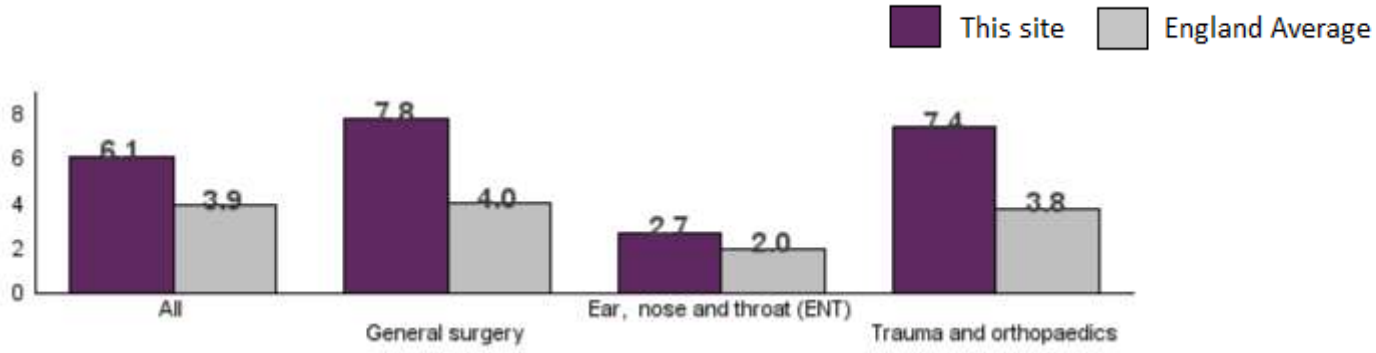
Access and flow

From July 2017 to June 2018 the average length of stay for all elective patients at Barnet General Hospital was 6.1 days, which was higher when compared to the England average of 3.9 days.

Of the top three specialties by number of admissions, the average length of stay for:

- General surgery elective patients at Barnet General Hospital was 7.8 days, which is higher when compared to the England average of 4.0 days.
- Ear, nose and throat (ENT) elective patients at Barnet General Hospital was 2.7 days, which is higher when compared to the England average of 2.0 days.
- Trauma and orthopaedics elective patients at Barnet General Hospital was 7.4 days, which is higher when compared to the England average of 3.8 days.

Elective Average Length of Stay - Barnet General Hospital



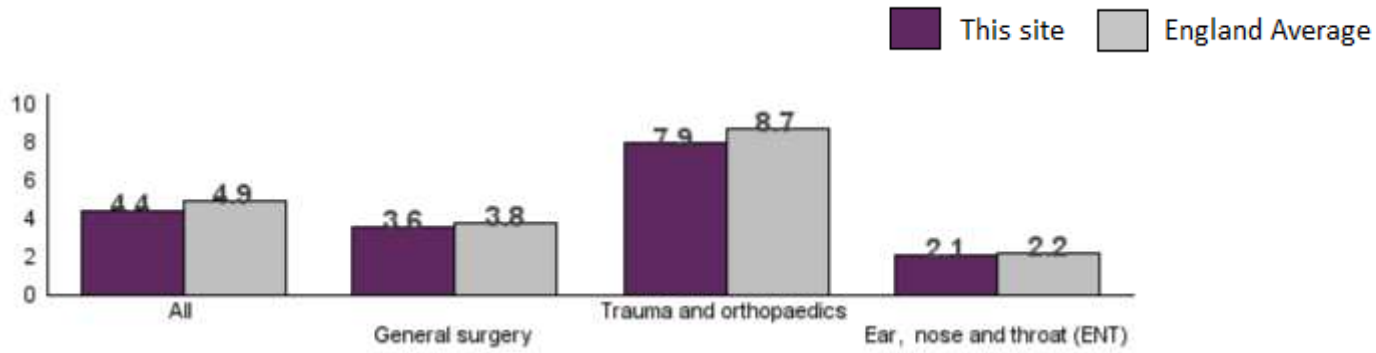
Note: Top three specialties for specific site based on count of activity.

The average length of stay for all non-elective patients at Barnet General Hospital was 4.4 days, which was lower when compared to the England average of 4.9 days.

Of the top three specialties by number of admissions, the average length of stay for:

- General surgery non-elective patients at Barnet General Hospital was 3.6 days, which is similar when compared to the England average of 3.8 days.
- Trauma and orthopaedics non-elective patients at Barnet General Hospital was 7.9 days, which is lower when compared to the England average of 8.7 days.
- Ear, nose and throat (ENT) non-elective patients at Barnet General Hospital was 2.1 days, which is similar when compared to the England average of 2.2 days.

Non-Elective Average Length of Stay - Barnet General Hospital

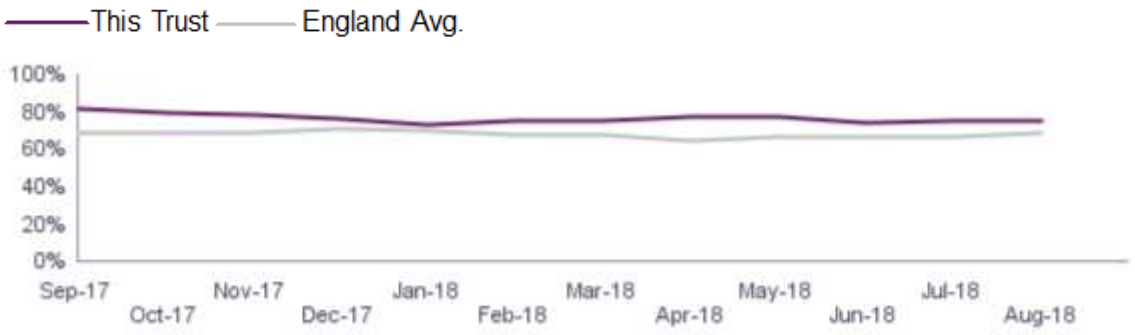


Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was better than the England average.
In the latest month, August 2018, the trust scored 75.7% compared to the England average of

68.5%.



(Source: NHS England)

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery (September 2017 to August 2018).

Specialty grouping	Result	England average
Cardiothoracic surgery	100.0%	79.6%
Ophthalmology	92.2%	68.2%
Urology	85.3%	76.7%
General surgery	76.0%	72.6%
Oral surgery	65.1%	59.4%
ENT	64.6%	63.1%

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Plastic surgery	80.9%	81.1%
Trauma & orthopaedics	45.1%	60.0%

We present the most up to RTT data for surgical specialities in the table below.

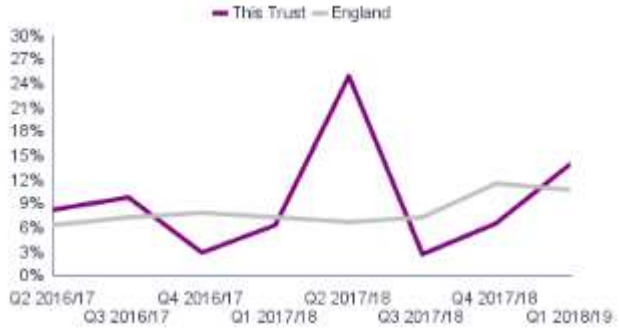
Specialty	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Anaesthetics	100%	100%	100%	100%	100%	100%	100%
Breast surgery	97%	98%	99%	100%	99%	99%	98%
Cardiothoracic surgery		100%	100%	100%	100%	100%	0%
Colorectal surgery	88%	88%	90%	85%	86%	86%	73%
Ear, Nose and Throat	98%	98%	98%	98%	96%	95%	87%
General surgery	67%	64%	68%	71%	71%	74%	63%
Hepatobiliary & Pancreatic surgery	0%	50%	0%	0%	100%		100%
Maxillo-facial surgery	99%	99%	99%	99%	99%	98%	76%
Neurosurgery	100%	100%					
Ophthalmology	98%	98%	95%	93%	95%	94%	83%
Oral surgery	85%	83%	84%	87%	85%	81%	34%
Orthodontics	84%	73%	56%	63%	81%	91%	64%
Plastic surgery	88%	83%	74%	65%	68%	66%	71%
Thoracic surgery	100%	100%	100%	100%	86%	100%	100%
Transplantation surgery	100%	100%	100%	100%	79%	47%	17%

Trauma & orthopaedics	83%	84%	86%	86%	85%	85%	69%
Upper Gastrointestinal surgery	100%	100%	100%	100%	100%	100%	0%
Urology	94%	94%	93%	88%	83%	91%	70%
Vascular surgery	87%	90%	88%	90%	89%	93%	79%

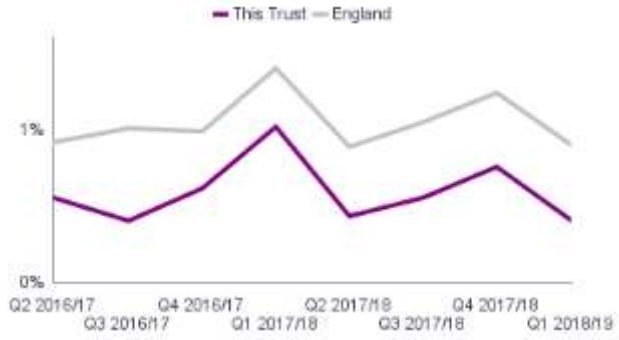
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

Over the two years, the percentage of cancelled operations at the trust had been similar to the England average. The only exception is in Q2 2017/18 (July 2017 – September 2017) where the trust had 25% of cancelled operations not treated within 28 days.

In the most recent quarter, Q1 2018/19 (April 2018 – June 2018), this trust cancelled 78 surgeries. Of the 78 cancellations 14% were not treated within 28 days.



Over the two years, the percentage of cancelled operations at the trust was similar to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.



(Source: NHS England)

The department cancelled 130 operations on the day the surgery supposed to take place in April to October 2018 this was approximately 3% of 4390 operations performed during this time.

Cancellation reason	2018/04	2018/05	2018/06	2018/07	2018/08	2018/09	2018/10	Grand Total
Hospital Cancellation - clinical	**22**	**6**	**19**	**11**	**7**	**8**	**21**	**94**

Operation not necessary (hospital cancelled)	12	1	8	3	2	1	6	33
Unfit for surgery (hospital cancelled)	2	1	3	4	3	4	6	23
Other	3	2	6	1	1	1	3	17
Pre-op guidance not followed	2		1		1	1	1	6
Unfit with acute illness (hospital cancelled)			1	2			2	5
Emergencies / Trauma took precedent		1					3	4
Unsuitable for day surgery	3							3
Pre-existing medical condition		1		1		1		3
Hospital Cancellation - non-clinical	**9**	**4**	**5**	**4**	**3**	**5**	**6**	**36**
List Over run	3	1	2	1		2	2	11
Emergencies / Trauma took precedent	3		2				2	7
Surgeon unavailable		2		3				5
Other					1	2	1	4
Equipment failure/unavailable	2				1			3
Unfit for surgery (hospital cancelled)		1				1		2
Booking error					1		1	2
Ward beds unavailable			1					1
Operation not wanted (patient cancelled)	1							1
Grand Total	**31**	**10**	**24**	**15**	**10**	**13**	**27**	**130**

The department did not monitor ‘did not attend’ rates for planned surgical procedures. The site undertook primarily emergency work and the majority of elective work took place on Chase Farm site.

Staff record meetings indicated that habitual lateness of some staff had not been managed appropriately and this possibly affected day to day operation of theatres.

Delayed theatre lists at Barnet Hospital (elective sessions).

YEAR	MONTH	% late start (15 - 30 mins)	% late start (>30 mins)
2017	Nov	32%	34%
	Dec	29%	51%
2018	Jan	37%	37%
	Feb	20%	47%
	Mar	32%	37%
	Apr	24%	33%
	May	24%	37%
	Jun	25%	31%
	Jul	24%	31%
	Aug	23%	40%

	Sep	26%	45%
	Oct	22%	41%
Total		**27%**	**38%**

We noted that there were spare bays in the recovery room which meant patients did not need to wait to be admitted post-surgery.

The trust told us that the theatres utilisation rate for elective cases from November 2017 to October 2018 varied between 45% and 75% with average of 61%. Although this meant that theatres were underused they were available to accommodate for emergency and trauma cases. The trust told us this was due to the implementation of the theatre strategy programme rationalising theatres on the Barnet site and in the process of moving services to Chase Farm Hospital.

Ward rounds of the surgical patients took place daily (including weekends) and were usually consultant led. There was a specialised frailty team available in the trust and a dedicated physician to supervise the medical needs of orthopaedic patients. Systems for review of medical patients on surgical wards appeared robust with daily consultant review and a ward base junior doctor.

There was a large whiteboard used for patient details the information was updated twice daily and the estimated discharge date reviewed daily.

Surgical assessment unit (SAU) had been refurbished in 2018. There were two bay areas of six beds designated for single sex use. There was also space for two extra trolleys in each bay for escalation in times of bed shortages. These were not in use at the time of the visit. Washing and toilet facilities were available in each bay with extra toilet facilities available. One extra bay was used for the ward reception and had five chairs for ambulatory patients. At the time of the inspection there were two patients waiting there for abscess drainage. These had been seen in the ED during the previous 12 hours and staff asked them to report to SAU and refrain from eating from 6.30 am in preparation for surgery. Five hours after patients' admission staff were still not clear when they would be going to theatre. There was no system to feedback to the wards when patients would be going to theatre. This meant that patients could be kept 'nil by mouth' for unnecessarily extended periods which could lead to ongoing and avoidable longer-term problems.

Consultants, clinical fellows, and trainee doctors told us they were happy that the SAU worked well and that it was safe. Patients could be referred directly from the emergency department or the GP via the surgical admitting team to ensure that only appropriate patients were seen there. There were two consulting rooms which provided good levels of privacy for patients and could be used for difficult conversations/breaking sad news.

As part of the patient flow bundle the department undertook a systematic multi-disciplinary team review of patients with extended lengths of stay (over seven days – also known as 'stranded patients') with a view to facilitate prompt discharge and address any potential problems preventing discharge. This was chaired by one of the divisional directors and attendance included a nursing representative from each ward, matron, therapists, orthopaedic and general surgical on-call teams, as well as a member of the complex discharge team.

Learning from complaints and concerns

There were processes in place to ensure complaints were dealt with effectively. From September 2017 to August 2018 there were 383 complaints about surgical care. The trust took an average of 36 days to investigate and close complaints. This is not in line with their complaints

policy, which states complaints should be closed within 35 days however there is an option to extend the deadline if previously agreed with complainant.

The top four subjects of complaint were:

Subject	Total
All aspects of clinical treatment	217
Appointments, delay/cancellation (out-patient)	58
Communication/information to patients (written and oral)	40
Attitude of staff	39

Breakdown at the three main sites was as follows:

Site	Total
Royal Free Hospital	213
Barnet Hospital	108
Chase Farm Hospital	56

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

From September 2017 to August 2018 there were 148 compliments within surgery.

The breakdown by the three main sites is shown in the table below.

Site	Total
Royal Free Hospital	69
Barnet Hospital	42
Chase Farm Hospital	31

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

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The hospital's divisional director provided clinical oversight of the service, they reported to the hospital's medical director. There were also four clinical directors supported by clinical service leads for the different surgical specialities.

There were senior nursing leads for theatres, pre-assessment, and surgical wards. They reported to the divisional director of nursing who was line managed by the director of operations and professionally accountable to the director of nursing.

The surgery service was managed by a divisional director of operations who reported directly to the hospital's director of operations. Four clinical operations managers, line managed by the divisional director of operations, were responsible for providing operational oversight of surgical services at the hospital.

The local leadership team were experienced and demonstrated a good understanding of the performance challenges and risks within the surgical services. Ward managers and deputies we spoke to had been in post for several years and had a very good knowledge of their staff, the hospital and its systems.

Staff spoke positively about the service and site leadership teams. We heard that senior staff were visible and supportive and that the site leadership team including the chief executive were very approachable.

Department's staff did not share with us any negative comments about their senior or local management teams. Divisional and ward level management appeared experienced, competent and knowledgeable.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Staff were reminded to practice the trust's values during departmental meetings where trust's values was a standard agenda item.

Departments strategy was aligned to the Barnet Hospital's clinical strategy and master plan. The hospital vision was to become a major urgent and emergency care hub for Barnet and the surrounding area and provide a full range of secondary healthcare services to the local population. There were plans to minimise the elective work and improve collaboration with the Hertfordshire clinical commissioning group.

The department planned to further develop its specialist colorectal surgery services by building an academic hub and by exploring new opportunities.

Orthopaedic strategy was also driven by the trust's strategy. There were three priorities: reduce variation within the trust, focus on safety and governance, increase research and clinical trials opportunities.

Culture

Managers across the department promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

All staff we spoke with enjoyed working at the hospital and felt well supported in their roles. They said the hospital was "a great place to work", they felt well supported in development told us it was a "safe hospital". Incident reporting culture was strong, and feedback was provided to staff that reported incidents. It was possible to report anonymously if required.

Nurses told us there was a "good spirit" and that senior managers were approachable. They felt there needed to be more recognition of healthcare assistants and other lower pay banding staff as they were "brilliant", and the trust needed to focus on providing them with more development opportunities. Some healthcare assistants had been given the opportunity to progress to train in nursing but nurses we spoke to feel the programme needed to be extended to ensure everyone had that opportunity.

None of the staff had mentioned any concerns about patient's safety. Staff we spoke with had good knowledge of whistle blowing procedures.

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There was a clear quality governance structure within the surgical and associated services division (SAS) which demonstrated how governance was discussed and reported through the quality governance managers for the SAS up to the head of quality and governance. The division had a quality and governance manager on post and was supported by business partners.

Surgical specialities within the division, held their own audit days and mortality and morbidity meetings. Meeting minutes showed that where complications had occurred patient outcomes were reviewed, and areas identified for improvement, recommendations for learning or best practice were captured and shared.

The division held a monthly board meeting which alternated between focusing on performance and quality and safety. Meeting minutes we reviewed demonstrated that issues relating to patient safety, outcomes and experience were discussed. Safety incidents, complaints and risks were reviewed to identify areas of concern and opportunities for improvement. Divisional board meetings, chaired by the divisional director, were well attended by operations managers, clinical directors, business partners and matrons. There was an action log, reviewed during every meeting, which listed issues and tasks, and how and when the department was to address those.

Management of risk, issues, and performance

The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was an allocated analytics business partner for surgery and associated services division. Their role was to help with gathering and analysing data. The data to helped senior leaders to monitor performance and benchmark it against other trust's sites and other health providers.

Individual speciality teams organised cyclical clinical audit days to find out if healthcare was being provided in line with standards and check where the service was doing well, and where there could be improvements. The aim was to allow quality improvement to take place where possible with an intention to improve outcomes for patients. Clinical audits looked at care nationwide (national clinical audits) and local clinical audits. The day was used to update staff on changes to clinical practice and discuss outcomes of clinical audits undertaken within the department.

There were no Commissioning for Quality and Innovation (CQUIN) targets for 2018/2019 that would be specific to provision of surgery at the Barnet General Hospital.

The service had a local risk register which was updated regularly. The risks highlighted on the risk register were current and controls had been put in place to minimise it. There were leads allocated to each of the item placed on the risk register responsible for overseeing any mitigation actions.

Seven top divisional risks, rated high and above, are presented in the table below.

Description	Risk level (current)	Date Risk entered on Datix	Review date
Non- adherence to national cancer performance targets within	Extreme	08/06/2018	31/10/2018

otorhinolaryngology and oral and maxillofacial specialities			
Non- adherence to national cancer performance for colorectal surgery	Extreme	08/06/2018	30/11/2018
Non- adherence to national plans - patients waiting 52 weeks + to start treatment and increasing patients tracking list.	Extreme	08/06/2018	31/12/2018
Clean utility room in Willow ward: the treatment room has an increased temperature.	High	13/04/2017	31/12/2018
Risk of legal claim for damages for alleged breach of contract.	High	26/09/2017	30/11/2019
National Hip Fracture Database – 'alert' related to increased 30 mortalities in 2017	High	24/08/2018	30/12/2018
Unsafe formalin dispensing - there is a risk of spillage of formalin.	High	21/05/2018	31/03/2019

Information management

The department collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards.

We were not made aware of any data security breaches that occurred at the hospital within the past 12 months prior the inspection.

Access to individual patient's records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role. Electronic patient's records (EPR) were stored in line with data security standards and entries made in patient's records could be easily ascertained to person creating them. EPR training session was organised to all staff and was introduced in November 2018.

When required the department submitted reports through available systems such as the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) promptly to support shared learning and to share information with external bodies.

The department used information available through performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery, the information was also timely and relevant.

Engagement

The department engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The department engaged patients by encouraging them to take part in surveys such as Friends and Family. Patients were invited to attend board meetings to discuss their experience of services and how pathways might be improved.

The trust told us about various initiatives where patients were engaged in reviewing the service or clinical pathways. For example, a questionnaire considering pre-operative assessment was distributed to patients with a view to understand how patients wanted the clinic to work and what

was important to them. We were told this influenced the design of the pathway and how the clinic was organised. Patients were also given opportunity to influence decisions taken in relation to clinical pathways such as those guiding the knee or hip replacement procedures or performing a tonsillectomy.

Staff told us they felt engaged in the day to day operation of the department and could influence changes. They had regular staff meetings which they used to share information related to complaint or incidents, for learning and sharing examples of good practice and to provide support to one another. Staff said they felt listened to when they had suggestions related to service delivery.

Individual wards issued regular newsletters which were used for information sharing. Staff had opportunity to have one to one time with the matron of the service during “moments with matron” or “what matters to you” meetings in addition to other more formal and agenda driven meetings. Feedback from those meetings was used to improve the service and improvements were recorded in the “you said we did” document.

Theatre’s leaders organised a “joy in work’ meeting in September 2018 to talk about obstacles staff faces in their day to day work and potential solutions that could be implemented to remove them. The meeting was well attended by 24 of the staff working in theatres and recovery unit.

Learning, continuous improvement and innovation

The department was committed to improving services by learning from when things went well and when they went wrong, promoting training, research, and innovation.

The department introduced a monitoring system that allows to carry out local audits and benchmark outcomes against other departments within the trust. It was a smartphone application for healthcare inspections which assisted nursing teams with monitoring the quality of care.

The hospital also introduced an electronic patient record system in November 2018 and was in the process of minimising use of paper record across the site. Staff gave positive feedback on using the new electronic record system. They were provided with training and adequate face to face onsite support to help with resolving any initial implementation problems.

The clinical pathway group programme supported the development of clinically led, evidence-based clinical pathways across a range of areas. This was supported by a digital programme with the aim of reducing variation, standardising care across the group, and reducing costs whilst improving access and patient experience. Examples of some of the changes introduced:

- The management of right upper quadrant pain and gallstone surgery was being redesigned through a one stop shop with early ultrasound and surgery to reduce readmission rates. The trust told us that improved pathways for management of acute epistaxis and acute tonsillitis had led to significant reduction in length of stay by around 0.5-0.8 days and a reduction in outpatient follow up.
- The introduction of straight to test pathways for patients with suspected colorectal cancer had led to a reduction in average time from referral to first intervention from 12 to two days.
- The department improved pathways for the management of paediatric torsion, facial lacerations, maxillofacial trauma, dental trauma during anaesthesia. They also improved renal referral pathways and efficiency and access to pre-assessment with a ‘one stop shop’ model to improve patient experience and ensure timely recognition of complex patient problems.

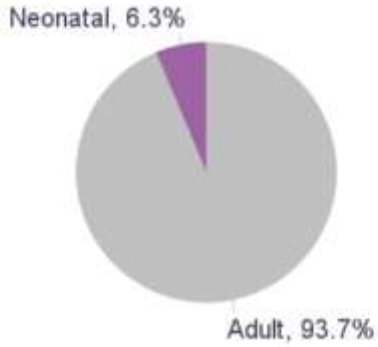
Critical care

Facts and data about this service

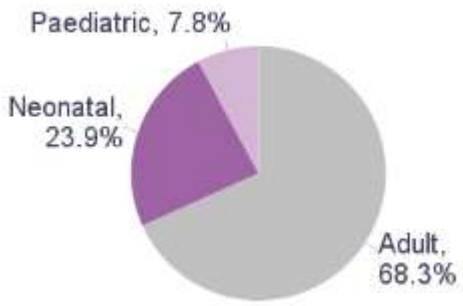
The trust, has 95 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Royal Free London NHS Foundation Trust and England.

This trust



England



(Source: NHS England)

At Barnet Hospital critical care services are delivered across two wards, Intensive Care Unit (ICU) North and ICU South, which operate as one unit. The critical care units have 23 beds, with 10 beds (including two side rooms) on ICU North and 13 beds (including three side rooms) on ICU South.

There is 24-hour consultant cover in place.

(Source: Routine Provider Information Request (RPIR) – Context acute)

There were 986 admissions to the service over the year 2017-2018, most were emergency admissions from the emergency department or unplanned surgery.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and most staff had completed it. However, medical staff compliance with mandatory training, was 74%, below trust target.

The trust set a target of 85% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 at trust level for qualified nursing staff in critical care is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	229	233	98.3%	85%	Yes
Infection Control L1	225	233	96.6%	85%	Yes
Resuscitation L1	224	233	96.1%	85%	Yes
Basic Radiation Safety	220	233	94.4%	85%	Yes
Fraud & Security	215	233	92.3%	85%	Yes
Health & Safety Awareness	215	233	92.3%	85%	Yes
Waste Management	215	233	92.3%	85%	Yes
Moving and Handling	214	233	91.8%	85%	Yes
Emergency Planning	214	233	91.8%	85%	Yes
Conflict Resolution	204	233	87.6%	85%	Yes
RTT L1	50	60	83.3%	85%	No
Equality, Diversity & Human Rights	194	233	83.3%	85%	No
Information Governance	194	233	83.3%	85%	No
Fire Safety	187	233	80.3%	85%	No
Resuscitation L2	187	233	80.3%	85%	No
Infection Control L2	186	233	79.8%	85%	No
Blood Transfusion	184	233	79.0%	85%	No

In critical care the 85% target was met for 10 of the 17 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the critical care department at trust level is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety	29	35	82.9%	85%	No
Basic Radiation Safety	25	35	71.4%	85%	No
Blood Transfusion	24	35	68.6%	85%	No
Emergency Planning	24	35	68.6%	85%	No
Fraud & Security	24	35	68.6%	85%	No
Health & Safety Awareness	24	35	68.6%	85%	No
Information Governance	24	35	68.6%	85%	No
Waste Management	24	35	68.6%	85%	No
BPAT	24	35	68.6%	85%	No
Moving and Handling	23	35	65.7%	85%	No
Conflict Resolution	23	35	65.7%	85%	No
Equality, Diversity & Human Rights	22	35	62.9%	85%	No
Resuscitation L1	22	35	62.9%	85%	No
Infection Control L1	21	35	60.0%	85%	No

Infection Control L2	19	35	54.3%	85%	No
RTT L1	18	35	51.4%	85%	No
Resuscitation L2	9	35	25.7%	85%	No

In critical care, the 85% target was not met for any of the 17 mandatory training modules for which medical staff were eligible in critical care.

Barnet Hospital critical care department

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the critical care department at Barnet Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	83	83	100%	85%	Yes
Resuscitation L1	82	83	98.8%	85%	Yes
Infection Control L1	81	83	97.6%	85%	Yes
Health & Safety Awareness	79	83	95.2%	85%	Yes
Moving and Handling	78	83	94.0%	85%	Yes
Basic Radiation Safety	78	83	94.0%	85%	Yes
Fraud & Security	77	83	92.8%	85%	Yes
RTT L1	20	22	90.9%	85%	Yes
Emergency Planning	75	83	90.4%	85%	Yes
Waste Management	75	83	90.4%	85%	Yes
Blood Transfusion	72	83	86.7%	85%	Yes
Conflict Resolution	72	83	86.7%	85%	Yes
Infection Control L2	72	83	86.7%	85%	Yes
Information Governance	71	83	85.5%	85%	Yes
Equality, Diversity & Human Rights	67	83	80.7%	85%	No
Fire Safety	63	83	75.9%	85%	No
Resuscitation L2	59	83	71.1%	85%	No

At Barnet Hospital critical care department, the 85% target was met for 14 of the 17 mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Records to end November 2018 showed improvement in compliance with Resuscitation L2 to 98%; Equality, Diversity & Human Rights 96%; and Fire Safety 89%. There was a drop in compliance with Fraud & Security to 76% and RTT L1 at 71%. We saw records confirming 92% overall compliance with mandatory training for nurses.

Matron and the leadership team closely monitored compliance and we saw messages displayed that bank nurses were not able to work unless up to date with mandatory training. Nursing staff told us the training was useful and could be completed through e learning and some face to face sessions. There were some difficulties with the e learning system recording completion of modules accurately. Staff scanned completion certificates to send to the education department to update training records as completed training was not always updated electronically.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the anaesthesia and critical care department at Barnet is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	58	86	67.4%	85%	No
Resuscitation L1	57	86	66.3%	85%	No
Fire Safety	55	86	64.0%	85%	No
Health & Safety Awareness	54	86	62.8%	85%	No
Infection Control L1	54	86	62.8%	85%	No
Basic Radiation Safety	52	86	60.5%	85%	No
Equality, Diversity & Human Rights	51	86	59.3%	85%	No
Fraud & Security	50	86	58.1%	85%	No
Moving & Handling	48	86	55.8%	85%	No
Emergency Planning	48	86	55.8%	85%	No
Waste Mgt	44	86	51.2%	85%	No
Blood Transfusion	43	86	50.0%	85%	No
Infection Control L2	38	86	44.2%	85%	No
Information Governance	38	86	44.2%	85%	No
Conflict Resolution	37	86	43.0%	85%	No
RTT L1	35	86	40.7%	85%	No
Resuscitation L2	33	86	38.4%	85%	No

At Barnet Hospital anaesthesia and critical care department, medical staff did not meet the 85% completion target for any of the 17 mandatory training modules as at August 2018.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust told us critical care medical care staff work across both anaesthesia and critical care and so figures had been reported for the directorate of anaesthesia and ITU and not specifically critical care. We requested mandatory training records for critical care medical staff. Overall mandatory training compliance was reported as 74%, which is below trust target. We did not receive a detailed breakdown of training completed.

Medical trainees told us it was difficult to complete e learning as not all computers were compatible, sometimes incorrect modules were completed different staff group. They told us there was little flagging of when training was due and they were not clear what still needed to be done. The trust told us that all substantive staff received reminder emails within one month of expiry of any mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. However, medical staff compliance with mandatory training, including safeguarding, was below trust target.

The trust set a target of 85% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 at

trust level for qualified nursing staff in critical care is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	228	233	97.9%	85%	Yes
Safeguarding Children L1	226	233	97.0%	85%	Yes
Safeguarding Adults L2	224	233	96.1%	85%	Yes
Safeguarding Children L2	224	233	96.1%	85%	Yes

In critical care the 85% target was met for all four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for medical staff in the critical care department at trust level is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	24	35	68.6%	85%	No
Safeguarding Adults L2	24	35	68.6%	85%	No
Safeguarding Children L1	21	35	60.0%	85%	No
Safeguarding Children L2	21	35	60.0%	85%	No

In critical care, the 85% target was not met for any of the four safeguarding training modules for which medical staff were eligible.

Barnet Hospital critical care department

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for qualified nursing staff in the critical care department at Barnet Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	82	83	98.8%	85%	Yes
Safeguarding Children L1	82	83	98.8%	85%	Yes
Safeguarding Children L2	82	83	98.8%	85%	Yes
Safeguarding Adults L2	80	83	96.4%	85%	Yes

At Barnet Hospital critical care department, the 85% target was met for all four safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

This was confirmed by updated records to end November 2018, seen at inspection. These also showed 95% eligible nursing staff had completed Safeguarding Children L3 training. Children were not generally admitted to the unit, the service told us one 16-year-old, requiring level 3 care, was admitted to the unit for in the past 12 months. Staff needed to be trained to recognise and respond appropriately to any issues relating to families and visitors

In addition to trust wide training, we were sent a clinical competency assessment for safeguarding vulnerable adults, for critical care nurses.

Staff demonstrated a good understanding of how to protect patients from abuse. At inspection we observed that staff identified concerns and responded appropriately to disclosures made by patients. Staff were able to identify potential safeguarding concerns for patients and wider family or visitors, adults and children. Staff knew how to raise safeguarding alerts and said they were supported by the hospital safeguarding team. They said they received feedback on actions taken in response to alerts and were informed when cases were closed. Safeguarding concerns were part of safety discussion at nursing handover at the start of each shift to ensure information was communicated and there was shared learning.

In discussion, staff we spoke with were aware of powers under the Mental Health Act (MHA) and obtained advice from the psychiatric liaison team based in the emergency department, referring for assessment as needed. Patients held on the unit under section of MHA were cared for with 1:1 support of a registered mental health nurse.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for medical staff in anaesthesia and critical care department at Barnet Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	51	86	59.3%	85%	No
Safeguarding Children L1	50	86	58.1%	85%	No
Safeguarding Adults L2	48	86	55.8%	85%	No
Safeguarding Children L2	46	86	53.5%	85%	No

At Barnet Hospital anaesthesia and critical care department, medical staff did not meet the 85% target for any of the four safeguarding training modules as at August 2018.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust told us critical care medical care staff work across both anaesthesia and critical care and so figures had been reported for the directorate of anaesthesia and ITU and not specifically critical care. We requested updated safeguarding training records for Barnet critical care medical staff. We did not receive the detail in relation to safeguarding training at the time of inspection. Following receipt of the draft inspection report we received training data for critical care consultants as at 28 February 2019, which showed some improvement in compliance, but this data was beyond the inspection timeframe.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The unit had five side rooms for infection control isolation purposes. The two side rooms on ICU North had ante rooms and negative air pressure to ensure contaminated air did not leave the room. The side rooms on ICU South did not have this level of infection prevention and control.

Staff took a risk-based approach, in consultation with microbiologist, in making decisions about where patients were treated. There were over 40 adverse incidents reported where infected patients needing to be care for in the open unit as there was no a side room available. These were managed well, there were no out breaks of *C difficile,* for example. A senior nurse told us the unit reported to the local network if any patient was nursed in the main ward with microbiology advice. ICU South was closed for deep cleaning and comprehensive outbreak control measures were put in place after increase in of Carbapenemase producing Enterobacteriaceae (CPE) colonised patients was identified. Matron told us this was detected as a result of a more sensitive screening test. The interventions were successful in terminating the outbreak.

The service submitted data to the Intensive Care National Audit and Research Centre (ICNARC) showed the unit was well within expected limits for unit acquired infections. There were no concerns in relation to hospital acquired blood stream infections such as MRSA, when compared to other units.

At inspection the unit was visibly clean. We observed equipment with 'I am clean' stickers detailing the date and time they were last cleaned. Individual equipment items were cleaned and ready for use. We observed some equipment in the store room did not have green stickers, Matron told us they were clean if in the store room.

Curtains were changed regularly to control the potential spread of inspection and labelled with last date of change. Nursing staff were trained and assessed in the procedures for cleaning bed space and equipment. There were antibacterial computer keyboards in the clinical areas, these were washable with antimicrobial coating.

Monthly environmental cleaning audits, of both ICU South and ICU North, consistently scored overall compliance of at 98% over the year up to 12 November 2018. We observed some high-level dust in south unit.

There was easy access to personal protective equipment, hand wash sinks and sharps boxes in bed spaces and across the unit.

Infection prevention and control (IPC) was included in mandatory training requirements. 95% of nurses had completed infection control training level 1 and 98% level 2, by end November 2018. This was above the trust target of 85%.

Monthly observational hand hygiene audits evidenced high performance in IPC. Actions to address any noncompliance with the trust policy or steps of hand washing included advice and training for staff, often at the bedside. At inspection we saw latest hand hygiene results were displayed as 100% compliant.

We observed staff providing direct care to patients were 'bare below the elbows', washing hands between each patient contact and using personal protective equipment such as gloves and aprons. Staff and visitors used hand gel on entering the unit.

There were regular audits of the standards in the use of invasive devices such as catheters, peripheral and central venous cannulas. This audit was to check care bundles were followed and included processes to reduce infection control risks. A consultant had completed an observational audit of central venous catheter (CVC) insertion and CVC maintenance.

Environment and equipment

The service had suitably safe premises and equipment and looked after them well. Staff were trained to use equipment.

ITU North was purpose built and included two side rooms suitable for respiratory isolation. ICU South was a converted surgical ward and the configuration of bed spaces did not maximise space around beds but was not unsafe. The side rooms on ICU South were not in line with best practice for critical care as they did not have ante rooms and pressure ventilation. Staff risk assessed their use.

The environment was bright and airy and in a good state of repair. Matron was continually reviewing the environment to make improvements, for example to storage rooms which were too hot for IV fluid storage.

A blood arterial gas analyser was available in each unit, which was regularly checked. Emergency equipment, resuscitation and difficult airway, was in kept tamper evident tagged trolleys. We saw completed records of checks confirming the tag was checked as secure twice a day on each shift. The trolley contents were checked once a month, with a clear pictorial guide for staff showing the equipment required in each drawer.

The equipment manager had responsibility for ensuring equipment servicing, staff training on equipment and the ordering of stores. There were databases detailing equipment inventory and servicing records and staff training requirements for each piece of equipment (risk rated). We saw equipment had stickers confirming servicing and electrical testing was in date.

There were databases of detailed training modules, assessments and training compliance records. Details of individual staff needs, such as language, competencies and specialist skills were also recorded, to assist with planning equipment training for the unit.

There were safety audits of the use of equipment and patient bedside environment which were communicated to staff. Audit in April 2018 showed improvements on the results of Jan- February 2018 audit.

Staff told us there was sufficient equipment to cater for an increase in numbers of level 3 patients, for example the unit had 13 ventilators for the allocated nine level 3 patients. We saw one incident report in September 2018 where 13 patients were ventilated and one deteriorated so 14 ventilators were required. Medical staff took emergency action for 15 minutes whilst awaiting equipment. In response staff highlighted when 12 patients were being ventilated, so additional machines could be made ready. Staff could access the equipment library out of hours.

There were arrangements for appropriate segregation and management of waste. Each bed area had clearly labelled ‘hands free’ pedal bins and large sharps boxes, which were also sited appropriately across the unit and in clinical rooms. There were also recycling bins and confidential waste disposal bins.

Assessing and responding to patient risk

Staff completed a range of risk assessments for each patient using the unit electronic patient record system, specifically designed for use with critical care patients. Eighty-five percent of patients were admitted within four hours of decision to admit. Consultants were involved in discussion and management plan pre admission, but not all patients were reviewed by a consultant within 12 hours of admission.

The ITU did not have a critical care outreach team but the hospital wide Patient at Risk Resuscitation Team (PARRT), which was managed within surgical services, provided this as part of their role. The trust wide team was led by a consultant nurse specialist. A band 8a lead nurse and six band 7 specialist nurses, with ITU or A&E backgrounds, worked at Barnet hospital. The team worked closely with critical care consultants and trainees and were available everyday 7.30am to 8pm. An early warning system (NEWS 2) was used throughout the hospital for

detecting the deteriorating patient, along with a sepsis care bundle (sepsis 6) for identifying and managing sepsis. The PARRT point prevalence audit of two surgical wards found has complete sets of observations, and triggering patients with appropriate escalation and treatment plans. PARRT provided resuscitation and simulation training education to across the hospital and in situ simulation training to ward staff every two months.

Ward staff contacted the medical team and PARRT if a patient triggered escalation. They were supported by PARRT and critical care medical staff as needed, including visiting the ward with an ITU consultant and admission to ITU if needed. The consultant covering North unit was responsible for following up referrals and admissions during the day.

An average of 65 patients per month were identified as 'at risk' and band 7 PARRT nurse attended on average within 1.5 hours. PARRT also followed up discharges from critical care, including those with tracheotomies, averaging 56 per month. PARRT routinely discussed patients of concern, across the hospital, with ITU medical team. They had meetings first thing in the morning and through the day. PARRT gave a priority list to the Hospital at Night team at evening handover who liaised with critical care trainees as needed. All admissions out of hours were discussed and agreed by the on call ITU consultant.

ICNARC report 2017-18, seen at inspection, showed there were not a high number of high risk admissions, or high-risk sepsis admissions, from the wards when compared with units nationally.

The data provided showed 46% patients were admitted within 4 hours of decision to admit, so the service did not meet the standard for 54% patients. It was not clear that this information was accurately recorded on the electronic system. A note on the data stated it was possible that, contrary to guidance, some theatre cases were recorded as time accepted before the start of surgery. The critical care beds were pressured due to high levels of delayed discharges. A report to the executive team, 9 October 2018, stated that following review of incidents there was no evidence of harm as a result of delay to admissions to ITU. Following receipt of the draft inspection report the trust explained that some admissions had been recorded as admitted at the time of bed booking and then recorded correctly using a different data set. The trust provided the different data set which showed 85% of patients were admitted within 4 hours of a decision to admit, which met the standard.

Consultant review on admission, recorded on the system, was not always within 12 hours. Data submitted at the time of inspection showed 72% patients reviewed within 12 hours, with another 20% patients reviewed within 18 hours. Staff told us a consultant reviewed patients prior to admission, on occasions visiting and assessing in other areas of the hospital and this was not recorded on the unit electronic system. The lead consultant acknowledged that at times new patients were not reviewed by consultants as priority before a ward round, and this was being considered going forward. Following receipt of the draft inspection report the trust explained that some admissions had been recorded as admitted at the time of bed booking and then recorded correctly at admission to the unit using a different data set. The trust provided the different data set which showed 80% patients were reviewed within 12 hours of admission. Every admission to the unit required consultant discussion and management plan and patients were reviewed as soon as possible bearing in mind clinical urgency.

Staff completed a range of risk assessments for each patient admitted onto the unit, using the unit electronic patient record system, specifically designed for use with critical care patients. The system alerted both nursing and medical staff if any assessments and ongoing reviews were not completed, as well as highlighting variations in patient condition. Nurses used a recognised model of patient assessment and evaluation. Nursing risk assessments included pressure areas, moving

and handling, nutrition and, venous thromboembolism (VTE) and falls. Safety thermometer data recorded all patients as VTE assessed December 2017 to November 2018. Patients could be weighed whilst on their bed and this helped to determine appropriate care such as pressure mattress settings and dosage of medicines.

Patient consciousness levels were recorded using the Richmond Agitation-Sedation Scale (RASS). Staff were encouraged to use the Confusion Assessment Method for the ICU (CAM ICU). Following audit of delirium screening in January 2018, additional bed side staff training and flow charts on ICU (CAM ICU) were introduced to improve staff confidence and use. It was not clear this had extended to the wider multi-disciplinary team. An allied healthcare professional we spoke with was not aware of delirium screening.

High impact interventions were regularly audited to check staff were following safety standards for patients with indwelling catheters, peripheral and central lines and ventilators including reducing ventilator associated pneumonia. Medical staff had developed local safety procedures, for example insertion of arterial lines and checks for removal of guidewire. We also saw an intubation checklist, to be read out loud, and difficult intubation guidelines.

Nursing and medical staff were confident in the escalation processes and felt well supported by consultants and senior nurses. Consultants were proactive in encouraging medical trainees to escalate any concerns, it was mandatory to call a consultant out of hours if staff had any concerns.

Nurse staffing

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The trust has reported the following qualified nursing staff numbers in critical care from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	102.8	84.3	82.0%	99.8	82.3	82.5%
Royal Free Hospital	209.2	148.7	71.1%	206.2	146.9	71.2%
Total	312.1	233.0	74.7%	306.0	229.2	74.9%

From April 2017 to March 2018, the trust reported a staffing level of 74.7% for qualified nursing staff in critical care. This was about the same with 74.9% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Fill rates for September to November 2018, seen at inspection, were slightly better ranging from 89.1% to 96.4%.

The unit staffing allocation included a matron, 12 band 7 team leaders (one was a band 6 in development role), 22.8 WTE band 6, 39.3 WTE band 5, and 9.4 band 2 nurses. Nurses worked in 12 cluster teams in two larger teams ‘Daisy’ or ‘Buttercup’, allocated to ICU North or ICU South, for 3-month period. Matron told us this improved safety governance, continuity of care and complex discharge planning. There was a standardised handover at the beginning of each shift; this incorporated a written ‘pre-flight’ briefing and ‘hot topics’ discussion. In addition, there was a

bedside handover once patients had been allocated.

The nursing establishment was based on patient acuity of nine level 3 and 14 level 2 patients, additional staff were found if the acuity increased due to emergency admissions. At inspection we found that every day there were several level 1 patients awaiting discharge. Nurse staffing was sufficient to meet professional standards of 1:1 registered nurse to level 3 patients and 1:2 registered nurse to level 2 patients, and supernumerary band 7 coordinator nurse on each unit every shift. An additional float nurse was based on ICU South and worked across both units as needed.

Staff rotas were planned by band 7 nurses supported by a band 4 administrator who helped cover gaps and swaps in shift for example contacting staff for extra shifts using mobile phone apps. The administrator was clear about the skill mix required for each shift.
Staff told us they worked 12.5-hour shifts but were not paid for breaks, as paid for 11 hours. They said that as a result staffing felt tighter, although they did cover each other's breaks, and in effect they worked an extra day every six weeks. Training was often undertaken in their own time.

From September 2017 to August 2018, the trust reported a vacancy rate of 25.8% in critical care. This was higher than the trust target of 12%.

- Barnet Hospital: 18.9%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The matron told us vacancy rates at time of inspection were 6.2% for band 6 and 17.9% for band 5 nurses but this would increase with recent resignations of nurses going back to Portugal (this followed the return of several Spanish nurses). There was ongoing recruitment with monthly trust wide open days, and an ITU open day was planned for January. Following previous success across the trust, the matron told us further overseas recruitment campaigns were planned for surgery services and critical care.

The Patient at Risk Resuscitation Team (PARRT) was understaffed by one WTE; a clinical nurse specialist had been recruited for February 2019.

From September 2017 to August 2018, the trust reported a turnover rate of 22.1% in critical care. This was higher than the trust target of 13%.

- Barnet Hospital: 29.2%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

The nurse retention project had some effect in reducing turnover rates from previously higher levels. The aim of the project was to reduce nurse turnover in ICU to 25% by December 2018. This was achieved in May 2018 ahead of schedule. However, several of the European nurses were due to return home.

From September 2017 to August 2018, the trust reported a sickness rate of 3.2% in critical care. This was lower than the trust target of 3.5%.

- Barnet Hospital: 4.9%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 24% of nursing staff shifts in critical care were filled by bank staff and 2% of shifts were filled by agency staff. In addition, 2% of shifts were not filled by bank and agency staff to cover staff absence.

The breakdown by site is shown in the table below:

Site	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Barnet	217,762	41,263	19%	467	0%	11,115	5%
Royal Free	436,945	115,693	27%	15,319	4%	3,631	1%
Total	**654,706**	**156,955**	**24%**	**15,786**	**2%**	**14,746**	**2%**

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The unit employed bank nurses who worked regularly on the unit and had completed mandatory training. Many had ITU qualifications. Senior staff aimed to comply with using less than 20% agency or bank staff per shift. Nurses told us that they very rarely worked with any bank or agency staff who did not know the unit.

The service told us that staffing levels flexed up and down according to patient acuity, sometimes only 17 rather than 19 staff were needed and so the shift was not filled by bank. On occasions when the required staffing levels were not filled the band 6 practice educator, or band 6 equipment manager were absorbed into the nursing numbers. If unable to cover a full shift they covered for breaks and assisted with patient interventions and procedures.

Medical staffing

The service generally had enough medical staff with the right qualifications, skills and training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, consultant rotas for weekend afternoons did not meet the recommended guidelines for consultant to patient ratio.

The trust reported the following medical staff numbers in anaesthesia and critical care from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	72.6	83.9	Over-established by 16%	89.6	88.1	98%
Royal Free Hospital	36.5	32.6	89.3%	41.5	35.6	85.8%
Total	42.0	39.6	94.3%	41.5	36.6	88.2%

From April 2017 to March 2018, the trust reported a staffing level of 107% for medical staff in

anaesthesia and critical care. This had decreased to 94 % from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The trust told us critical care medical care staff work across both anaesthesia and critical care and so figures had been reported for the directorate of anaesthesia and ITU and not specifically critical care.
In the critical care unit, patient care was led by a consultant in intensive care medicine. Twelve consultants worked one in six rotas in weekly blocks in ITU, which increased continuity. They had dedicated job plans so no responsibilities outside ITU when allocated. There were two consultants on duty each shift, one each for ICU South and ICU North.
The service met the guidelines for provision of intensive care services (GPICS) standard for consultant other than weekend afternoons. GPICS states that in general a consultant to patient ratio should not exceed between 1:8 and 1:15. Overall, during weekdays there was one consultant per 11.5 beds 8am- 6pm. At weekends, there was one consultant 8am-6pm and one 8am-12pm, so one consultant for 23 beds Saturday and Sunday afternoon. Out of hours one consultant was on call from home for 23 beds 6pm-8am, able to attend the hospital within 30 minutes.
Junior doctor day time cover was provided by five clinical fellows (post foundation), four CT2 trainees in anaesthetics, one trust grade, and two senior clinical fellows. Clinical fellows had been successfully recruited where specialist trainee posts were unfilled. They sometimes needed additional airway training, which was provided in house, but the lead consultant told us they were of a good standard. During the day and out of hours, including nights and weekends, the service planned to have a minimum of one post foundation anaesthetics trainee on each unit who was trained in advanced airway techniques. The consultant meeting minutes November 2018, highlighted gaps particularly after 6pm and this was addressed with the rota coordinator. There was also a specialist trainee (ST3 or above) 'float trainee' available to assist out of hours. Trainees worked 1 in 8 rotas on call. The trust told us there was a minimum of one trainee per 11.5 beds 24/7, generally three trainees per shift. November 2018 rotas showed the GPICS standard, (1:8, doctor/ patient ratio), was met on all but two shifts over the month where it was 1:11.5 trainee;patient ratio. Staff we spoke with told us there was always sufficient medical support and suitable trained doctors available to review patients or respond to emergencies.

Medical handovers took place twice each day, at start and end of shifts. Consultants held twice daily formal ward rounds. The main round in the morning was held at the bedside, followed by a shorter board round in the afternoon.

From September 2017 to August 2018, the trust reported a vacancy rate of 5.1% in critical care. This was lower than the trust target of 12%.

- Barnet Hospital: Over-established by 43.4%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

There was a stable consultant workforce on the unit and there were no vacancies. Clinical fellows were recruited to cover gaps in trainees. An advanced critical care practitioner was also assigned to the team and was following the Kings College course.

From September 2017 to August 2018, the trust reported a sickness rate of 0.4% in critical care.

This was lower than the trust target of 3.5%.

- Barnet Hospital: 0.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

There was no sickness and minimal turnover and no medical bank or locum use at Barnet ITU.

Records

Staff kept detailed records of patients' care and treatment on the critical care unit electronic records system. They were clear, up-to-date and easily available to all staff providing care on the unit.

Detailed multi-disciplinary patient records were created and stored on an electric system. It was designed and continually upgraded/amended, by one of the consultants, to meet the needs of the critical care unit. All staff, without exception, told us the system met their needs, was responsive and supported safe patient care and record keeping. The system automatically generated doctor and nurse alerts if records were not completed. For example, a red flag on the overview screen alerted that ward round notes had not been completed and saved for that day. It 'flagged' repeated issues and areas where staff needed additional support and training in assessments and records. Changes were regularly made to the record system in response to incidents for example the completion of safety checklists and witness confirmation of guidewire removal was added following a never event.

All records we reviewed on the system were legible, dated and electronically signed. The summary page gave clinicians the up to date observations and safety information needed. Allergies and resus status were clearly visible. There were records of summary of events prior to admission, consultant review on admission, ward rounds, nursing assessments, observations, fluid balance, review of indwelling lines. There was also multi-disciplinary team input, for example physiotherapist records of treatment plans and progress. Time of decision to admit and actual admission was not clearly recorded on the records we reviewed.

The system was standalone to the unit and a new and different electronic patient record system (EPR) was implemented across the hospital wards at Barnet and Chase Farm in mid-November 2018. Staff needed to work the two systems in parallel, to review pre-admission information and input information for discharge to wards. There were also some paper records that were generated prior to EPR.

Some staff were not so skilled in navigating the unit patient records system, for example they were unable to find underpinning assessments and documents when asked. Some critical care staff were concerned that they had not received sufficient training on the new EPR system, they found the e-learning package insufficient. This led to some difficulties and risks in accessing pre-admission records and assessments from emergency department and wards. For example, staff could not find the full DNACPR forms to support a decision of not for resuscitation on one patient and on interrogation EPR showed a different (incorrect) resuscitation status to that on the unit records. The clinical nurse educator immediately sought advice from the EPR team and found a solution to resolve this. The team continued to raise requests for additional face to face training, as this had not been deemed necessary as the EPR was not yet implemented on the unit.

The trust subsequently told us that at the time of inspection EPR was in the third week of the implementation and the priority training areas were identified and risk assessed for all clinical areas fully using the EPR system. The staff had e-learning but did not require face to face

classroom training as there are no immediate plans to introduce a new EPR system into ITU. There was 24 hours on site support for ITU around the EPR roll out in the form of floor walkers who could be bleeped as required to assist with admission and discharge interface issues.

The trust planned to eventually implement the new EPR system hospital and trust wide. All critical care staff were concerned that the EPR system was not, in its current state, fit for purpose for adoption on an ICU, and would create patient safety risks. The trust told us the system would not be introduced to Barnet critical care until there was sufficient assurance that it was fit for purpose.

Medicines

The pharmacist cover on the unit did not yet meet the standard for critical care, and the storage of medicines and intravenous fluids was not always safe or secure. Medicine storage rooms, cupboards and fridges were unlocked and some storage rooms were too warm. We found 'mixed' boxes of IV fluids, both type and dosage stored together, which created high risk of error, and some out of date medicines.

One band 7 pharmacist, in post since May 2018, worked part time Monday to Friday on the unit, supported by a pharmacy technician. This was insufficient cover for the ITU and did not meet guidelines for provision of intensive care standards. The pharmacist undertook reconciliation and review of medicines, attended the multi- disciplinary meeting and ward rounds when available. A business case was in progress for an additional whole-time specialist pharmacist for theatres and ITU. In the interim the pharmacist was supported remotely by the ITU specialist pharmacist at Royal Free Hospital, who provided guidance and advice.

Medicines on both north and south unit were stored in clean utility rooms with key pad lock. We observed the key pad on the door was usually disabled so the room was unlocked. In the rooms we found some emergency cupboards and fridges were unlocked. They contained dangerous medicines, and some with potential for abuse. There was high risk of unauthorised access to medicines. We were told this arrangement was to give medical staff ease of access in emergency. This medicines security concern was identified at the last inspection, and had since been risk assessed. It was on the ITU risk register and assessed as residual low risk, however this assessment was made on the understanding that the medicine cupboards and fridges were locked within the room.

Intravenous (IV) fluids were not always stored safely. We found 'mixed' boxes of IV fluids, both type and dosage, in both clean utility rooms and in a storage room, which created high risk of error. For example, a box labelled enteral feeds contained a mix of potassium infusions, mannitol infusions and glucose saline, another box contained intralipid along with potassium infusions of different doses. IV fluids were stored on the same racks as irrigation and inhalation fluids in the treatment rooms and labelling was not clear to prevent confusion. Some empty bed spaces had IV fluids and other medicinal items in trolleys, the issues were raised with Matron at the time.

Medicines were stored safely at the bedside in individual lockers with a keypad lock.

Controlled drugs (CD) were generally well managed, safely stored with regular stock checks. Staff knew how to escalate discrepancies. However, we found some crossings out in the CD register which is not in line with Misuse of Drugs Act regulation 20(c). We saw records of pharmacy team CD audits February, March and August 2018.

Medicine fridge temperatures were regularly checked, but there were a few gaps in records and when exceptions were recorded no clear action was taken other than 'reset'.

There were high temperatures in one stock room where IV fluids were stored, regularly 28 C, which could affect the efficacy and expiry dates. There was no immediate action to mitigate this risk other than a fan in the room, and pharmacy was not engaged in advising on the issue. The matron had identified alternative storage in a cleaner's cupboard but was awaiting sign-off of necessary work to make the move. Subsequent to the inspection, the trust told us they had checked with manufacturers that IV fluids were safe to use up to 30C and had agreed actions should the temperature rise above this. They reported the completion of work to move the store room and that temperatures were now maintained at 23 degrees.

We were told that junior doctors had responsibility for checking transfer bags, checks were not well completed and there was a potential risk that in emergency, contents would be out of date.

We found the anaphylaxis kit on ICU South was out of date and there were some out of date diazemuls in the North side fridge. This information was shared with the matron who took immediate action to address this.

Emergency trolleys were regularly checked, medicines and oxygen were in date, and staff had a clear understanding of what happened when the emergency box was used.

Staff followed best practice when prescribing, giving and recording medicines. The prescribing and administration of medicines was integrated into the electronic records system. Allergies were clearly documented on the system. Reasons for antibiotics with start and finish dates were clear. Sedation was regularly reviewed following patient assessments. Staff told us of a medication error due to working with dual systems, following the recent introduction of the new EPR across the rest of the hospital. All staff we spoke with were aware and were taking care to avoid similar errors.

A full set of protocols to guide prescribing/ use of medicines was held electronically, on the on the computer. There was also a folder with some laminated protocols at the bedside. However, these 'hard copies' were not always the up to date version and there were some duplicates with different dates.

Audits of medicines administration showed high levels of compliance, with reasons for non-administration documented.

Results of audits of bedside drug infusion showed 100% compliance, prescription, infusion running and pump rate (February, April, June and November 2018).

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff used the electronic reporting system for any adverse incidents. All staff we spoke with were aware of how and when to report incidents and had used the reporting system. They received feedback on outcomes of investigation and learning across the unit and wider trust was shared during handover safety briefings and hot topics. There was a 'blog' function which senior staff used to share learning with all staff including the multi-disciplinary team. Medical staff discussed incidents and learning at weekly governance meetings.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

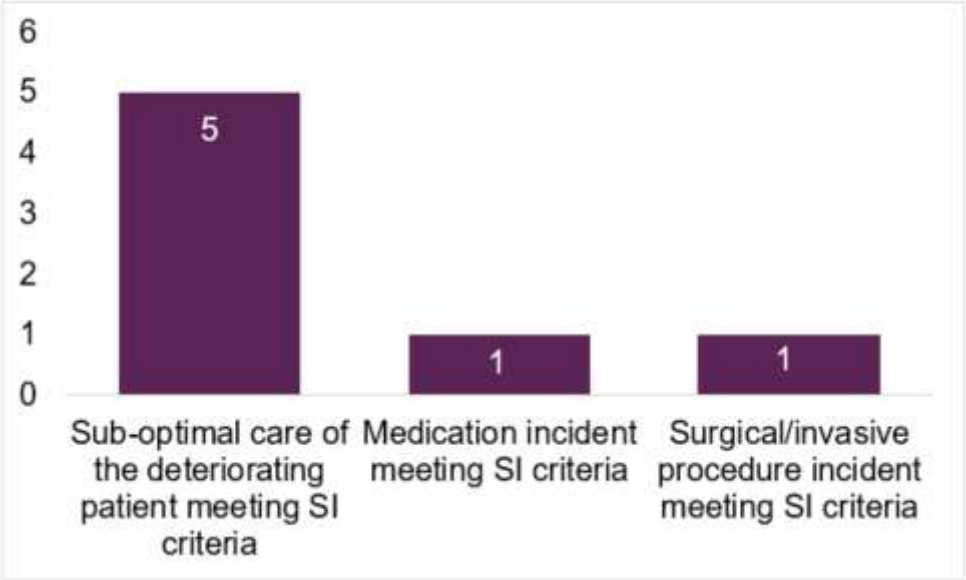
From September 2017 to August 2018, the trust reported no incidents classified as never events

for critical care.

(Source: Strategic Executive Information System (STEIS))
In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from September 2017 to August 2018.

These incidents were for:

- Sub-optimal care of the deteriorating patient meeting SI criteria with five (71.4% of total incidents).
- Medication incident meeting SI criteria with one (14.3% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (14.3% of total incidents).



Site specific information can be found below:

- Barnet Hospital: three
- Royal Free Hospital: four

(Source: Strategic Executive Information System (STEIS)
During the inspection visit the matron and clinical lead told us that they had categorised the surgical invasive procedure incident as a never event as it related to a retained guide wire. They reported this as a never event through trust governance processes and thought it had been reported formally as such. The investigation of the event had led to a post procedural safety checklist and witness to the removal of guide wire. The electronic record system had been amended to include the checklist and recording of the removal of guide wire.

We saw thorough investigation, learning and actions from one serious incident, classified as the sub- optimal care of the deteriorating patient, where a tracheostomy was dislodged during turning. This resulted in changes to moving and handling training and tracheostomy emergency /deteriorating patient induction training and simulations for trainees and nurses. The second incident had been reported by the unit as a naso-gastric tube had been found during a scan, this had not been inserted whilst the patient was on the unit and so was incorrectly attributed to staff practice there. It was referred to relevant service at the Royal Free hospital site for investigation

All staff we spoke with were aware of these serious incidents on the unit and the changes made to improve safety. They were also aware of the Duty of Candour a regulatory duty that relates to

openness and transparency. It requires providers of health and social care to notify patients (or other relevant persons) of certain notifiable harm incidents and provide reasonable support to that person. We saw evidence of compliance with Duty of Candour in incident investigations, informing the family as soon as possible and a full apology to patient and family followed by a letter of apology and further information. Patients and relatives were offered a face to face meeting and a copy of final investigation report.

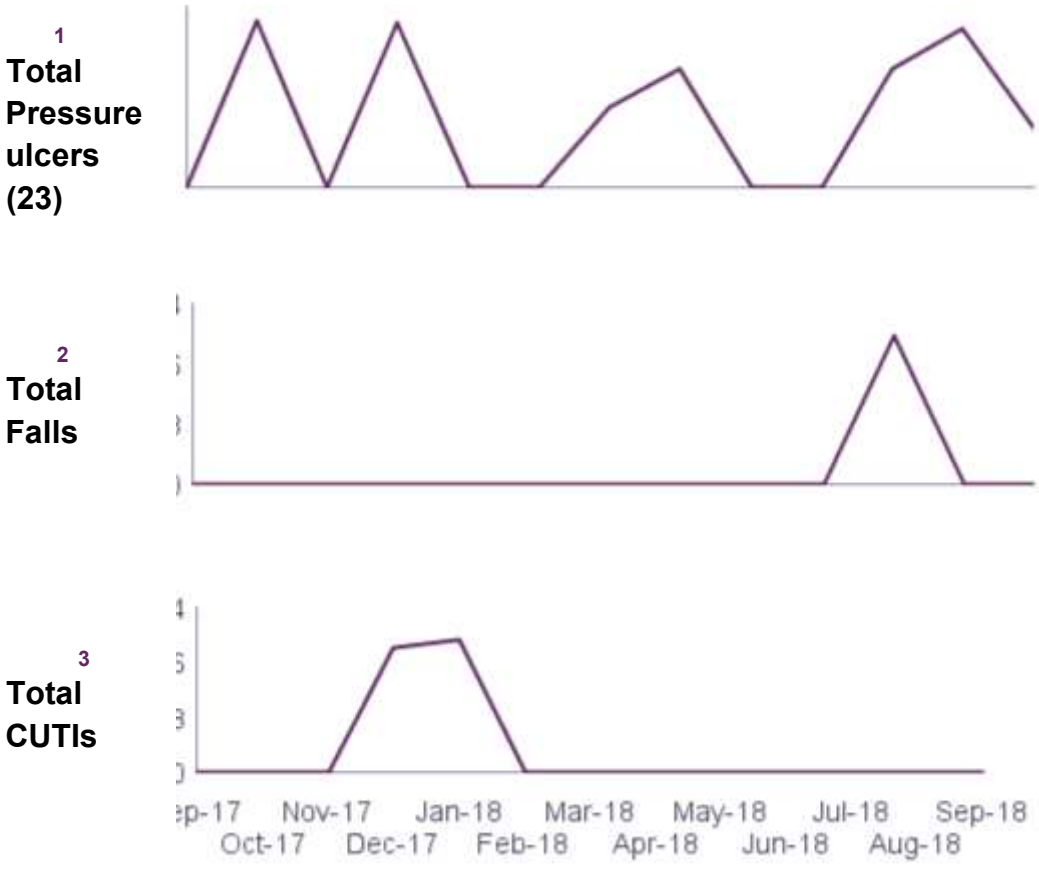
Safety thermometer

The service used safety monitoring results to improve the service. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported 23 new pressure ulcers, one fall with harm and four new catheter urinary tract infections from September 2017 to September 2018.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Royal Free London NHS Foundation Trust



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only. *(Source: NHS Digital)*

The critical care unit participated in the NHS safety thermometer scheme and data from one day a month was reported. Data reviewed for December 2017 to November 2018 showed one month with harm free patients, four months with a patient acquiring a new pressure ulcer grade 2 or 3, one catheter related urine infection and one fall resulting in low harm. All patients were VTE assessed and the majority received VTE preventative medicine.

Information on harm free care was displayed in both North and South wing on a patient safety board, alongside staffing levels.

Staff had access to tissue viability nurse specialist as well access to more specialist pressure relieving equipment if needed.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. These were built in to the unit's electronic records system. Managers checked to make sure staff followed guidance.

Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges, the Intensive Care Society, the Faculty of Intensive Care Medicine and other relevant bodies.

Evidence based patient pathways were built into the unit electronic records system, staff told us this meant that they were alerted if there was any deviation from the pathway. Staff were very positive about the role of the system for ensuring evidence based care.

Senior staff audited adherence to high impact intervention care bundles, peripheral and central intravenous (IV) lines, VAP and catheters. These were used to reinforce best practice. Monthly audits September to November 2018 identified generally high compliance of 100%. There were some lapses in date of insertion IV-line dressing, and catheter pack traceability labels placed in paper patient records.

The PARRT were responsible for overseeing evidence based continuous positive airway pressure (CPAP) and tracheostomy guidelines, DNAR guidelines, deteriorating patient, and resuscitation guidelines across the hospital. They provided training in line with this guidance.

All policies and protocols were available electronically via computer terminals and there were folders with laminated copies of relevant protocols and guidelines at each bedside. However, these 'hard copies' were not always the up to date version. For example, oral care guidelines on the computer differed to the hard copy version. There were some duplicates with different dates, and we saw some out of date protocols pinned on the wall.

Patients had a rehabilitation assessment completed within 24 hours of admission to critical care and daily physiotherapy. Physiotherapists measured rehabilitation progress using Chelsea Critical Care Physical Assessment tool. Compliance with NICE CG83 was assessed in a retrospective records audit over a month June 2017- July 2017. This found partial compliance in some areas with improvements needed in goal setting and information provision. Audit in November 2018 showed improvements in these areas. However, there were some shortfalls with due to recent shortage of physiotherapists and no allocated occupational therapy and clinical psychology, which did not meet GIPCS. The trust told us, it was reviewing the provision of clinical psychology across services.

Staff told us they used patient diaries as evidence shows they reduced post-traumatic stress disorder for critical care patients.

There was a monthly follow up clinic, run by a consultant intensivist and a senior nurse, however there was no therapy or psychology input, as identified in the NICE CG83 audit. Patients were referred for psychological support when identified as needed.

The pharmacist was undertaking an audit an audit of anticoagulation with the aim of developing an agreed protocol for the unit.

The ICU followed NICE guidance CG135 by promoting and participating in a programme of organ and tissue donation. The service was above the national average in the potential donor audit.

The critical care unit participated in the ICNARC database for England Wales and Northern Ireland, so care delivered and patient outcomes were benchmarked against similar units nationally.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Nursing staff completed comprehensive competency assessments in nutrition and hydration including screening, referrals and enteral and parenteral support. Staff used the Malnutrition Universal Scoring Tool (MUST) on admission and at regular intervals. Staff used bed scales to obtain accurate weight. These were seen to be completed on the electronic record system along with fluid balance checks.

A band 7 dietitian was allocated to the unit, working weekdays and bank holidays, providing 0.05 hours per bed which met the national standard at the lower level. A band 6 dietitian, with critical care competencies, covered leave. Recent audit showed that nutritional support (enteral or parenteral feeding), was started within 6 hours of admission. Parenteral nutrition was not commenced until after MDT discussion, and rarely out of hours. The dietitian also led an audit to check that naso-gastric tube placement was checked by X Ray and documented

A speech and language therapist (SALT) was available Monday to Friday and bedside nurses were also trained to undertake swallow assessments.

Patients who were able to take oral nutrition were offered a menu with a wide range of dietary requirement food, clear labelling, and healthy choices. There was access to meals to meet cultural and religious needs.

Patients told us they enjoyed the meals and there was always clean water available to drink. One told us they liked the food but would prefer smaller portions, and we saw this was not available for all menu choices.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff used verbal and nonverbal assessments to assess and manage pain. The Critical Care Pain Assessment Tool (CPOT) was used to assess pain in patients who were unable to communicate. Pain levels were regularly reviewed and discussed at ward rounds; this was recorded in the electronic patient record.

Pain relief was managed by consultants on the unit, with input from specialist pain team available on request. Staff told us that the pain team included a psychologist if needed.

Staff competency assessment included patient controlled analgesia (PCA) for patients able to use it. Nurses told us there was a new policy and procedure developed following a few near miss incidents, and this was much clearer to use.

Patients we spoke with told us that pain had been dealt with immediately.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used findings to improve them. They compared local results with those of other services to learn from them.

The trust has two units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The data discussed in this report relates to critical care at Barnet Hospital.

For Barnet Hospital, Intensive Therapy Unit at Barnet General Hospital, the risk adjusted hospital mortality ratio was 1.2 in 2016/17. This was worse than expected. The figure in the 2015/16 annual report was 0.9.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
964 admissions	Risk-adjusted hospital mortality ratio (all patients)	0.9	1.2	1.0	none	Worse than expected

(Source: Intensive Care National Audit Research Centre (ICNARC)

ICNARC data from 2017-2018 report, seen at inspection, showed the risk adjusted mortality rate had improved to 1.0 within expected limits.

For Barnet Hospital, Intensive Therapy Unit at Barnet General Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.2. This was within expected limits. The figure in the 2015/16 annual report was 0.8.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
611 admissions	Risk-adjusted hospital mortality ratio for patients	0.8	1.2	1.0	none	Within expected limits

	with predicted risk of death <20% (lower risk)					

(Source: Intensive Care National Audit Research Centre (ICNARC)

ICNARC data from 2017-2018 report, seen at inspection, showed the risk adjusted mortality ratio for patients with a predicted risk of death of less than 20% had improved to 0.8, well within expected limits.

The divisional director told us that the hospital performed well in emergency laparotomy audits scoring 99% with low rate of mortality when compared nationally. They felt this was in part due to good access to high quality critical care post-operatively.

The unit held weekly mortality review meetings, and the format had been amended to meet the 'learning from deaths guidance'. Consultants reviewed cases prior to the meeting and submitted comments and learning points for discussion. Staff had open invites to the meetings which were attended by consultants, trainees, clinical nurse educator and matron. They reported positive learning from discussions.

ICNARC data from 2017-2018 report showed unplanned readmissions within 48 hours were well within expected limits, with out of hours transfers (non-delayed) and non-clinical transfers to another unit, also within expected limits.

The trust was an outlier for discharges direct to home, and for bed days of care post 8-hour and 24-hour delay (see responsive section of the evidence appendix).

There was some evidence of local audits listed on a 2018 audit calendar, with some audits to be done in 2019. These audits were mostly led by consultants, with some led or co-audited by junior doctors, therapists, physiotherapist, dietitian, pharmacist and SALT. The summary of findings and actions following audit over the last few years evidenced improvements made. For example, the audit of compliance with cuff pressures led to a pop up box with alerts on the electronic record system and re audit found sustained improvement.

As part of the North East and North Central London Adult Critical Care Network the unit participated in peer review. The latest report January 2017 found the unit met most standards. At inspection we found some steps had been taken to address areas for improvement such as morbidity and mortality reviews, the use of bank/ agency staff, percentage of nurses with post graduate qualification in critical care. The PARRT team were providing education to ward staff. However, out of hours discharges continued and the provision of sufficient pharmacist cover was still an issue.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Nurses had access to ongoing specialist training supported by a clinical education department. The unit had one full time band 7 clinical practice educator supported by a band 6 who also worked four shifts a month on the unit. Staff completed self-study and competency assessments through work books, as well as more formal and bedside training sessions.

Newly qualified nurses who wanted to work in critical care were seconded for nine months to a surgical ward to consolidate basic skills before starting on the unit. New staff, including those transferring from wards, followed an induction programme. They worked four weeks supernumerary, with weekly meetings to check progress. Staff were required to complete competency assessments, for example basic ventilator and competency assessment. Nurses working on the unit completed competencies in medicines administration and intravenous therapy.

We were shown development programmes for band 5 and band 6 nurses, plus a band 7 orientation pack and checks on competencies. There were also orientation packs for midwives and student nurses assigned to the unit.

The trust had ‘in house’ courses including introduction to critical care, held at the Royal Free hospital and now accessed by external trusts. 29% of unit staff had completed the introduction to Critical Care course. Nursing staff also followed a national competency framework for adult critical care nurses, level 1 and 2. Staff who transferred patients completed transfer competencies.

Band 7 nurses completed intermediate life support and advanced life support training in addition to annual basic life support.

49% of staff had a Critical Care qualification, just below the 50% standard, and we were told some bank staff had the qualification and increased the ratio on shifts. There was a rolling programme for staff to access the training.

Additional training programmes were provided on the unit and at the bedside, often in response to audit or learning from untoward incidents. We were shown the clinical practice educator sepsis training programme dated October 2018

Medical staff attended an induction programme on their first day. They were given a detailed and comprehensive induction pack with useful information including job role, meetings and teaching sessions, clinical guidelines and tips, referrals, electronic record system and other unit specific information. Teaching and learning opportunities included morbidity and mortality meetings, daily ward based teaching, radiological teaching, and a dedicated consultant led critical care half day each week, which they were expected to attend. Trainees were also expected to be involved and lead in the journal club.

Staff we spoke with were very positive about the training they received and told us it equipped them for their role and they received good ongoing support from their mentors, senior staff and clinical educators.

From April to September 2018, 78.0% of staff within critical care at the trust received an appraisal compared to a trust target of 85%. Nursing staff had a 79.0% completion rate and medical/dental staff had a 91.7% completion rate.

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Administrative and Clerical	1	1	85%	100%	Yes
Medical and Dental	12	11	85%	91.7%	Yes
Nursing Registered	195	154	85%	79.0%	No
Healthcare Assistants	19	11	85%	57.9%	No
Total	**227**	**177**	**85%**	**78.0%**	**No**

Barnet Hospital

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Administrative and Clerical	2	1	85%	50%	No
Medical and Dental	43	35	85%	81.4%	No
Nursing Registered	65	61	85%	93.8%	Yes
Healthcare Assistants	8	7	85%	87.5%	Yes
Total	**118**	**104**	**85%**	**88.1%**	**Yes**

At Barnet Hospital, nursing staff had a 93.8% completion rate, whereas medical staff had 81% completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Nurses told us their appraisal was helpful and was linked to trust values and objectives.

Data received following the inspection reported 91% appraisal completion rate for the medical team in critical care.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. However, therapist provision did not meet the guidelines for intensive care standards.

In addition to doctors and nurses the unit was staffed with a full-time dietitian. 0.8 WTE speech and language therapist and 3.8 WTE physiotherapists. The lead was band 7, there was no band 8 cover for the unit which does not meet the GPICS standard, and therapists also covered other wards. We were told this was on the therapies risk register. There were recent shortages of physiotherapists due to long term sickness and inability to recruit agency backfill.

The pharmacist was an active member of the team but it was recognised this provision needed to increase.

A microbiologist attended the unit every three days and was available for telephone advice. A radiologist attended weekly.

There were admission criteria for the unit. The final decision to admit rested with the consultant on the day. There was some variation amongst consultants as to the admission of patients likely to move quickly to end of life care.

The multidisciplinary team worked well together and attended or contributed to the morning consultant led ward round. There was wide representation at the weekly multidisciplinary meeting including doctors, nurses, dietician, speech and language therapist, pharmacist and microbiologist. Staff told us they found this beneficial for discussing holistic patient needs as well as discharge planning. The unit had a complex discharge lead and worked closely with the complex discharge team.

Rehabilitation was coordinated by the critical care therapy team. All level 2 and level 3 patients had a comprehensive assessment carried out weekly but due to lack of OT and clinical psychology input onto the unit, the cognitive / psychological part of this assessment was not detailed. The assessment was then reviewed at the MDT meeting and goals agreed and a plan put in place. We were told rehab specific goals were agreed with the patient and/ or family where possible. Physiotherapists measured rehabilitation progress using Chelsea Critical Care Physical Assessment tool, this was all documented on the unit electronic record system but could not be seen by ward physiotherapists. We were told physiotherapy staff shortages had impacted on some patients' goal setting and plans and not every patient received 45 minutes rehabilitation, so this was prioritised. This did not meet GPICS.

The physiotherapists worked with medical and nursing staff to plan and implement ventilator weaning programmes, for patients starting to breathe more on their own.

There was a discharge proforma, and since the introduction of EPR across the rest of the hospital staff added information to that system in readiness for discharge.

The PARRT followed up patients discharged to the wards, they liaised with consultants and junior doctors before patients were transferred. They told us not all were seen within four hours, many were delayed transfers.

Physiotherapists told us patients who required inpatient follow up rehabilitation or community rehabilitation were referred with comprehensive details of rehabilitation goals.

There was no dedicated occupational therapy (OT) or clinical psychology service for the unit, this did not meet GPICS. Patients were referred to OT for assessment prior to discharge home, and for any specialist assessment and equipment needs. Staff told us the pain clinic had a clinical psychologist if needed.

There was no therapy or psychology input to the follow up clinic. Any patients identified as having these issues were referred to psychiatry for review or the GP was asked to refer for follow up in the community. The trust told us, it was reviewing the provision of clinical psychology across services.

Seven-day services

There was consultant cover on-call at all times and most services were available seven days a week and out of hours.

There were consultant led ward rounds twice every day, including weekends and bank holidays. Consultants worked an on-call rota, they were accessible 24/7 and able to attend within 30 minutes. Junior doctors confirmed they were encouraged to call consultants if needed and they were always accessible.

There was no pharmacist on the unit at weekends, medicines advice out of hours was available from the on-call hospital wide pharmacy team. Physiotherapists worked seven days a week 8.30am - 4.30pm, there was no on call cover outside these hours.

Microbiology advice was available by phone seven days a week.

The PARRT worked 7.30am-8pm at weekends with the hospital at night team covering evenings.

Palliative care team provided a seven day a week service, they took referrals and attended the unit as needed.

Diagnostic imaging was available all hours, ordered via an electronic referral system, and could be prioritised. Interventional radiology was not available evenings and weekend, patients needed to be transferred to Royal Free for urgent procedures.

Health promotion

Patients were signposted to organisations that could support them and help them to manage their own health and wellbeing. The team made appropriate referrals to specialist health professionals when needed.

Staff identified patients who may need additional support and have long term conditions following their critical care. They referred patients to specialist teams as needed, for example the diabetes team, stoma nurse and pain team.

Staff signposted patients to organisations that may be helpful and useful contacts were listed in the booklet, Intensive Care –A guide for patients and relatives, (developed by an external organisation).

Physiotherapists provided patients with a rehabilitation manual which included a structured exercise programme.

Patient menus included meals labelled as healthy choices. The booklet, ‘Intensive Care - A guide for patients and families’ included advice on recovery and a section on ‘eating well to get better’.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The trust reported that from April 2018 to August 2018 Mental Capacity Act (MCA) training and deprivation of liberty (DOLS) training was completed by 92.1% of all staff in critical care compared to the trust target of 85%.

A breakdown of completion rates by site and staff group is below:

Site	Nursing staff	Medical/dental staff
Barnet Hospital	97.6%	100%
Royal Free Hospital	94.0%	76.5%
Total	**95.3%**	**88.3%**

Nursing staff had a completion rate of 95.3% across both sites and medical/dental staff had a completion rate of 88.3%.
(Source: Routine Provider Information Request (RPIR) –Training tab)

Service records for mid December 2018 Barnet critical care, showed 84% compliance with MCA and DOLS training for all nursing and medical staff.

Staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS), and the need to provide the least restrictive care and interventions. The electronic record covered consent and mental capacity assessment, least restrictive option and communication with families prior to application for DOLS.

Staff told us of a checklist they completed prior to the use of mittens, this required consideration of the least restrictive options to prevent someone pulling on lines and equipment. The use of mittens was then reviewed every 12 hours.

Matron told us that an independent mental capacity advocate (IMCA) was needed on occasions, for example six months ago in a case of withdrawal of care.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff were passionate about providing compassionate care to patients and those close to them. Staff described how they supported patients who were anxious or distressed, they were non-judgmental in their attitudes. We observed staff treating patients and relatives with compassion, dignity and respect.

Patients told us the care received on the unit was excellent. One told us, ‘‘Nurses are fantastic, they never make you feel in the way and are quick to provide information”. Another was very pleased that her husband was also well looked after, provided with a parking space and access to food. One patient told us they had undergone a procedure on a previous stay in critical care and had felt distressed by the experience, so this time staff had provided an epidural instead.

Patients and relatives were grateful that staff allowed flexible visiting

The unit did not participate in the Friends and Family test, however since our last inspection had started a patient feedback form. We were not shown a full analysis but all the responses we saw were very positive. Patients and relatives added comments to the forms using phrases ‘brilliant’, ‘phenomenal’ to describe the kindness and compassionate care they or their loved ones had received. Relatives commented “Over the three weeks I have received nothing but kindness and concern for my wellbeing”; “Staff go well beyond the call of duty night and day; every single member of staff is absolutely dedicated”. One patient wrote “All staff were gentle and caring” and “I could not ask for better care”.

Some messages from relatives were displayed on the ‘patient & relative experience feedback’ board. For example, “I have been so impressed by the very caring way the nurses look after my husband and are always ready to explain his treatment”;” All staff are very caring and helpful, they have done their upmost to my Dad as comfortable as possible” and “I could not ask for better care for my husband in the care of your wonderful nurses”

Many patients and relatives wanted to show their appreciation for the care received, through donations to the unit, and we saw many messages of appreciation, on the ‘Tree of Thanks’ displayed on both ICU North and ICU South.

Most staff introduced themselves before delivering care, but this may not have always happened, particularly when there were groups of staff at ward round. One of the patients we spoke with was puzzled what was happening and who staff were. They said, “The doctors just walk around and don’t introduce themselves”, “Groups of four, five, six people walk around and don’t explain themselves to us”

Emotional support

Staff provided emotional support to patients to minimise their distress.
A multi faith hospital chaplaincy team was available to provide support. The Iman had recently had an introductory visit to the visit and the Rabbi visited regularly.

Patients, and their families, who received life changing diagnosis were provided with support from staff and were referred to other services as needed. The specialist palliative care team was accessible and provided supportive care for complex social, emotional and spiritual matters. They worked with staff to support patients and families at the end of life and withdrawal of treatment.

Staff could also refer patients to the psychiatric team for psychological review if needed. They told us of a patient who was becoming increasingly withdrawn, who was referred to the team for assessment. Staff focused on building trust with the patient and encouraged them to talk about how they felt.

Staff were aware of the emotional needs of patients who had experienced critical care. They contributed to ‘patient diaries’ to keep a record of what had happened whilst patients’ were unconscious and receiving treatment. Relatives told us they also found the diaries were very helpful.

The service ran a monthly ‘Follow Up Clinic’. Its aim was to help patients, who had received level 3 care, understand their experience and to help in their rehabilitation. The discussion with intensivist and nurse, during the session of up to an hour, and helped these patients understand what they have been through and explain what their recovery process should be like. The clinic received positive feedback from patients stating they benefitted from explanations and reassurance the clinic offered. There was no clinical psychology input to the clinic. The patient’s GP was asked to make a specialist referral, such as a clinical psychologist for patients needing additional support and with post-traumatic stress disorder.

Staff told us that patients who were awake, awaiting transfer to a ward, could be distressed by the sights and sounds of critical care. They tried to provide emotional support through explanations and discussions whenever they could.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment that was being provided.

The entrance to the unit had a picture board of all staff, and friends and family were encouraged to speak with a member of staff if they had any questions or concerns. The relatives’ quiet room poster invited them to ‘speak to a doctor’.

Patients and relatives told us that staff took time to explain the care and treatment, they were friendly and informative. They were invited to call at any time.

Staff used the quiet rooms to meetings and discussions with families, and to break bad news. There was also the facility to use a conference telephone in one room, so that members of family unable to be present could join in discussions with the doctors and family on the unit. Outcomes of discussions were documented in the patient records

Treatment plans and rehabilitation goals were discussed and agreed with the patient and family where possible. The rehabilitation plan for each patient was discussed with patients and their families throughout their stay on ITU and when they moved to the ward. Physiotherapists gave patients an individual rehabilitation manual with information and contact details.

Staff followed processes to contact the Specialist Nurse for Organ Donation (SN-OD), to speak sensitively to relatives of patients about organ donation when treatment was being withdrawn.

Is the service responsive?

Service delivery to meet the needs of local people

Service delivery was impacted by the high number of patients staying on the unit longer than necessary, and the environment could not be flexed to accommodate them appropriately with the result that patients were regularly cared for in mixed sex accommodation.

Most of the admissions to critical care were unplanned from emergency department, theatre or wards and there was constant pressure on beds across the hospital wards. There was inefficient use of critical care beds and limitations in the responsiveness of the service, as many patients stayed on the unit longer than needed. The environment and equipment could be flexed to accommodate level 2 and level 3 patients as needed. However, the environment was inappropriate and could not be flexed to accommodate the high number of patients who were awake and no longer required critical care.

The needs assessment and planning for critical care services was being undertaken in the context of wider hospital activity and would take some time. In the interim, the divisional director had submitted a ‘first stage critical care capacity appraisal’ paper, to the Barnet hospital executive team October 2018. This outlined two possible options to address the current issues of delayed patients’ experience and mixed sex accommodation. A follow up paper November 2018 described critical care being used flexibly for HDU or step down, with the priority to keep an empty bed. It stated that models for cohorting or redesignating beds had been explored but no option offered a sustainable model due to overall bed pressures on the hospital site. Bedside lights, care packs and joint nursing therapies were the agreed actions to enhance the delayed discharge patient experience. However, the agreed mitigation actions did not fully address the environmental and mixed sex accommodation issues.

Consultants told us that interventional radiology was not available at all times and patients needed to be transferred to the Royal Free hospital for some procedures, in particular kidney problems as urology services were no longer provided at Barnet hospital. The trust explained that interventional radiology was a group clinical service which has been consolidated and patients had ready access as required. There were formal arrangements for patient access to these services with appropriate transfer pathways between Barnet Hospital and Royal Free Hospital.

There were appropriate arrangements in place for patients to receive specialist support through admission to regional weaning units, if this met admission criteria and was assessed as appropriate. Staff liaised with home ventilation service on discharge, if weaning was unsuccessful.

The PACE hospital team provided intravenous therapy to patients at home if needed following discharge.

The matron had used charitable funds to upgrade the facilities for relatives. There were recently decorated and furnished quiet rooms with kitchen facilities, on both ICU South and ICU North. These spaces were created to provide a quiet, restful and private place for family members, friends or carers of patients with life threatening illness, or recently bereaved. They were used by next of kin if they had a difficult decision to make or if they have received bad news.

There were two bed chairs for overnight stays, by the bedside or in a quiet room, with access to toilet facilities. In addition, there was a garden room in a courtyard of the hospital that could be used by relatives, friends and carers at any time of the day or night. Matron told us chairs were fitted in the light atrium outside the units, for visitors needing some time away from the unit.

There was a monthly ICU follow up clinic run by an intensivist care consultant supported by a nurse. There was not capacity for all patients to attend so patients were selected from a list who had received level 3 critical care for more than four days and/or with a tracheostomy. On average the clinic saw three patients a month and received positive feedback from patients.

Meeting people's individual needs

Patients remaining on the ICU when ready for discharge to a ward experienced an environment that could be disturbing and frightening to patients who were fully conscious..

Staff completed mandatory training on caring for patients living with dementia, they could access advice and resources from the hospital team. Staff encouraged carers and families to come in and support patients through their admission, and used 'distraction' aids where appropriate.

Patients with a learning disability carried information passports across the hospital. These contained important information about their needs and wishes, likes and dislikes and how best to communicate and interact with them. Staff had access to communication tools and support from the hospital learning disability nurse, who provided staff training sessions on the unit. Staff also relied on families to help support patients through their admission.

A critical care environment was unsuitable for these vulnerable patients when they were awake and fit for discharge from the unit. Staff tried to prioritise their immediate transfer to a ward, although this not always possible.

There were a high number of mixed sex breaches on the unit over the year. A mixed sex breach occurs when level one or level zero patients are accommodated in an open ward area with a member of the opposite sex. Mixed sex breaches should occur infrequently on critical care as patients are transferred to a ward once they reach level 1.

During the inspection we observed patients up and walking about, in mixed sex accommodation and in a bed next to critically ill patients on ventilators or patients at end of life.

Staff recognised that the critical care unit could be traumatic for patients and they tried to lessen the impact. They provided ear plugs and eye shields and closed their curtains at night, as there was a lot of noise and light when emergencies were admitted.

Staff reported 450 adverse incidents related to access, admission, and discharge over the year 1 November 2017 - 31 October 2018. Most of these related to delayed discharges and mixed sex breaches.

Staff referred patients to the psychiatric team when needed, they told us the service was responsive. The alcohol and drug liaison officer was based at the hospital and was very accessible, calling or visiting every day if advice or medicines prescriptions were needed for a patient on the unit.

Staff also worked closely with the hospital palliative care team who were very responsive to referrals for life limiting illness, and end of life care.

A translation service was available for patients and families. The main service was by telephone but face to face translation could be arranged.

The unit was not designed or staffed to provide care for children. Consultants told us that very occasionally an 'adult sized' child may be admitted for level 3 care.

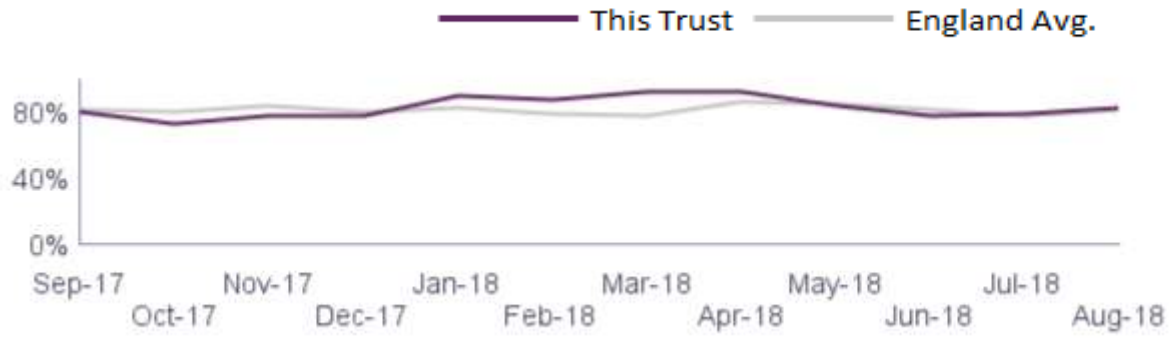
Access and flow

There were high numbers of patients on the unit who were fit for discharge waiting for transfer to the wards. Many patients were transferred to a ward out of hours, and some. were discharged home before a ward bed became available. The service was an outlier for delayed discharge by comparison with other units.

The issues of access and flow and patient experience, as a result of delayed discharges, had changed little since our last inspection in February 2016.

From September 2018 to August 2018, Royal Free London NHS Foundation Trust has seen adult bed occupancy about the same as the England average.

Adult critical care Bed occupancy rates, Royal Free London NHS Foundation Trust.



Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

The ICNARC data for Barnet unit, over the year December 2017 – December 2018 showed bed occupancy as 92.5%.

Most admissions were emergency cases. Trust data showed 85% patients were admitted to critical care within four hours of decision to admit. The divisional director told us that audit had identified there was an empty bed on the unit 80% of the time day and night.

There was a critical care escalation flow chart setting out actions when there was no bed available on the critical care unit. This included moving medically fit patients to recovery until a ward bed was available, or transferring an unwell patient to the anaesthetic room or, if not available, to

recovery. We saw adverse incident reports throughout the year where 'wardable' patients were transferred to the ward or recovery late at night or in the early hours of the morning, to free a bed for an emergency admission. From a safety perspective the divisional director told us the no patients transferred 'out of hours' had needed to be readmitted to the unit within 24 hours. However, it was recognised that out of hours transfers were not desirable for patients.

The PARRT told us that once or twice a month, patients on the ward were taken to anaesthetic room for intubation if there was no bed available on ITU. Some stayed there for one or two hours under the care of the consultant and PARRT until a bed was available.

When asked, the trust told us there was no data to support an occurrence of a patient being ventilated outside of critical care owing to bed pressures. Over 12 months two operations had been cancelled, due to no beds available on the unit, both in February 2018 and were cancelled on the day of operation. The divisional director told us that a colorectal case had never needed to be cancelled.

High bed occupancy across the hospital wards and numbers of patients needing admission to beds from the emergency department resulted in high numbers of delayed discharges on the unit.

For Barnet Hospital, Intensive Therapy Unit at Barnet General Hospital, there were 8,395 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 7.4%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 17.2%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
8,395 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	17.2%	7.4%	4.9%	0%	Not in the worst 5% of units

(Source: Intensive Care National Audit Research Centre (ICNARC))

ICNARC alerted the service about the number of non-delayed discharges transferred out of hours, as a safety concern. Examination of the data by the service identified issues with reporting. We were told that in an attempt to reduce numbers of delayed discharges, patients were not reported as delayed until a ward had been identified and this affected the data for non-delayed transfers out of hours.

More recent ICNARC data from 2017-2018 report, seen at inspection, showed the percentage of bed days of care occupied by patients with discharge delayed more than 8 hours increased to 10.5%. This compared to all units at 4.5% and similar units at 8.3%.

ICNARC data from 2017-2018 report, showed the percentage of bed days of care occupied by patients with discharge delayed more than 24 hours was 7.6%, this was an outlier when

compared to all units at 2.7% and similar units at 5.5%.

NHS England Specialised Services Quality Dashboard for both Q4 2017-18 and Q1 2018-19 showed the unit as an extreme outlier on the measure of percentage of critical care bed days utilised for patients more than 24 hours after the decision to discharge.

There were approximately 980 admissions a year to the unit. The service told us over December 2017 - December 2018 data from ICNARC showed 548 delayed discharges out of ITU. This is where the patient has remained on ICU for 4 hours and over after being declared fully ready for ward level care. This indicates that over half the patients admitted to the unit had delayed discharges of 4 hours and over. The service had not met the CQUINN to increase discharges within 4 hours, set by commissioners.

ICNARC had alerted the unit about the number of discharges home. The ICNARC 2017-2018 report showed this had risen steeply to 28.3% and was an outlier compared to 5.6% for all units and 12.7% for similar units.

The trust told us there were 178 patients discharged to home in 2018, of which eight were readmitted to the hospital within 30 days. The majority of these patients had been ready for discharge to a ward for a considerable period and were well enough to go home before a bed was found in the hospital.

At inspection we found there continued to be high levels of delayed discharges on critical care. Some were delayed because of complex needs and we were told that once a patient with tracheostomy waited 40 days as ward staff were not trained to care for him. On one day of inspection there were five delayed discharges awaiting a ward bed, most had waited two or three days, one had waited seven days. They were accommodated on an open area. There were two empty beds on the unit and the coordinator, told us that they did not expect patients to be moved from ITU that day, as the trigger to move patients was when the unit was full. The priority was admitting patients from emergency department to avoid 12-hour breaches. Two patients were discharged home the previous day and it was planned that two would go home that day. We were told between two and four patients a week were discharged straight home and this was becoming more regular.

Staff worked hard to facilitate discharge, there was a complex discharge lead and proactive planning. The unit submitted bed status and attended bed meetings, three times a day. They told us they liaised with bed management and tried to prioritise patients with special needs, but this was not always possible.

For Barnet Hospital, Intensive Therapy Unit at Barnet General Hospital, there were 1,021 admissions, of which 0.3% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 0.4%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
1,021 admissions	Crude non-clinical	0.4%	0.3%	0.4%	0%	Within expected range

	transfers					

(Source: Intensive Care National Audit Research Centre (ICNARC))

For Barnet Hospital, Intensive Therapy Unit at Barnet General Hospital, 6.1% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was worse than expected. The figure in the 2015/16 annual report was 0.7%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
641 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	0.7%	6.1%	1.9%	0%	Worse than expected

(Source: Intensive Care National Audit Research Centre (ICNARC))

ICNARC had recently alerted the service as an outlier status for non-delayed discharges between 22.00 and 06.59 in 2017-18 data. Senior staff reviewed the data quality and the amended data resubmitted to ICNARC showed a return to within expected limits for non- delayed out of hours discharge, but outlier status in delayed discharges from ICU. We were told that in an attempt to reduce numbers of delayed discharges, patients were not reported as delayed until a ward had been identified and so out of hours discharges were in fact 'wardable' patients fit for discharge. This reduced the safety concerns of transfers out of hours, but poor patient experience remained.

NHS England Specialised Services Quality Dashboard for both Q4 2017-18 and Q1 2018-19 showed the unit as an extreme outlier on the measure of percentage of live discharges discharged from critical care between 7am and 10pm, higher than the national average. The proportion of live discharges between 7am and 7pm was lower than the national average.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From September 2017 to August 2018, there were seven complaints about critical care. The trust took an average of 40 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 35 working days.

The most prevalent types of complaints were those relating to all aspects of clinical treatment (two, 28.6%) and attitude of staff (two, 28.6%).

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

We saw clear posters on both ICU North and ICU South explaining how to raise concerns and complain, with details of PALS. There was also information in the quiet rooms for relatives and families.

Most concerns were dealt with informally by staff on the unit, with issues being dealt with immediately. Senior staff fed back learning during daily handover and via the 'blog' on the electronic record.

We reviewed the response to two formal complaints about Barnet critical care. One was responded to in 40 days the other within 30 days, although the original letter of several months previously had apparently been mislaid. The response letters evidenced that the complaints had been taken seriously and investigated and lessons learned. Changes had been made as a result of both complaints and these were communicated to staff.

Complainants were given contact details if they had further questions and were given contact details of the Parliamentary and Health Service Ombudsman (PHSO). No complaints about the critical care unit had been forwarded to PHSO.

From September 2017 to August 2018 there were 10 compliments within critical care. Three compliments were about Barnet Hospital and seven compliments were about Royal Free Hospital.

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

There were many thank you cards and compliments displayed on the walls on both ICU North and ICU South. There were also two 'Tree of Thanks' which had been started following feedback from patients and their loved ones wanting to show their thanks and gratitude for care received on the unit.

Is the service well-led?

Leadership

Service leaders had the right skills and abilities to run a service providing high-quality sustainable care. The critical care leadership team was still developing; both the clinical director and operations manager also covered anaesthetics and theatres. There was a critical care matron and consultant lead for the unit.

A Barnet hospital leadership team was created in July 2017, along with clinical practice groups (CPG), as part of trust wide restructuring. This leadership team, including chief executive and executive director roles, reported to the trust group board. Critical care was part of the 'Surgery and Associated Services' (SAS) Division. This incorporated anaesthetics, theatres, surgical wards and services and critical care. It was led by a divisional director, a divisional director of nursing and a divisional director of operations.

Staff and critical care leadership generally felt the new trust structure had improved communication, accountability and understanding of the local critical care service. Some felt it added to layers of hierarchy in the trust and made it difficult to get timely action in response to issues. Staff spoke positively about the visibility of the divisional director of nursing.

The critical care service leadership team included a clinical director who also covered anaesthetics, theatres and pre- op (in post a year and a half), an operations manager who also covered anaesthetics and theatres (in post one year) and a critical care matron. The matron, with overall responsibility for nursing elements of the service, had been in the role for over three years. There was a designated lead consultant who had been in post six months.

There was a supernumerary clinical coordinator on duty 24/7 on both ICU North and ICU South as recommended in the Guidelines for the Provision of Intensive Care services (GPICS) 2015. An additional supernumerary RGN was based on ICU North but able to cover both units as needed.

Nursing staff were organised into cluster teams led by a band 7. Many staff had followed one of the trust leadership development programmes, 'step up to lead' for band 6 and 'licence to lead' for band 7. Matron had just finished a coaching course.

All senior nurses completed a leadership academy 360-degree feedback assessment on their performance and leadership style in May 2018. The intention was to strengthen leadership capabilities as a team.

Staff told us the team structure was very good, they were clear of their roles and spoke positively about their leaders. They said band 7 leaders were very good facilitators and found it easy to talk to senior staff about anything. Junior doctors/trainees valued the leadership and support provided by consultants.

The matron was visible and approachable and tried to work clinically once a week. She was highly regarded by all staff. A consultant described her leadership as phenomenal and pivotal to ensuring medical and nursing staff worked together as a team.

Vision and strategy

The service leads had not yet developed a strategy and plan for critical care. A hospital wide needs assessment had begun but there was not yet a critical care strategy for the future. There was no involvement from patients, staff and wider stakeholders to develop this and turn it into action.

There was a Barnet critical care mission statement, displayed on noticeboards, the tree of thanks leaflet and staff induction documents: 'Our mission is to deliver world class care and we strive to provide an excellent patient, visitor and staff experience'. We saw staff and service leaders were committed to this vision and trust values.

There had been little progress on addressing the number and impact of delayed discharges on the service and patient experience. The lack of plans to address these issues was highlighted at our last inspection. The service had a clear objective of moving 'wardable patients' to appropriate wards and there were some clearer agreements with the bed management team, but this had little impact. The local service leadership team told us that senior management acknowledged the shortfalls, but there were still not any short or medium term plans to address the issues. The 'critical care capacity paper', November 2018 described how the team had not been able to find a sustainable model for reorganising beds on the unit, as a short-term mitigation plan. Critical care was being used flexibly for HDU or step down, with ongoing mixed sex breaches and patients nursed in unsuitable environment. Staff were frustrated by the situation, some described it as 'hitting your head against a brick wall'. Staff and the local leadership team all felt the issue was caused by lack of capacity in the wider hospital, and there was a sense of helpless resignation.

The service leads had not yet developed a strategy and plan for critical care. The divisional director told us, the hospital and divisional leadership team were at the early stages of needs

assessing the requirements for critical care services at the hospital. This was being done in the context of a wider trust strategy and reorganisation of surgical services. They told us that the needs assessment for medicine services had been completed, taking into account seasonal variation and the need for a higher number of level 3 critical care beds in winter. Surgical planning would finish by next summer, this and the theatre strategy across the trust's three sites would impact on the strategy and plans for critical care services.

The operations manager told us the team was planning to hold meetings next year with a wider 'user group' to look at options for the future. The intention was to develop one, five and ten-year plans. They had spent the last year planning for theatre usage as part of wider hospital strategic planning.

The trust strategy was to implement the new EPR system across all sites. This had very recently been rolled out onto the wards at the hospital. Critical care staff were very anxious that the new system did not meet the needs of the unit and did not ensure patient safety. The leadership team told us there were discussions ongoing with the IT team about how the system could be adapted, with the ITU consultant involved in advising on this. The trust told us that the Critical Care module of EPR was planned to be deployed at the Royal Free hospital first and would only move to Barnet critical care once assurance that it was fit for purpose.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There was a positive collaborative team approach to providing high quality patient care, across the multidisciplinary team. We saw staff at all levels lived the trust values in the way they went about their work. Staff told us trust values were linked to appraisal and discussed at supervision sessions.

Band 7 team leaders told us they saw themselves as role models working alongside and supporting nursing teams. They held 'cluster team days' for team development and learning, also inviting regular bank staff to join. Staff told us they were well supported and the individual debrief by the nurse in charge at end of shift.

Staff told us they were 'very happy' and 'loved working on the unit', where there was great team work and they felt respected and valued. They said they were given sufficient autonomy and very helpful constructive feedback when needed. There was a culture of 'no blame' with staff encouraged to raise concerns and learn from incidents. One told us they felt more satisfied with the level of care they could provide for patients on the unit, than in previous jobs. Staff consistently told us they felt supported and empowered to provide high quality care. They were proud of the unit and the positive feedback they received from patients and families. One told us this was the best unit they had worked at in the UK.

Staff came from a wide range of cultures and backgrounds, many from overseas. Those we spoke with described a multicultural diverse, respectful and equal community, where staff acknowledged differences and worked towards common goals.

There was a local staff recognition scheme, Employee of the Month, along with a 'shout out' board for staff to leave compliments about colleagues' work. We saw the notice board was full of comments.

Junior doctors told us they were very well supported by consultants who were responsive to their suggestions to improving patient care. For example, changing grab bag contents; changing handover time to facilitate a more detailed ward round and teaching.

The matron had upgraded the staff room to provide better facilities for staff when taking a break. Junior doctors/trainees were concerned they had insufficient rest/sleeping facilities on night duty or before driving home, this was highlighted to the leadership team at inspection.

Governance

Although there was a clear governance structure in the wider division, there were no unit wide meetings or forums for assessing and monitoring the quality and safety of the ICU, including risks arising from not fully adhering to professional guidance and standards. The governance around development and management of protocols was not clear.

There was a governance meetings structure in the trust and the SAS division. The triumvirate leads attended the monthly theatre and ITU speciality meetings, chaired by the operations manager. This meeting discussed a range of governance and performance issues across all specialities, there was limited discussion of critical care specific issues, minutes of meetings were sparse with no clear actions identified. The leads also attended the monthly SAS divisional board meeting and quarterly safety and quality board meeting. The divisional quality and safety board meeting had a set agenda covering key areas such as quality and safety, finance, and workforce. Minutes we viewed included updates on quality and safety reports, governance reports for the division and issues pertaining to critical care. Matron told us, services were asked to undertake a self-evaluation of successes and risks. The August minutes discussed high numbers of critical care incident reports on mixed sex breaches. The openness of reporting was welcomed, along with the need for a working group to address issues.

Matron attended the monthly surgical matrons meeting chaired by the divisional director of nursing.

The service took part in peer review to assess compliance with DPIC standards. January 2017 results identified the insufficient pharmacy provision for the unit, and the need for mortality and morbidity reviews. The latter had been addressed, but funding was still awaited for the pharmacist.

There was a monthly consultants meeting, attended by matron who provided the link with nursing staff. Meeting minutes identified allocated actions arising from discussions of issues. There was also unit meeting for nurses, chaired by a band 7. The agenda was set by staff and the matron, and minutes highlighted governance issues were discussed and staff were able to raise concerns. The meeting was meant to be held monthly but this was often quarterly and attendance was limited. Matron told us the most effective way of cascading important messages to all staff was through ‘hot topics’ at handover or via the unit ‘blog’. There was not a unit wide meeting or forums to discuss departmental issues across the multidisciplinary team. Matron was the informal link for all communication and concerns across teams.

There was a consultant lead for governance who over saw the audits programme and weekly morbidity & mortality /governance meetings. These meetings were open to all staff and they were well attended by doctors, matron, clinical educator, PARRT and some therapists. Agendas evidenced multidisciplinary presentations, audit updates as well as case presentations, SI reviews and mortality data reviews. Unit nurses were invited found it difficult to attend when on duty. There were no formal minutes but we were sent discussion notes and action logs for the M&M meeting, we were told a monthly M&M newsletter was circulated. Newsletters sent to us as additional

evidence were dated January and February 2019, outside the inspection period. There was a governance notice board detailing learning from incidents.

Many protocols were locally produced, discussed and reviewed at monthly consultant and MDT meeting. The governance around the management of protocols was not clear. We found there was some variation in electronic and hard copies; there was no clear version control.

Management of risk, issues and performance

There was not a systematic process to identify, assess and reduce all department level risks. Some department level risks had not been identified or adequately addressed, there was no unit level risk register and we did not see any identification or assessment of any additional current or potential risks.

We asked for the risk register and received an extract from the divisional risk register. This listed two risks for critical care, one related to delayed discharges and one relating access to medicines storage through unsecured doors. These were added as a risk April 2017 and January 2016 respectively, and although regularly reviewed at divisional meetings they had not been resolved. The delayed discharge risk level had been raised to 'high' as the leadership team had implemented all actions and had no other solutions.

The risk assessment of medicines storage was inaccurate. It assumed the room door key pad locks were used, acknowledging the doors did not shut automatically so may be left open and may be open to reduce high ambient temperature in store room. It stated the drug cupboards were locked in the unsecured rooms, but at inspection but we found some cupboards and fridges were kept unlocked. It was assessed as low risk on this information and as there had been no incidents there was a suggestion it should be removed from the register. The divisional director later confirmed that it should stay on the risk register as it did not meet standards.

The issue of high temperature storage of IV fluids and medicines was added in the notes of the review of medicines storage room risks, at a later date. Matron told us the storage room temperature risk had recently been moved to the estates register, the proposed action to mitigate was not clear on the documents provided. The trust later told there were site wide issues with maintaining appropriate temperatures and it was agreed in October 2018 that this would be managed as part of the hospital wide risk register. Matron had identified plans to move a storage room and was taking the lead in following these up. Pharmacy had not been consulted about any immediate mitigating actions that could be taken in the interim.

It was not clear how all the risks pertaining to the unit, across the multidisciplinary team, were systematically collated and managed. The critical care leads attended the monthly theatre and ITU speciality meetings, where performance scorecard and risks were presented. These covered, for example, nursing staffing, sickness and turnover rates, and low rates of medical mandatory training and appraisal. There were no clear actions arising from minutes of these meetings. There was no unit level risk register and we did not see any identification or assessment of any additional current or potential risks. For example, the impact of the new hospital EPR system and insufficient EPR training for unit staff was not identified. It was not clear how or where the risk of insufficient pharmacist cover for critical care had been assessed. Our inspection identified several medicine safety issues that had not been identified or addressed in part due to insufficient specialist pharmacist cover.

We were told the physiotherapy cover for the unit was on therapies risk register, as current provision did not meet the standard. However, in discussion, the critical care leads were unaware of this.

ICNARC report 2017-18, seen at inspection, showed there were not a high number of high risk admissions, or high-risk sepsis admissions, from the wards when compared with units nationally. The service leads were not aware of any audits of sepsis, and compliance with pathways.

There was a programme of audits with findings were presented at audit meetings and the weekly M&M and governance meeting. Many local clinical risk issues were mitigated or resolved through making adjustments to the local electronic record system.

The service leads were responsive to local concerns and risks raised by staff. Risk issues were disseminated to staff through handover 'hot topics', the blog and by email. We saw a safety notice board, displaying 'safety lesson of the week'.

The service had not yet identified cost improvement savings (CIPS) for the year. The operations manager told us they planned to speak with staff for ideas, particularly the equipment manager who had innovative ideas for saving money.

Information management

The service collected, analysed, managed and used information well to support all its activities, using a secure electronic system with security safeguards.

The critical care unit electronic record system was highly regarded by all staff working in the service. It was clinically led and designed by an intensive care consultant and was accessible to the multidisciplinary team. In addition to holding patient records it incorporated protocols and patient pathways and was used to monitor and improve quality and safety of care. The system could be interrogated for audit purposes. It was secure and we were told that, although a 'standalone' system and server, there were backup arrangements in place and staff could revert to paper records in extreme circumstances.

The new EPR system had very recently been rolled out onto the wards at the hospital. It was not in use on critical care, staff told us they were very anxious that it did not meet the needs of the unit and was unsafe for patients. The two systems were running in parallel as staff needed to access information for admissions and input information in readiness for discharge. However, many staff told us they had not received sufficient training to use the system, as they were offered e learning only. The trust told us that at the time of inspection EPR was in the third week of the implementation and the priority training areas were identified and risk assessed for all clinical areas fully using the EPR system. The staff had e-learning but did not require face to face classroom training as there are no immediate plans to introduce a new EPR system into ITU. There was 24 hours on site support for ITU around the EPR roll out in the form of floor walkers who could be bleeped as required to assist with admission and discharge interface issues.

The hospital wide EPR system needed to be adapted to meet the specific requirements of critical care staff and patients, before it could be introduced safely to the unit. The trust told us it would not be introduced until there was sufficient assurance it was fit for purpose.

A lead consultant oversaw the quality checking and clinical coding of data entry. The electronic record system included critical care minimum data set and alerted when data was not completed on the system. ICNARC results showed 100% data submission. There were some data quality issues due to inaccurate reporting of delayed discharges that led to a query from ICNARC (see responsive section), this was resolved retrospectively.

The data provided showed 46% patients were admitted within 4 hours of decision to admit, so the service did not meet the standard for 54% patients. It was not clear that this information was accurately recorded on the electronic system.

Staff were aware of their responsibilities in relation to confidentiality and data security. Some paper patient records were used and we observed these were secured in notes trolleys with a digital lock. Patient information was clearly displayed on a white board to assist staff in care, patients' names obscured when the board was folded to closed position. A password system had been devised for relatives phoning to ask about relatives, this system had been improved following a complaint.

Staff had access to a wide range of information, policies and guidance on the trust intranet. The unit had several information boards for staff, patients and visitors. Staff all felt well informed about issues via the daily handovers and the electronic blog.

Engagement

The service had started to engage with patients, staff and relatives to plan and manage appropriate services. It was recognised that more collaboration with local and partner organisations was needed to plan and manage services in the future.

Since our last inspection had started a system of patient feedback forms with the message 'your views are important to us' with explanation that it was to improve quality and care and experience of service users. There was a feedback board and the request for views and ideas was widely advertised on notice boards and in quiet rooms.

The matron told us relatives had been consulted about the refurbishment of the quiet rooms.

A physiotherapy audit report stated that the rehabilitation manual was revamped following feedback from patients and had recently been re-launched.

Patients and relatives were now invited to team cluster days, to talk to staff and share their experience of critical care.

The IT department had started to engage with the consultant lead for the unit electronic record system, discussing options for implementing an amended hospital EPR to critical care.

The operations manager was hoping to engage patients and key stakeholders in strategy development and planning critical care services

There had been thorough staff engagement, over six months, as part of a project to improve staff retention and staff wellbeing. This involved staff focus groups and meetings and led to changes such as, self-rostering for more flexible working; team cluster days; access to training; reduction in handover length. All staff were surveyed in February to see if the changes were impacting on their work life balance. The project was ongoing. The matron did not have national staff survey results when asked and was focusing on actions following local unit surveys.

There was a staff engagement and wellbeing board with details of ongoing projects and a drop box for staff to leave anonymous comments. Most staff told us they didn't need this as felt they could talk directly to senior staff.

Learning, continuous improvement and innovation

The service was committed to improving critical care by learning from when things went well and when they went wrong, promoting training and innovation.

There had been improvement in mortality following the introduction of mortality and morbidity meetings and 'learning from deaths' methodology had been followed for the last two months. This alongside the discussions at governance meetings provided opportunities for learning and improvement.

The service made changes, developed protocols and provided additional training as needed in response to audit and incident investigations. The lead consultant told us the diabetic ketoacidosis protocol was recently changed to make it bespoke to critical care. The changes were made in consultation with endocrinology and pharmacy, and matron attended the consultant meeting to discuss.

The service was part of the local adult critical care network and attended meetings for sharing learning, for example from serious incidents. There was little direct shared learning across Barnet and Royal Free critical care services

The trust provided formal training in quality improvement (QI) methodologies, several staff told us they planned to attend.

Matron had won a trust quality improvement award for the project 'Reducing Nursing Turnover in ICU by Improving Joy in Work'. The aim of the project was to reduce nurse turnover in ICU to 25% by December 2018. This was achieved in May 2018 ahead of schedule. This was completed with the support of the Institute for health Improvement, there was a clear action plan as a result and we saw actions had been taken. This resulted in greater staff satisfaction and higher retention rates.

A physiotherapy audit of compliance with CG83 NICE guidelines on rehabilitation of critical care patients was presented as a therapy services QI project It resulted in improvement particularly in the quality of information for patients and identified areas still needing to be addressed.

The end of life care lead nurses were working with end of life physiotherapist on an end of life quality improvement project

Staff were recipients of trust wide awards, an administrator received an unsung hero award for their work supporting staff rotas and fund raising. The equipment manager was nominated for an award for innovative work to improve value for money in the purchasing and use of equipment.

The service did not undertake formal research.

Chase Farm Hospital

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www.royalfree.nhs/uk/chase-farm-hospital/

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

Urgent Care Centre

Facts and data about this service

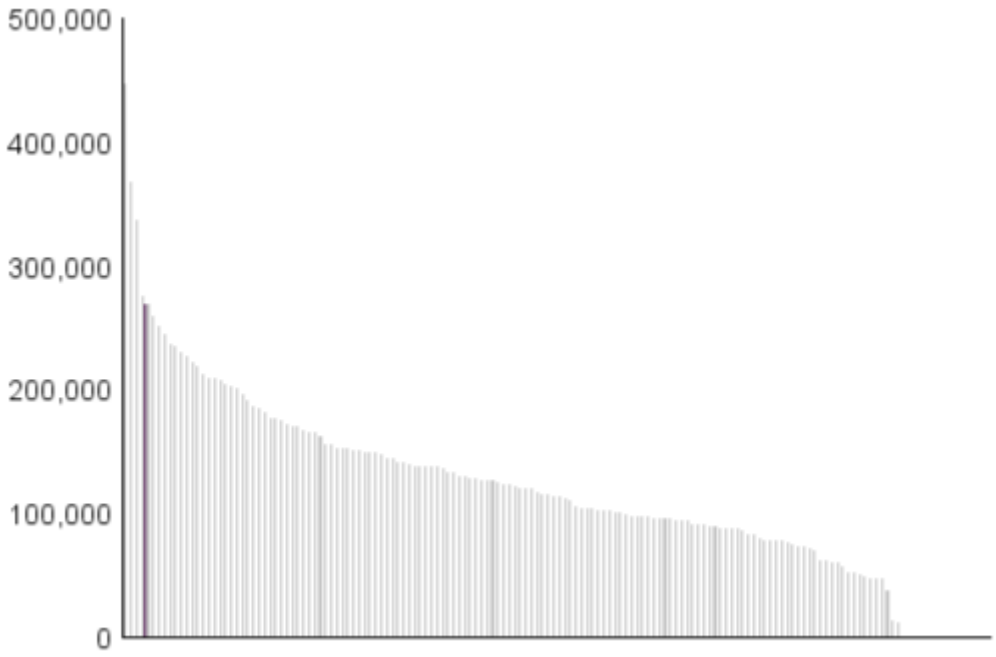
The urgent care service provides services to approximately 40,000 patient visits from Enfield, Barnet, Potters Bar and surrounding areas.

Chase Farm Urgent Care Centre (UCC) was opened In December 2013 and commissioned by the Enfield and Barnet Clinical Commissioning Group (CCG) to provide GP and nurse practitioner led treatment for urgent, but non-life threatening, illnesses and injuries.

The urgent care centre at Chase Farm Hospital is staffed by GPs, a radiographer and nursing staff and is open 8am to 10pm every day. Outside the UCC's operating hours patients were usually redirected by the 111 services to the nearest Emergency Department at Barnet Hospital or North Middlesex University Hospital. The trust also has two emergency departments (also known as A&E), one at Barnet Hospital and another at the Royal Free Hospital. Barnet ED is a type 1 consultant led department and trauma unit.

Since the last inspection in 2016, the UCC moved to its new hospital building in September 2018. The UCC is located next to the paediatric outpatients and older person assessment unit.

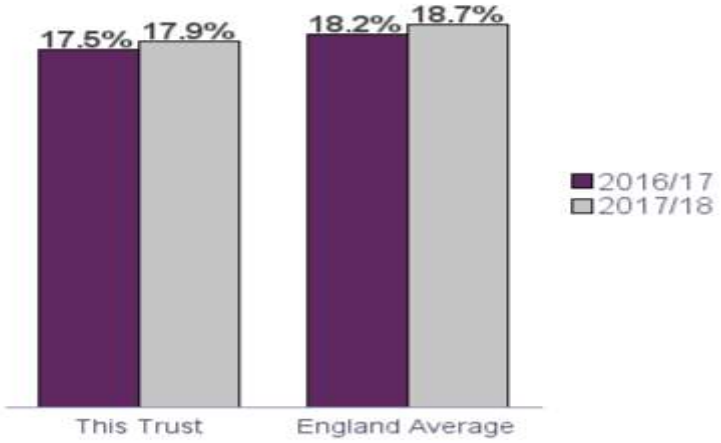
The service was located on the ground floor and has 11 rooms, dedicated x-ray facilities with hot reporting and provides GP-led and nursing led care for adults and children. The UCC also had a dedicated consultation room in the paediatric outpatient department which was next to the service from 9am to 5pm and during out of hours they had access to all their clinical rooms. In the last 12 months before the inspection the UCC saw 33,876 patients of which 29% were children. The UCC's capacity was 150 attendances per day. The UCC saw an average 110 attendances per day.



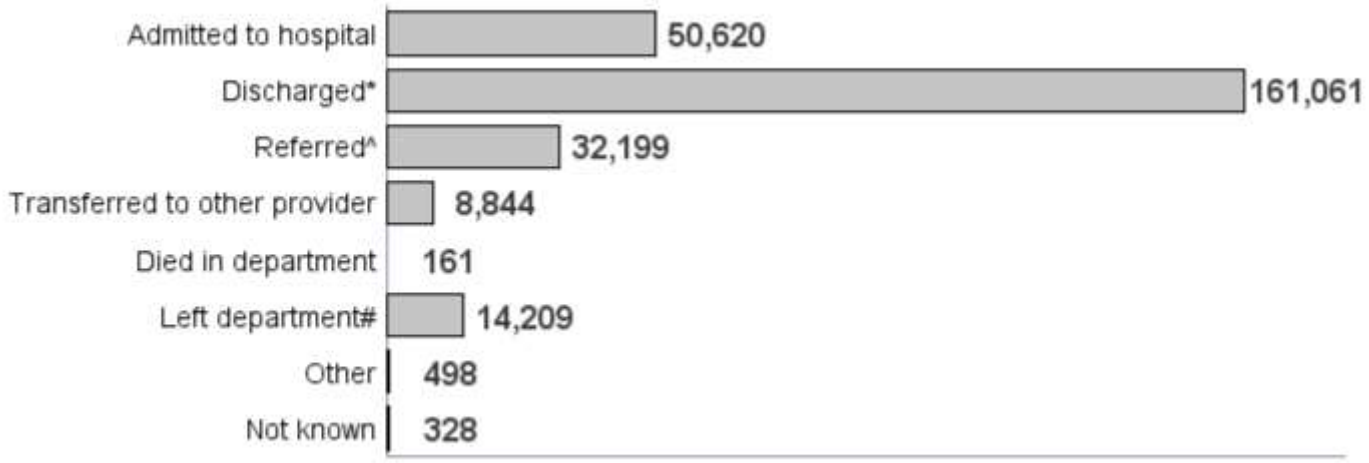
From July 2017 to June 2018 there were 267,920 attendances at the trust's urgent and emergency care services as indicated in the chart above. *(Source: Hospital Episode Statistics)*

The chart below shows the percentage breakdown of attendances that resulted in an admission.

Urgent and emergency care attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission remained similar in the most recent year compared to previous year. In both years, the proportions were lower than the England averages. *(Source: NHS England)*



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

(Source: Hospital Episode Statistics)

We last carried out an announced comprehensive inspection of the urgent care service in February 2016. The service was rated good for safe, effective, caring and responsive and well-led. The service was judged to be good overall.

We carried out an announced inspection of the urgent care service on 11 to 13 December 2018. Before visiting, we reviewed a range of information we held about the hospital. During our inspection, we visited all clinical areas in the service including the x-ray. We spoke with 12 patients and their relatives and 22 members of staff, including nurses, GPs, senior managers, student nurses, paramedic, domestic staff, receptionist and support staff. We observed care and treatment and reviewed 14 medical care records and prescription charts. We also reviewed the service performance data. We observed a multidisciplinary meeting and four patients' procedures and consultations. We also carried out a focus groups for clinical and non-clinical staff during inspection.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff but not all staff had completed it.

The trust had an 85% standard for the completion of mandatory training and staff met this for seven of the 16 modules for which qualified nursing staff were eligible.

The service provided mandatory training in key skills to all staff, such as conflict resolution, equality, diversity and human rights, basic prevent awareness training, resuscitation level 1 and 2, information governance, fire safety, manual handling, infection control level 1 and 2, emergency planning and basic radiation safety. Training was provided via e-learning modules or face-to-face sessions. Staff we spoke with understood their responsibility to complete mandatory training.

The trust provided mandatory training to all staff on a rolling annual programme via face-to-face sessions and e-learning modules. The trust had provided training to staff on the new electronic patient record; staff felt well prepared with the transition to electronic records and were satisfied with the training received.

Locum or temporary staff were required to provide evidence of mandatory training compliance from their employers.

The service had a recording system in place to monitor staff mandatory training, which highlighted when training was needed and gave a good oversight of completion. Staff received reminders via email when they were due training.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	178	181	98.3%	85%	Yes
Resuscitation L1	175	181	96.7%	85%	Yes
Infection Control L1	169	181	93.4%	85%	Yes
Basic Radiation Safety	159	181	87.8%	85%	Yes
Health & Safety Awareness	157	181	86.7%	85%	Yes
Emergency Planning	156	181	86.2%	85%	Yes
Fraud & Security	155	181	85.6%	85%	Yes
WRAP	144	170	84.7%	85%	No
Waste Management	149	181	82.3%	85%	No
Equality, Diversity & Human Rights	144	181	79.6%	85%	No
Moving and Handling	141	181	77.9%	85%	No
Information Governance	137	181	75.7%	85%	No
Conflict Resolution	123	181	68.0%	85%	No
Fire Safety	122	181	67.4%	85%	No
Infection Control L2	120	181	66.3%	85%	No
Resuscitation L2	118	181	65.2%	85%	No
Blood Transfusion	110	181	60.8%	85%	No
RTT L1	63	181	34.8%	85%	No

At trust level in urgent and emergency care the 85% target was met for seven of the 18 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 at trust level for medical staff in urgent and emergency care is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)

Resuscitation L1	116	166	69.9%	85%	No
BPAT	114	166	68.7%	85%	No
Infection Control L1	103	166	62.0%	85%	No
Health & Safety Awareness	102	166	61.4%	85%	No
WRAP	28	46	60.9%	85%	No
Fire Safety	100	166	60.2%	85%	No
Basic Radiation Safety	98	166	59.0%	85%	No
Fraud & Security	94	166	56.6%	85%	No
Equality, Diversity & Human Rights	93	166	56.0%	85%	No
Emergency Planning	92	166	55.4%	85%	No
Moving and Handling	86	166	51.8%	85%	No
Waste Mgt	84	166	50.6%	85%	No
Blood Transfusion	78	166	47.0%	85%	No
Resuscitation L2	78	166	47.0%	85%	No
Information Governance	75	166	45.2%	85%	No
Conflict Resolution	74	166	44.6%	85%	No
Infection Control L2	69	166	41.6%	85%	No
RTT L1	68	166	41.0%	85%	No

At trust level in urgent and emergency care the 85% target was not met for any of the 18 mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the UCC at Chase Farm is shown below:

Name of course	**Staff trained**	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Resuscitation L1	11	11	100%	85%	Yes
Equality, Diversity & Human Rights	11	11	100%	85%	Yes
RTT L1	11	11	100%	85%	Yes
Infection Control L1	10	11	90.9%	85%	Yes
Health & Safety Awareness	10	11	90.9%	85%	Yes
Conflict Resolution	10	11	90.9%	85%	Yes
Resuscitation L2	10	11	90.9%	85%	Yes
Basic Radiation Safety	9	11	81.8%	85%	No
Emergency Planning	9	11	81.8%	85%	No
Moving and Handling	9	11	81.8%	85%	No

Information Governance	9	11	81.8%	85%	No
Fire Safety	9	11	81.8%	85%	No
Infection Control L2	9	11	81.8%	85%	No
Fraud & Security	8	11	72.7%	85%	No
Waste Management	8	11	72.7%	85%	No
Blood Transfusion	8	11	72.7%	85%	No

At Chase Farm UCC, the 85% target was met for seven of the 16 mandatory training modules for which qualified nursing staff were eligible. Although Chase Farm UCC mandatory training completion rates were worse than Barnet Hospital's urgent and emergency care department (11 of 18 completed), however they had higher completion rates than Royal Free Hospital's urgent and emergency care department (four of 17 completed).

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the UCC at Chase Farm is shown below:

Name of course	**Staff trained**	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Moving and Handling	3	3	100%	85%	Yes
Basic Radiation Safety	3	3	100%	85%	Yes
Blood Transfusion	3	3	100%	85%	Yes
Emergency Planning	3	3	100%	85%	Yes
Equality, Diversity & Human Rights	3	3	100%	85%	Yes
Fire Safety	3	3	100%	85%	Yes
Fraud & Security	3	3	100%	85%	Yes
Health & Safety Awareness	3	3	100%	85%	Yes
Infection Control L1	3	3	100%	85%	Yes
Resuscitation L1	3	3	100%	85%	Yes
Waste Management	3	3	100%	85%	Yes
BPAT	3	3	100%	85%	Yes
Conflict Resolution	2	3	66.7%	85%	No
Infection Control L2	2	3	66.7%	85%	No
Information Governance	2	3	66.7%	85%	No
Resuscitation L2	2	3	66.7%	85%	No
RTT L1	2	3	66.7%	85%	No

At Chase Farm UCC urgent and emergency care department the 85% standard was met for 12 of the 17 mandatory training modules for which medical staff were eligible. The completion rate for Chase Farm UCC medical staff was better than both Royal Free Hospital and Barnet Hospital.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Recent data received from the trust during inspection showed the overall mandatory training compliance for medical and nursing staff was 94% which was better than trust target of 85%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked collaboratively with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. However, the service did not have oversight of the number of patients who left the service before been seen, including vulnerable children and adults.

The trust had clear systems, processes and practices in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. However, during inspection, we saw that the service did not had a formal process, policies and guidelines for staff for the follow up the patients that left before been seen. Following the inspection, the service had developed a flow chart for patients who did not answer call for streaming and triage, and those who did not wait to be seen by clinician.

Policies were available to guide staff on how to protect people from abuse. There were policies available on the internal computer system relating to the safeguarding of adults and children. These were up to date and referred to relevant legislation and guidance. The policy included flow charts providing a quick reference guide to staff on what to do should a concern be identified.

The trust had a policy for recording and reporting suspected female genital mutilation (FGM). The policy included how to code for FGM on a discharge summary. Staff in the UCC had not made any FGM referrals but understood this process. The trust had a policy for recording and reporting suspected cases of child sexual exploitation (CSE). The trust provided training for CSE in mandatory safeguarding courses which utilised multi-media resources and case studies to help staff identify signs and risk factors. In February 2018, the trust introduced a tool in UCC to help staff identify CSE in young people and children at risk of exploitation. Children safeguarding leads had additional CSE training to help them support staff to think about risks.

Staff were trained in safeguarding and knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Staff knew how to make a safeguarding alert and did when it was appropriate. We saw an example where safeguarding concerns were identified by staff and referrals were made and multiple professionals such as the GP and health visitor were notified.

From September 2017 to August 2018, urgent and emergency care services reported 508 adult safeguarding referrals and 192 child safeguarding referrals in the trust. The UCC reported 12 safeguarding referrals for the period of December 2017 to November 2018 of which 50% referrals were adult and 50% were paediatric concerns.

Staff also signposted patients to charities, organisation and support groups for additional safeguarding support such as the independent domestic violence advisers (IDVA). This was in line with national guidance.

The service reviewed safeguarding concerns on a regular basis. There were weekly paediatric meetings to review paediatric safeguarding concerns. The service also held a multidisciplinary psychosocial meeting for paediatric patients which reviewed safeguarding, mental health, and child and adolescent mental health services (CAMHS) cases. We saw an example where a patient with safeguarding and mental health concerns had been referred and admitted to Barnet Hospital for an assessment and support.

Staff were knowledgeable about protecting vulnerable adults and made referrals to the older person’s assessment unit (OPAU) at Chase Farm hospital from 8am to 4pm for further assessment.

During our inspection we saw staff had referred two patients in a 24-hour period to the OPAU, resulting in admission avoidance.

Staff could see if a child or adult was known to the safeguarding services by a computer system. Staff notified patients' social services, health visitor, or other appropriate service following consultation and treatment of vulnerable patients seen at the urgent care centre. The service kept a spreadsheet to document referrals made and we saw evidence that staff thoroughly filled out safeguarding referral forms. This meant that the service had a good process in place to record all safeguarding referrals.

The service identified a risk that they were unable to communicate child attendances to the child protection safeguarding team who were not on the Chase Farm hospital site. Staff told us this was mitigated by communicating patient attendance through emails. During inspection we were not assured that the service had oversight of safeguarding of adults and children as they did not record and check safeguarding for patients that left the service before being seen by nurses and doctors.

The service did not audit 'failure to attend' patients who booked in with reception but left before being seen. At the time of our inspection, there was no system in place for managers to audit these patients' records to ensure staff had documented and escalated to the safeguarding team and other relevant professionals. This meant that the service could not ensure everything was done by staff to safeguard vulnerable adults and children patients. Although the trust acknowledged that this was a risk in the paediatric outpatient department and was discussed at the clinical performance and patient safety committee, this was not on the risk register for the urgent care centre. There was no evidence that the trust was mitigating risk for vulnerable adults and paediatric patients in the UCC.

We expressed our concerns to the trust for the follow-up and audits of patients who left the service before been seen. Following our inspection, the service completed an audit to know the number of patients that left before been seen in October 2018. The data showed 140 patients left the service before been seen of which 42 patients were children and 11 were elderly patients between 70 to 87 years old. We noted that some of the children that left before been seen had three head injuries and while some of the elderly patients had high blood pressure and injuries. Studies have shown that injuries including head injuries are signs of physical abuse in children and adults. There was no evidence of a comprehensive assessment and follow-up of the physical presentation of these patients with injuries with other professionals.

Following the inspection, the trust told us that discharge summaries were sent all patient's GP including patients who checked in but did not wait to be seen. The UCC team would review the national summary care records for the patients and will flag by email to the relevant authorities any patient who attended that has a safety alert such as child protection concerns in the summary care record. The team would include in this email whether they were concerned about the patient presentation or not. However, this was an informal process and was not currently in a written document such as policies and guidelines.

Following inspection, the service submitted four examples of automated discharge summary letters sent to the GP of patients from September 2018 to October 2018 that left before been seen. All these discharge letters reviewed were not comprehensive and did not include brief assessment of patient's physical presentation or mental health wellbeing following initial assessment from staff which can indicate sign of abuse or safeguarding concerns. The letter did not include any evidence of liaison or follow-up with other professionals such as health visitors or social services for children or those with safeguarding concerns that left before been seen. The trust did not provide any further evidence of follow-up or summary letters and emails sent to the social services and health visitor for patients that were children or had safeguarding concerns. For example, an automated summary

sent to the GP for a patient with safeguarding concerns, highlighted that an email would be sent to the patient social worker and this evidence was not provided to us as requested.

A breakdown of trust wide compliance for the safeguarding training course from April 2018 to August 2018 for qualified nursing staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	179	181	98.9%	85%	Yes
Safeguarding Children L2	179	181	98.9%	85%	Yes
Safeguarding Adults L1	155	181	85.6%	85%	Yes
Safeguarding Adults L2	150	181	82.9%	85%	No
Safeguarding Children L3	123	181	68.0%	85%	No

Trust wide, the urgent and emergency care department 85% target was met for three of the five safeguarding training modules for which nursing staff were eligible.

A breakdown of trust wide compliance for the safeguarding training course from April 2018 to August 2018 for medical/dental staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L3	31	49	63.3%	85%	No
Safeguarding Children L1	103	166	62.0%	85%	No
Safeguarding Children L2	98	166	59.0%	85%	No
Safeguarding Adults L1	94	166	56.6%	85%	No
Safeguarding Adults L2	90	166	54.2%	85%	No

Trust wide, the urgent and emergency care department 85% target was not met for any of the five safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018 for qualified nursing staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	11	11	100%	85%	Yes
Safeguarding Children L2	11	11	100%	85%	Yes
Safeguarding Adults L1	10	11	90.9%	85%	Yes

Safeguarding Adults L2	10	11	90.9%	85%	Yes
Safeguarding Children L3	3	11	27.3%	85%	No

At Chase Farm UCC urgent and emergency care department the 85% target was met for four of the five safeguarding training modules for which nursing staff were eligible.

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018 for medical/dental staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	3	3	100%	85%	Yes
Safeguarding Adults L2	3	3	100%	85%	Yes
Safeguarding Children L1	3	3	100%	85%	Yes
Safeguarding Children L2	3	3	100%	85%	Yes
Safeguarding Children L3	2	3	66.7%	85%	No

At Chase Farm UCC urgent and emergency care department the 85% target was met for four of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During our inspection the overall safeguarding training compliance for medical and nursing staff was 100% for both level 1 and level 2 and while staff achieved 94% for the level 3 safeguarding training. Clinical staff such as the nurses, HCAs and consultants received safeguarding level 3 training.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. There were systems and processes to control and prevent the spread of infection. The department was visibly clean, tidy and free of any odours and we saw **standards of cleanliness were maintained**.

The UCC service had moved into a new facility one month prior to our inspection. We saw evidence the trust performed deep cleaning in the department prior to their move in date to minimise risk of cross infection. Patients we spoke with were pleased with the new facilities and found them clean and tidy.

The service had a designated housekeeping staff responsible for cleaning all areas of the department and we found all areas were maintained to a good standard of cleanliness.

The service had two rooms with pressurised air flow which could be used to treat patients with infectious diseases. There was a designated room to be used as an infection control room.

We saw that most hand sanitisers were full and accessible. However, one wall mounted hand sanitiser at one of the UCC entrances was empty. When highlighted to staff it was replenished immediately. Hand-washing stations were available in each clinical room and wall mounted hand sanitisers were available in each clinical room.

The trust provided us with 37 hand hygiene audits from the period of 1 January to 30 September 2018, which showed an overall 83% compliance on all elements of hand hygiene audited such as

hand hygiene before and after patient contact, correct technique carried out, no watches, bare below the elbow and non-band rings.

We saw staff adhered to good hand hygiene practice, bare below the elbow principles and wore personal protective equipment (PPE), such as gloves and aprons. We observed staff changed PPE between patient contact to minimise cross infection, in line with best practice. Patients told us they saw staff cleaning their hands before and after they were treated, and handwashing facilities were available. We observed most staff applied hand sanitising gel in between patients in accordance with national guidance (National Institute for Health and Care Excellence (NICE) Infection prevention and control: QS61).

There were systems to ensure clinical waste, such as sharps, was appropriately disposed of. Clinical waste was correctly segregated, stored, labelled and disposed of regularly. We checked five sharps bins and found all to be assembled correctly, dated, signed and was not over full.

The UCC cleaning audit from March 2018 to November 2018 showed 99% compliance on the seven standards audited. The audit tracked cleanliness of 49 areas in the UCC, including the environment and equipment, beds, curtains, and surfaces.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The service had moved to the new hospital environment in September 2018. The new environment was spacious and fit for purpose and an improvement from the last inspection as it was purpose-built for the service. Staff and patients' feedback about the new building was very positive. Patients were happy with the facilities and environment and staff were proud to work in the new building.

We found the service had a clean, tidy and calm environment and the waiting areas in the service had enough seating available. The main waiting room was bright, clean and tidy. The x-ray and plaster room had their own waiting area with adequate seating.

There were 11 rooms in the UCC. Additionally, paediatric patients were seen in a designated room for UCC use in the adjacent paediatric outpatient department. If more than one paediatric assessment room was required, the service could negotiate with the outpatient department for an additional room.

The service had processes in place to ensure equipment was in good working order, safe for patients and was routinely tested to ensure it was fit for purpose. The trust contracted out the maintenance of medical equipment standards which was monitored through monthly contract review meetings. The medical equipment we inspected was serviced and tested for electrical safety with labels showing when the next test was due or last test carried out. This included clinical equipment, fire extinguishers and medical gas cylinders.

Although the UCC had an emergency telephone at the hospital's main entrance for out-of-hour admittance to the building and a separate entrance which led directly to the service however we found that there could be better signage for patients to direct them to the service. There was no signage at this entrance to advise or direct patients to the service. During inspection, majority of patients seen who accessed the service used the second entrance in the hospital building and unfamiliar with the main entrance. This was not in line with the Royal College of Emergency Medicine (RCEM), Emergency Department Care 2017 guidelines.

Assessing and responding to patient risk

Clinical staff completed and maintained risk assessments for each patient seen in the UCC. They kept clear records and asked for support when necessary. However, there was no system in place for staff to escalate to the safeguarding team and risk assess patients that left the service before being seen after booking in.

The service had pathways and guidance that was used to stream and triage patients to various streaming pathways and advised staff on the categories of patient conditions accepted and treated in the unit and categories of patients not accepted to ensure patient safety to minimise patient risk. Patients not accepted and transferred to other services included acutely unwell patients, victims of assault and pregnancy related issues.

The service used a colour coded streaming system to indicate severity of illness determine their initial treatment. Patients were streamed to red and amber in the service following initial assessment with conditions, such as severe burns, acute mental health, stroke and urinary retention, were redirected to an emergency department at the nearest hospital. Patients assessed as blue stream with low or medium risk were referred to their GP, community nursing service or emergency dental service. The pathways also detailed guidance to staff on using SBAR (a technique used to facilitate prompt and appropriate communication: situation, background, assessment and recommendation) for clinician to clinician handover.

Staff were offered influenza (flu) vaccination in in line with national guidance to prevent cross infection and minimise safety risk. The flu vaccine uptake of staff at Chase Farm Hospital was 100% which exceeded the trust target of over 70%.

Staff used an ambulance hospital transfer flow chart that provided guidance when requesting hospital transfers. It also helped establish response times during clinical emergencies for patients that could not be treated in the service. Staff could access a specific phone in the nursing station which served as the blue call that warned staff of any emergencies brought in by ambulance and for emergencies requiring transfer to A&E by the ambulance. Data received from the trust showed the service was meeting their target and patients were transferred to other service promptly. Staff also received handover of patients brought in by the ambulance immediately. There was a medical emergency team (MET) available in the hospital who were available to assist staff with managing and transferring deteriorating patients.

There were systems were in place to identify and respond to patients in need of immediate treatment. Health care assistants and nurses responded appropriately to patients. We saw an example where nursing staff consulted with medical staff following clinical assessment of a patient with chest pain. However, there was no formal process for reception staff to highlight sick patients to nursing or medical staff.

Patients with suspected sepsis were transferred or redirected to Barnet Hospital in line with national guidance by giving antibiotics and intravenous fluids where indicated. The UCC team did not collect data on suspected sepsis or sepsis-related transfers. This meant we could not establish their track record of performance against trust standards.

As part of patient's assessment, staff undertook x-ray, electrocardiogram (ECG), vital signs, and urine testing to assess and identify and possible patient risk when indicated. At the time of our inspection there were no blood tests done in the service. Patients that required blood test were transferred or redirected to the nearest ED.

There were safety huddles three times a day where staff discussed staffing issues. Once a day they discussed staffing issues at the 'gold safety huddle' meeting with the site senior executives. This was an improvement following the last inspection and from staff feedback.

The service had storage room that had equipment for major incidents, such as a tent to be used for decontamination following a chemical incident.

There was a good line-of-sight between waiting room patients and the receptionists, with CCTV covering any hidden areas. This meant patients were observed while waiting, however the service did not train receptionists to respond to deteriorating patients.

However, there was no CCTV in the paediatric outpatient area. The service did not designate staff out of hours to the paediatric outpatient area which meant that there was no oversight of these patients. The service identified this as a risk. Staff relied on parents to keep an eye on children when they waited in the paediatric outpatient area. Staff were not assured that patients were not deteriorating when out of their sight. This was on the service risk register and reviewed in November 2018; the trust did not submit actions undertaken for this risk.

The service had processes in place to escalate when there was overcrowding and no GP cover in the UCC which might trigger early closure or redirection of patients. We requested how often this had been activated in the 12 months prior to our inspection but the trust did not provide this data. However, during inspection staff told us there had been no closure of the service in the last 12 months.

The hospital had security staff located at the hospital entrance near to the service to keep staff and others safe and protected from violence. Staff we spoke to told us the security staff responded between one and two minutes when needed.

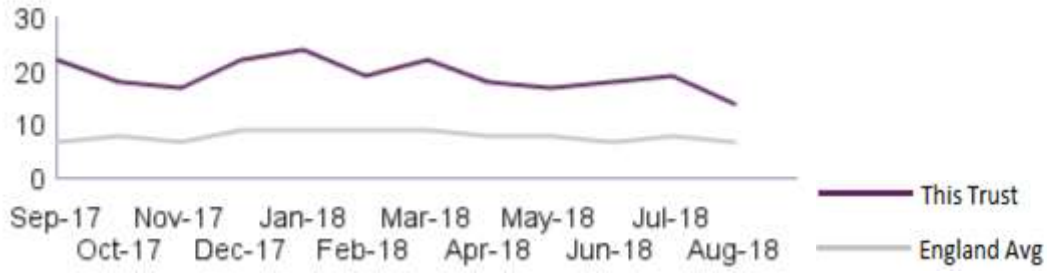
The trust scored worse than other trusts for one of the five Emergency Department Survey questions relevant to safety. The trust scored "about the same" as other trusts for the remaining four questions.

Question	**Score**	**RAG**
Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	7.3	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	5.4	About the same as other trusts
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	5.6	About the same as other trusts
Q33. In your opinion, how clean was the emergency department?	7.9	Worse than other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.3	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

The median time from arrival to initial assessment was consistently better than the overall England median over the 12-month period from September 2017 to August 2018.

In the latest period, August 2018 the median time to initial assessment was 14 minutes compared to the England average of 7 minutes.

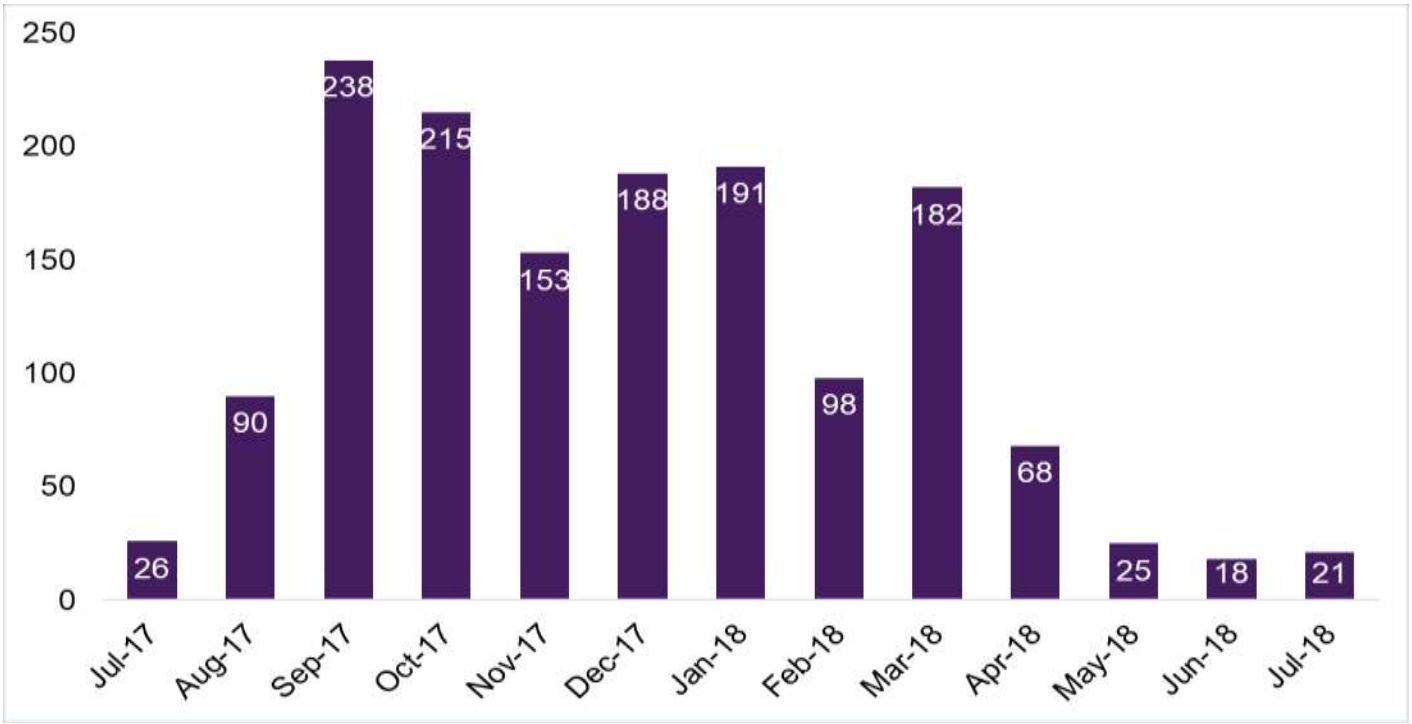


(Source: NHS Digital - A&E quality indicators)

From 22 March 2018 to 31 May 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times within eight minutes for patient transferred or redirected to a nearest ED from the UCC. In this period, 63.4% of patients had turnaround times within eight minutes, 22% transfer within 60 minutes and 2.4% transfer over 60 minutes

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

From July 2017 to July 2018 the trust reported 1,513 “black breaches”, with a downward trend over the period.



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

NHS England require ‘black breaches’ (ambulance handovers >60 minutes) to be reported as serious incidents and to be investigated accordingly.

There were no black breaches at the urgent care centre. Paramedics were seen immediately by staff and handover took place within five minutes and patient that did not meet the service criteria were redirected to another ED.

Nurse staffing

There were high vacancy, turnover, and sickness rates in the service compared to the other trust sites and the service had plans in place to address this. Shifts were often overstaffed against the planned numbers and this was managed through reliance on bank and agency staff.

During our inspection, we saw evidence that staff had various clinical backgrounds, such as community nursing, pharmacist and paramedic and were in trainee development posts.

At the time of our inspection, the service had five band 6 registered nurses in post with a new staff member starting in January 2019, three band 7 emergency nurse practitioner (ENP) staff in post, a band 6 emergency care practitioner (ECP) and a band 7 ECP. Staff told us, and we observed during inspection that there was always a paediatric trained nurse on shift who assessed and managed the care of children in the unit.

The service had an eight-year pathway plan to recruit or develop ENPs.

The trust has reported the following qualified nursing staff numbers in urgent and emergency care from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	122.7	100.5	81.9%	125.2	88.8	70.9%
Chase Farm Hospital	19.0	11.8	62.1%	18.3	12.4	67.5%
Royal Free Hospital	110.9	84.0	75.7%	120.7	81.0	67.1%
Total	**252.6**	**196.3**	**77.7%**	**264.1**	**182.1**	**69.0%**

From April 2017 to March 2018, the trust reported a staffing level of 77.7% for qualified nursing staff in urgent and emergency care. This had decreased to 69.0% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From September 2017 to August 2018, the trust reported a vacancy rate of 23.9% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 12%.

- Chase Farm Hospital: 37.3%

The Chase Farm UCC nursing vacancy rates were worse than the other trust UEC sites.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

During our inspection we noted that the service held weekly vacancy control meeting. We noted that the vacancy rate for ENP staff was 48% for the period of 5 November to 26 November 2018, with a staff in the pipeline.

From September 2017 to August 2018, the trust reported a turnover rate of 27.1% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 13%.

- Chase Farm Hospital: 33.8%

The Chase Farm UCC nursing turnover rates were worse than the other trust UEC sites.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 3.3% for qualified nursing staff in urgent and emergency care. This was lower than the trust target of 3.5%.

- Chase Farm Hospital: 6.1%

The Chase Farm UCC nursing sickness rates were worse than the other trust UEC sites.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 20% of all staff shifts in urgent and emergency care were filled by bank staff and 6% of shifts were filled by agency staff. In addition, 1% of shifts were over-filled by bank and agency staff to cover staff absence.

The breakdown by site is shown in the table below.

Site	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Barnet	282,484	61,876	22 %	12,281	4%	Over-filled by 19,139	Over-filled by 7%
Chase Farm	41,363	4,979	12 %	11,316	27%	2,576	6%
Royal Free	254,980	51,447	22 %	8,301	4%	11,041	4%
Total	**578,827**	**118,301**	**20 %**	**31,898**	**6%**	**Over-filled by 5,522**	**Over-filled by 1%**

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

Medical staffing

The service had medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust has reported the following medical staff numbers in urgent and emergency care from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
	118.5	124.4	Over-			

Barnet Hospital			established by 5.0%	140.9	132.4	93.9%
Chase Farm Hospital	5.6	2.7	48.2%	7.8	3.0	38.7%
Royal Free Hospital	45.7	34.0	74.4%	46.0	34.3	74.5%
Total	**169.8**	**161.1**	**94.9%**	**194.7**	**169.7**	**87.2%**

From April 2017 to March 2018, the trust reported a staffing level of 94.9% for medical staff in urgent and emergency care. This had decreased to 87.2% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The clinic lead had taken control of the doctor's roster from the staffing agency. This ensured that the nine GP staff previously working for an agency were now working for the trust as temporary staff and under the trust indemnity. The service now had a full medical team during our inspection. The service now provided the appraisal through the NHS and GMC process. The service developed training information for temporary medical staff including for GPs.

At the time of the inspection we saw that the medical staffing fill rate had improved. There was a 95% fill rate since the recruitment of GPs by the trust. Staff told us the fill rate while GPs were on the bank system was poor and was low, down to 15% at one time.

The service had two middle grade doctors with an A&E background and 11 GPs in post.

From September 2017 to August 2018, the trust reported a vacancy rate of 10.8% for medical staff in urgent and emergency care. This was lower than the trust target of 12%.

- Chase Farm Hospital: 63.4%

We noted that The Chase Farm Hospital UCC medical vacancy rates were worse than the other trust UEC sites

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 7.8% for medical staff in urgent and emergency care. This was lower than the trust target of 13%.

- Chase Farm Hospital: 41.1%

The Chase Farm UCC medical turnover rates were worse than the other trust UEC sites.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 0.7% for medical staff in urgent and emergency care. This was lower than the trust target of 3.5%.

- Chase Farm Hospital: 0.4%

The Chase Farm UCC, medical sickness rates were better than one other trust UEC site and better that the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 10% of medical shifts in urgent and emergency care were filled by bank staff and 5% of shifts were filled by locum staff.

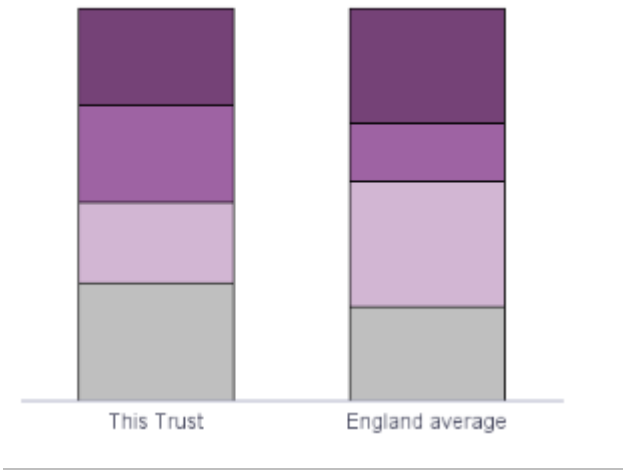
The breakdown by site is shown in the table below:

Site	Total hours available	Bank Usage		Locum Usage		NOT filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Barnet	250,029	15,603	6%	3,030	1.2%	Over-filled by 1,301	Over-filled by 1%
Chase Farm	12,996	5,107	39 %	0	0%	3,127	24%
Royal Free	89,577	13,452	15 %	13,457	15%	Over-filled by 1,181	Over-filled by 1%
Total	**352,602**	**34,162**	**10 %**	**16,486**	**5%**	**646**	**0%**

The Chase Farm UCC medical bank and locum rates were high but had improved from the previous year.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In July 2018, the proportion of consultant staff and the proportion of registrar group reported to be working at the trust were both lower than the England average. The proportion of junior (foundation year 1-2) staff and middle career were both higher.



	This Trust	England average
Consultant	25%	29%
Middle career^	25%	15%
Registrar group~	21%	32%
Junior*	30%	24%

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

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment, however records were not always stored securely and appropriately. Records were clear, up-to-date and easily available to all staff providing care.

The trust implemented a new model electronic patient record (EPR) at Chase Farm Hospital in November 2018. This allowed for advanced clinical functionality, which included electronic prescribing and medicines administration (EPMA) and clinical noting at the point of care. It included a health information exchange (HIE) which meant that providers could access patient data in real time. It also included a patient portal for patients to access key clinical information and transactional services online. Staff received training for the new EPR and received a handbook. Staff reported no concerns with the new system. The service was mostly using digital systems and only recorded on paper for downtime and for patient labels.

We reviewed 14 patient records and prescription during inspection. Records were legible and very detailed and included patients' allergies, holistic assessment, pain assessment, smoking status and medical history such as tuberculosis (TB).

The service carried out an x-ray audit in 2018 to assess the quality of clinical details provided in the radiology request by non-medically qualified staff. The result showed that 84.5% requests had adequate information filled in by staff while 15.5% had inadequate information, which increased the limitation of radiographers to give appropriate report findings. We noted that the audit result was discussed with staff and the service planned to re-audit in six months.

During inspection we noted that during the safety huddle it was highlighted that x-ray results were not being saved in the computer systems due to IT issues and this was escalated to the IT department. The x-ray result was available in a paper copy and scanned into the electronic record.

During inspection we found that staff did not store records securely. We found approximately 50 patient records and sticky labels with identifiable information and results in an unlocked storeroom in the UCC. This room was accessible to non-clinical staff. Staff were rarely at the nursing station during inspection and we noted that this store could be accessed by patients or visitors. We also found three boxes with training materials and staff professional revalidation folders that had their personal details and personal and professional information and certificate, as well as feedback from patients and other staff with their details. There was the risk that if the revalidation folder was lost or stolen this could impact on staff professional folder and affect renewing their professional membership to work as a nurse. When escalated, the matron told us lockable cabinets have been ordered and they were awaiting delivery. When we inspected the room the next day we saw that the store room was locked, and the patients' records had been removed, however the staff professional revalidation folder was still stored in the room. At the time when we raised the issue, senior staff did not initially see this as a concern.

We also found the ambulance log unsecured at the nursing station with patient identifiable information. This document was not locked in a secured area and was easily accessible to patients and visitors as there was no designated staff at the nursing station. This was escalated to senior staff and following the inspection the ambulance log had been moved to the triage room which was only accessible to UCC staff members.

Following our inspection, the trust told us that staff were meeting the trust mandatory training on information governance and had received newsletter before the inspection on record keeping.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Medicines were in date, well organised and stored at correct temperatures. We found that most medications were secured in a locked medications room. The nurse in charge held keys to the

controlled drug cupboard. On one occasion, we found a medicine cabinet unlocked and staff immediately locked it.

Emergency medicines were in date and available to staff, it included medication to support people undergoing anaphylactic shock and those with hypoglycaemia. Although the emergency medicines were stored in a tagged box within the resuscitation trolley, the trolley was not tagged. This meant that in an emergency, staff could not always be assured that all resuscitation equipment was available.

Medicines were prescribed and administered in line with relevant legislation and best practice guidance. Patient Group Directives (PGDs) allow non-prescribing health professionals to administer medicines or specific groups of patients that meet pre-defined criteria. PGDs were in place for nurses to supply simple medicines, such as analgesia, to patients. We observed this in practice when nursing staff gave patients pain medications.

The service had access to pharmacy consultation services 24 hours a day, 7 days a week. The hospital had a pharmacy opened from Monday to Friday 9.00am to 5.15pm to supply medications to the UCC and outpatients. Out of hours and at weekends patient were required to pay for prescriptions using a payment machine in the service and nursing and medical staff would dispense medicines to them.

The hospital also had arrangement where Barnet hospital or on-call pharmacy service provided medicines used in the service during out of hours and weekend.

Incidents

Although the service managed patients safety incidents well, staff did not always report safety incidents and had limited knowledge of incident themes reported. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From September 2017 to August 2018, the trust reported no incidents classified as never events for urgent and emergency care.

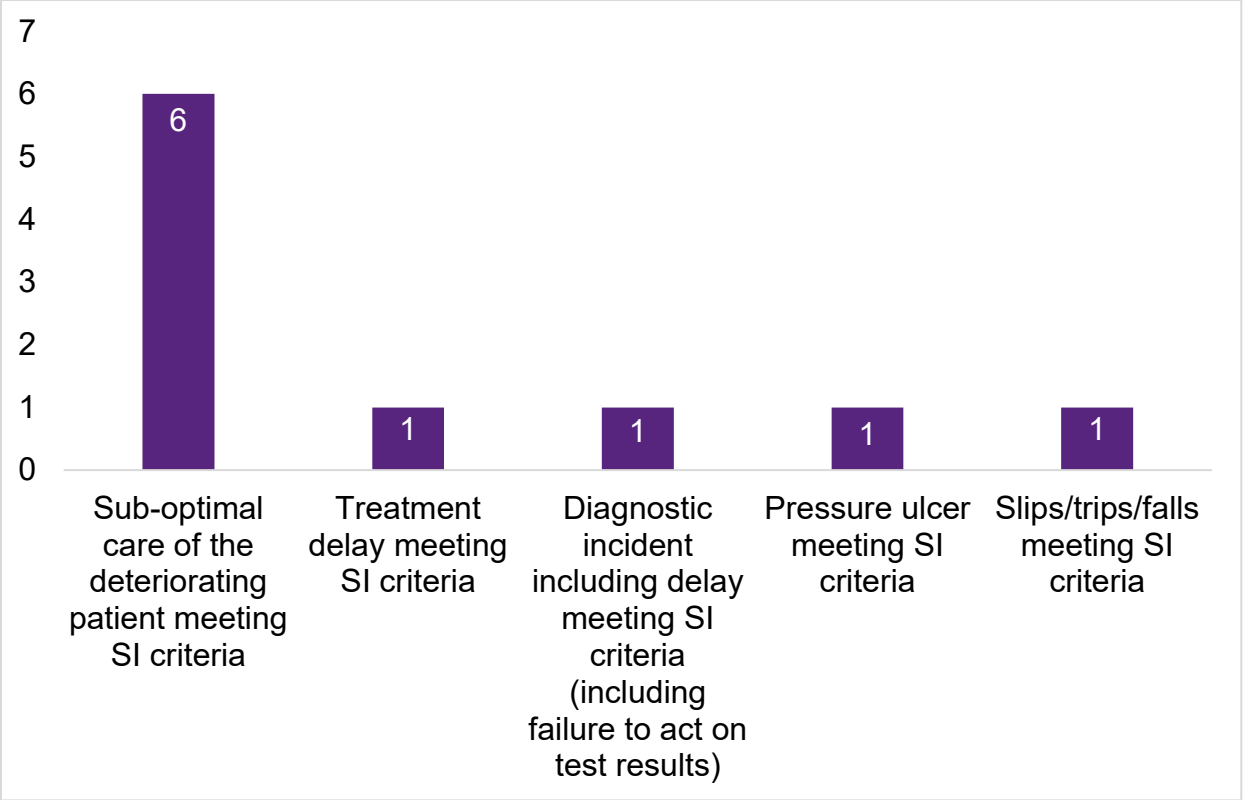
(Source: Strategic Executive Information System (STEIS))

The service reported no never events from the period of December 2017 to November 2018.

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from August 2017 to September 2018.

These were:

- Sub-optimal care of the deteriorating patient meeting SI criteria with six (60% of total incidents)
- Treatment delay meeting SI criteria with one (10% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (10% of total incidents)
- Pressure ulcer meeting SI criteria with one (10% of total incidents)
- Slips, trips and falls with one (10% of total incidents)



(Source: Strategic Executive Information System (STEIS))

For the period of December 2017 to November 2018 the service reported no serious incidents in UCC which met the reporting criteria set by NHS England

For the period of 1 November 2017 to 31 October 2018 the service reported 82 incidents.

Level of harm	Number of incidents	Percentage
No harm	77	94%
Low harm	4	5%
Moderate harm	1	1%
Total	82	100%

The service had a quality governance bulletin which updated staff on incidents reported in the service and hospital. We reviewed the December 2018 bulletin and noted that staff were informed of nine events that have occurred trust-wide from April 2018 to November 2018. The brief showed that there were 62 incidents reported for the service from April 2018 to December 2018 and the top five incidents were:

- Security (20).
- Access, admission, transfer and discharge (10)
- Clinical assessment (8)
- Infrastructure (staffing, facilities, environment) (5)
- Patient accident including falls (3)

Staff had limited knowledge on the incidents reported in the service and never events in the hospital. However, staff knew they involved patient violence and aggression. Few staff we spoke with had reported incidents and received feedback and this related to violence and aggression from patients.

Staff were not encouraged to always report safety incidents. During inspection we, found a culture of low levels of incident reporting. We had mixed views from senior managers about reporting safety incidents such as inadequate staffing on a shift “as this was on their risk register and was discussed at their safety meeting and reporting such incidents served no purpose”. This was not in line with the Royal College of Emergency Medicine (RCEM) Quality Standard. We noted that the service reported zero medicines incidents from April 2018 to December 2018 despite the use of PGD, administering and prescribing of medicines.

Staff told us that incident learning were shared through ‘Chase it Up’ meetings, safety lessons of the week, morning briefs, a newsletter group and weekly blog. We saw evidence that Incidents were discussed at various meetings, such as clinical governance, safety huddle, safety lessons of the week (SLOW) and at the trust board. Some examples of learning from incidents included awareness of patient allergies and ways staff could improve their security on the hospital grounds.

Staff told us that any breaches that occurred in the service were presented and discussed at the hospital serious incident (SI) panel (SIP) to identify actions that may be required to prevent recurrence.

The service did not undertake mortality and morbidity meetings. However, staff told us that any learning from the hospital mortality and morbidity meetings were discussed at governance meeting and shared with staff.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person. We saw evidence that staff apologised and reviewed circumstances surrounding incidents. Staff understood the duty of candour and applied it in practice. For example, we saw an instance that staff apologised to a patient following an incident, explained the learning from the incident and measures that were put in place to prevent similar incidents. Staff apologised when there were errors and understood certain incidents needed to be documented and dealt with in a timely manner.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from September 2017 to September 2018 within urgent and emergency care.

The service reported four falls incidents for the period of December 2017 to November 2018.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The urgent care centre had systems in place to ensure policies, protocols and clinical pathways were reviewed regularly and reflected national guidance, best practice and legislation.

Staff we spoke told us they had a range of clinical pathways and good practice guidelines which were available on the intranet and computer system and were updated, accessible and guided by recommendations from advisory bodies, such as the Royal College of Emergency Medicine (RCEM), National Institute for Health and Care Excellence (NICE) and relevant legislation such as the Mental Health Act. Documentation and screening tools were updated to consider new guidance such as the traffic light policies and sepsis guidance. The service used evidence-based clinical care pathways such as feverish illness in child, head injury, headaches, back pain and deep-vein thrombosis in the service to standardise the care given.

New guidance was discussed, reviewed and updated at the monthly trust and divisional clinical governance team meetings. This helped the trust to identify newly published or revised guidance and recommendations from advisory bodies, such as Royal College of Emergency Medicine (RCEM), National Institute for Health and Care Excellence (NICE) and relevant legislation such as the Mental Health Act. This information was then cascaded to the trust sites through the relevant governance teams for identifying the relevant specialties and establishing the compliance status within three months. We noted that staff were informed of changes to national guidance and local policies and procedures

The use of guidelines in the service ensured patients received treatment that was in line with the latest evidence-based guidance and best practice.

We reviewed eight policies and guidance related to the service and we noted they were up to date and detailed. However, we found three out of date printed policies such as the chaperone policy, dress code and uniform policy, and the trust urgent care centre at Chase Farm hospital operation policy at the nurse station during inspection. This was escalated to the matron and was removed immediately by staff. We noted that these three policies were up to date on the intranet but had not been printed out by staff. Staff we spoke to told us they often refer to the intranet for updated policies and guidelines and not the printed copy.

The trust was part of a formal clinical partnership with other NHS trusts and as part of this clinical partnership, they shared clinical pathways and best practice with other trusts in this group.

The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment patients. The service participated in local and national audits programmes and collated evidence to monitor and improve care and treatment when indicated. Where the service could not submit national data, staff carried out a local audit and benchmarked themselves.

The audit committee decided on the audit programme in response to national audits, national guidance, best practice initiative, practice related issues, risks and trends from their electronic reporting system. The service had plans to have more regular process of internal audit to identify and address issues earlier as well as increasing the scope and targeting of data quality reports.

We saw that service leads were aware of how their performance benchmarked against national or local standards and had implemented plans for improvement where this had been identified.

The UCC had systems in place which provided staff guidance on approach to take during critical and non-critical patient transfers. The UCC only dealt with minor illnesses and minor injuries and any seriously ill patient that could not be treated in the service was transferred to the nearest hospital or wards. Staff demonstrated good understanding of the patient relocation protocols.

The service had received accreditation by the Royal College of Nursing on minor injury and minor illness.

Nutrition and hydration

The nutrition and hydration needs of patients was considered during their time in the service, taking their cultural, dietary and religious need in consideration, to ensure they were not at risk of malnutrition.

Staff gave advice and followed up patients where nutrition and hydration concerns were identified through assessment such as dehydration.

The patients that accessed the UCC were treated and discharged within two hours of arrival therefore the department did not have any formal catering arrangements in place. However, patients waiting to be transported, unwell and under close observation or waiting for long to be seen were offered tea, toast, sandwich, drinks and biscuit. Since the last inspection the service now had their own kitchen to arrange patients' meal and did not need to contact the hospital canteen, this was an improvement.

Relatives and patients waiting to be seen could also access snacks and drink through vending machines in the waiting room and hospital restaurant.

In the CQC 2016 Emergency Department Survey, the trust scored 6.1 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was about the same as other trusts. *(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)).*

Pain relief

Patients' pain was assessed and managed appropriately by staff on arrival at the department, including those with difficulties communicating.

Staff used various pain assessment tools to assess pain in adults and children. For example, staff told us they would use visual pain assessment tools for children or adults unable to provide a score.

The receptionists highlighted on the electronic record system dashboard during a patient's booking if they are in pain. Patients with severe pain would be given pain relief during streaming or triage while still waiting to be seen by the doctor or nurse for consultation or assessment

Patient we spoke to told us they had been given pain medicines when in pain. From the patients record reviewed we saw that staff assessed patient pain and recorded the pain score on the electronic system.

We observed medical and nursing staff checking the system regularly and providing pain relief when flagged on their system at booking. We observed patients' consultation during inspection and observed nurses and doctors asking patients about their pain and responding appropriately. Staff also asked patients if any pain medicines had been taken before coming to the centre and if appropriate offered analgesia.

Emergency nurse practitioners and medical staff could prescribe analgesia which was dispensed in the outpatient pharmacy or in the department out of hours. Staff we spoke to told us they would offer advice to patients on how to manage pain and use the medicine prescribed and advise them to come back if they feel unwell.

In the CQC Emergency Department Survey, the trust scored 5.6 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts.

The trust scored 7.2 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

Question – Effective	Score	RAG
Q31. How many minutes after you requested pain relief medication did it take before you got it?	5.6	About the same as other trusts
Q32. Do you think the hospital staff did everything they could to help control your pain?	7.2	About the same as other trusts
Q35. Were you able to get suitable food or drinks when you were in the emergency department?	6.1	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. The RCEM audit cycle did not apply to the UCC however the service benchmark their own clinical outcomes with national and local target and those of other services to improve the service.

The service monitored their daily performance against the four hours target, and breaches related to delays of treatment and care. We saw evidence that the UCC consistently met the four-hour target. For the period of December 2017 to November 2018, the service reported that 99.9% of patients were seen and discharged within four hours compared to 95% national target.

The April 2018 audit showed that 89% of patient that accessed the service were seen and discharged without further input, referrals or redirected to other service which was outstanding for the level of service delivered in UCC.

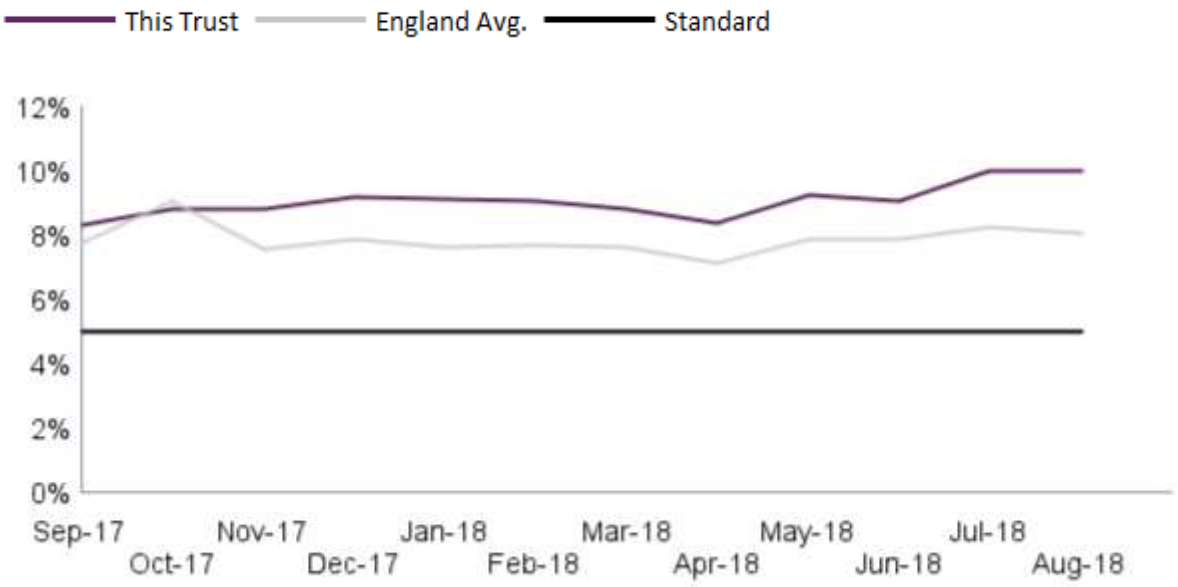
For the period of December 2017 to November 2018 the average length of stay in UCC was 108 minutes which was better than their 120 minutes discharge target and national average of 146-160 minutes.

The service aimed to see, treat and discharge 80% of patients within two hours of arrival as set by their commissioners. For the period of January 2018 to September 2018, 68% patients were treated and discharged within two hours and required no further input or directed to other services such as plastics. We noted that the service only met their target within this period in the month of August 2018 (86%). Staff told us that the figures reflected patients that needed further investigation, such as x-rays, or needed review by senior nurses or doctors before decisions were made on the wound dressings. Staff told us with the improved staffing level they had improved and meeting their two hours target. During inspection majority of patient seen were seen and discharged within one to two hours.

The trust’s expectation was that 95% of patients would be initially assessed within 20 minutes of arrival. The service aimed to triage patients in 20 minutes or less from booking at reception. For the period of January 2018 to September 2018, the service triaged 64% of patients for their initial assessment in 20 minutes or less. The 64% figure included patients seen and discharged by the streaming nurse, triage nurse or other health professional and not just those triaged for their initial assessment. Adult patients had to been seen by the streaming nurse who either discharged or directed them to the triage nurse if further assessment was required. This meant the service was

performing well when compared to other EDs nationally. At the last inspection, the service did not audit this data and therefore this was an improvement.

From September 2017 to August 2018, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average apart from October 2017 where performance was similar to the England average. In the latest period, August 2018, trust performance was 10.0% compared to an England average of 8.1%.



(Source: NHS Digital - A&E quality)

During inspection, we note that the re-attendance within the urgent care centre relate to patients that visited the service three to four times a week for their wound dressing.

Competent staff

The service made sure staff were competent for their roles. Patients were cared for by staff with the right qualifications, skills and knowledge to provide safe care. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The staff skills and competence within the service was appropriate for dealing with minor emergency and primary care conditions. Staff we spoke to told us they had access to training and were given protected time to complete their training. Staff told us they felt supported in their role and were happy with the level of training they received.

Since the last inspection, the service had recruited advanced nurse practitioners (ANPs) and paediatric emergency nurse practitioners. The paediatric ENP, medical staff and some of the senior nursing staff had received paediatric assessment to support them in assessment of children in line with the recommendations of the Royal College of Paediatrics and Child Health.

The service had applied for a training fund to help develop nurses and other health professionals such as paramedics and pharmacists to ENP and ANPs. The service was training and developing six qualified pharmacist practitioners on an 18-month programme with support from Health Education England to become advanced emergency practitioners and ENPs as part of NHS England five-year development plan. We noted that one of the training pharmacists was a prescriber. Staff we spoke with who were undertaking the development programme felt well supported and expected to register to the RCEM following their course.

Since the last inspection, the service now had qualified nurse mentors and had student nurses from a nearby university that undertook placement as part of their nursing programme.

The service had a band 6 sepsis nurse champion who had received additional training on sepsis with the aim of supporting colleagues and commencing audits on sepsis in the future. This was an improvement from our last inspection.

The service had plans to train staff on minor injury and illness and the adults module had been approved by a local university. The service was awaiting faculty approval for the paediatric module. The course would help the service develop their own ENP and ACP staff. The service had developed a staff development programme of staff across all grades from band 2 to band 8 as part of their ENP and ACP 8-year plan.

The nursing staff had competencies they had to complete before undertaking certain duties. For example, the emergency department assistants (EDAs) could stream patients with certain conditions and provide treatments as directed, such as plastering, wound care or taking clinical observations such as ECG.

The trust had trained staff using their bespoke training model on 'making every contact count' (MECC) as part of a national programme by Public Health England to increase the capability and confidence of frontline clinical staff to talk to patients around a range of lifestyle and behaviour issues, which are affecting their health. This program was accredited by the Royal Society of Public Health. One of the nursing staff we spoke with during inspection told us they had received training on giving health promotion advise to patients.

The service had developed a GP induction folder, which was very detailed to support temporary and new GPs employed to the service.

The GPs were trained to work in the urgent care setting and supported by the clinical lead. The two middle grade trust doctors that worked in the service had A&E training and background. The nursing staff would primarily deal with trauma and minor injuries while GPs were mostly looking after primary, day-to-day healthcare and children.

Medical staff received 72 hours training and learning as part of their CPD and the middle grades doctors were allocated half a day once a week to carry out audits as part of their development.

Medical staff received face to face informal educational support from the clinic lead however there was no formal regular teaching for medical and nursing staff in the service.

Clinical supervision for the middle grade doctors was with an ED consultant in Barnet. However, the doctors did not have regular meetings or observed regularly by the ED consultant.

From April to September 2018, 73.7% of staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 85%. Nursing staff had a 78.8% completion rate and medical/dental staff had a 75.3% completion rate.

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Estates and Ancillary	1	1	85%	100%	Yes

Nursing Registered	146	115	85%	78.8%	No
Medical and Dental	73	55	85%	75.3%	No
Healthcare Assistants	40	23	85%	57.5%	No
Administrative and Clerical	10	5	85%	50.0%	No
Total	**270**	**199**	**85%**	**73.7%**	No

Chase Farm Hospital

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Healthcare Assistants	2	2	85%	100%	Yes
Medical and Dental	2	2	85%	100%	Yes
Nursing Registered	9	8	85%	88.9%	Yes
Administrative and Clerical	7	3	85%	42.9%	No
Total	**20**	**15**	**85%**	**75.0%**	**No**

Nursing staff at Chase Farm Hospital had a completion rate of 88.9% and medical/dental staff had a completion rate of 100%, compared to the 85% trust target. Although the overall appraisal rate (75%) did not meet the trust target of 85%, we noted this was an improvement from the previous year's appraisal rate of 67%. (Source: Routine Provider Information Request (RPIR) - Appraisal tab)

During inspection the overall appraisal rate for medical and nursing staff was 95%. We noted medical staff had achieved 100% compliance and nursing staff achieved 85% compliance. Staff we spoke to told us their appraisals was robust and covered their training needs and progression.

There was a system to provide support for nursing and medical staff and monitor their professional revalidation. Data received from the service showed 100% compliance with staff revalidation.

Multidisciplinary working

There was effective internal multidisciplinary team working within the service and across other discipline. Doctors, nursing staff, receptionist, radiographer and other healthcare professionals supported each other to provide good care.

We observed and were told the multidisciplinary team (MDT) staff such as the middle grade doctors, GPs, nurses, radiologist and administration staff communicated and liaised well with each other for

advice and expertise to deliver safe patient centred-care. Specific comments from staff included: “good MDT working”, “you can approach anyone including the doctors”, “no hierarchy in decision and working process”.

The department had a flexible multidisciplinary workforce including medical and nursing staff with various clinical backgrounds such as community nurses, paramedics and pharmacists who used their current and previous knowledge to provide safe and effective patient centred-care.

The UCC service model was that clinicians would assess all patients attending the department. The initial assessment through the streaming or triage process would decide whether treatment should continue in the UCC or transferred to the ED or redirected to their local GP.

There was a clear pathway for patients who were discharged into the community, with liaison with the community teams when necessary. Discharge letters were sent to the patient’s GP on discharge from the service (either discharge into the community or transfer to another hospital).

We saw good MDT working and referral to maxillofacial service, plastics surgery in Royal Free hospital and the safeguarding team in the hospital and community.

The UCC staff could refer elderly patients to the Older Persons Assessment Unit (OPAU), which was another primary care unit opened during week between 9am and 7pm. OPAU offered a range of treatments and diagnostic tests, such as blood tests, blood transfusions x-rays and ECGs.

We saw good MDT working with social services and health visiting service following safeguarding concerns identified in the service. The service had a designated community liaison health visitor situated off site who visited the service bi-monthly. The service also held bi-monthly MDT psychosocial meeting where concerns around safeguarding, child and adolescent mental health services (CAMHS) and mental health concerns were discussed. We reviewed two minutes and saw this were well attended by professionals of a psychosocial meeting held on 26 January 2018 which was well attended by MDT staff and 16 cases were discussed which involved CAMHS cases and safeguarding issues such as trafficking.

The service held brief daily situation reports meetings (SitReps) three times a day, which were attended by nursing, medical and administrative staff, EDAs, the matron and the clinical lead to discuss patient care, staffing, access and flow. Staff told us that vital information discussed at this meeting would be repeated the next day for the benefit of those not in attendances.

Staff gave us numerous examples of effective working with other departments such as the OPAU and musculoskeletal (MSK) service and transferring patients to other hospitals and specialist services, such as Barnet Hospital and North Middlesex Hospital.

Staff we spoke to told us they had a good relationship with the pharmacists who were easy to contact for advice and support when needed.

The service shared two rooms with allied health professionals in the hospital and staff told us they would contact them for advice and support if needed. If a patient required further support referrals were made to the physiotherapist or occupational therapist.

Seven-day services

Chase Farm Hospital’s urgent care centre operated a seven-day service from 8am to 10pm.

GPs and middle grade doctors were available seven days a week.

The service had access to the anaesthetist consultants who provide advice on patient care seven days a week.

Patients had seven-day access to x-ray diagnostic services in line with the NHS Priority Clinical Standard 5. The x-ray room in the service operated every day between 8.30am and 10pm with access to a radiologist for review of x-ray. This was an improvement from the last inspection.

The outpatient pharmacist service was not open seven days a week and operated Monday to Friday, 9am to 5pm. Out of hours (5pm to 9am) and weekends patients were required to pay for their prescription using the prescription payment machines in the service and medicines was dispensed by nursing or medical staff in the unit. Senior staff told us the service had plans to introduce a prescription machines for dispensing prescribed medicines such as antihistamine and analgesia.

Health promotion

People were not always supported and empowered to managing their own health. During inspection there were no displayed health promotion leaflets and posters in the service.

Staff we spoke to told us since they moved to the new building departments were not permitted to display any leaflets on the wall as they were promoting a paperless culture. We noted that there were also no stands with printed health promotion leaflets.

Staff told us the service had plans to display information such as health promotion advice on the television in the waiting area. However, during inspection the two televisions installed in the waiting area were not in use and needed a software update. The service was working with their patient group and local Healthwatch to agree on a package and what information would be displayed on the television screen such as norovirus and topics of the week.

The clinic lead told us they were not a health promotion service and would not necessarily give health promotion advice to all patients and would instead signpost them to the NHS Choices website. The matron and some nursing staff told us they would print out health promotion leaflet from the electronic system such as flu, healthy eating and smoking to patients.

Data received from the trust during inspection showed they had a no smoking policy and were actively promoting a no smoking culture for patients and staff in the hospital as part of the national Commissioning for Quality and Innovation (CQUIN) prevention goals. At Chase Farm Hospital the trust was embedding the local stop smoking community provider into a weekly drop in clinic in the hospital. We did not find any evidence in the UCC service which portrayed the trust pledge to smoking cessation and healthy life style as there were no posters or leaflets on display. Staff did not refer or signpost patients to smoking cessation service.

The trust had a rolling training programme for staff on offering brief advice on health promotion which focused on giving advice and support for patients around healthy weight. Not all medical and nursing staff we spoke with had received or were aware of the training.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Mental Capacity Act (MCA), and Deprivation of Liberty Safeguards (DoLS) were part of mandatory training. The trust reported that from April 2018 to August 2018 MCA and DoLS training was completed by 50% of staff in urgent and emergency care compared to the trust target of 85%.

The breakdown by site was as follows:

- Royal Free Hospital emergency department: 52%
- Barnet Hospital emergency department: 54%

- Chase Farm UCC: 39%

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

At the time of the inspection, the training records showed that 94% of the UCC staff completed MCA and DOLS training against the trust's target of 85%.

Staff were provided with policies and guidance on consent, DOLS and MCA. Staff had good understanding of the relevant consent and decision-making requirements of the MCA 2005 and the Children Acts 1989 and 2004 and how it affected their care of patients. Staff we spoke to had good understanding of consent, DOLS and MCA and its implication to their practice.

During inspection we observed nursing and medical staff obtaining patient informed consent before carrying out a medical assessment. Patients understood what was happening to them and we saw staff explaining what tests were needed and why.

The UCC staff did not carry out mental health assessments that required a mental capacity assessment and would transfer patients to a local ED where the assessment would be carried out.

Is the service caring?

Compassionate care

Staff cared for patients with compassion, respect, dignity and kindness. However, patients' confidentiality was not managed appropriately due to the service environment. Feedback from patients confirmed that staff treated them well and with kindness.

We saw that the service had two thank you cards with feedback from patients on the care received. Some comments from patients said that they received: "endless care, help and kindness shown to me by you all which at times reduced me to tears". Other feedback highlighted that staff were accommodating to patients and gave advice in a sympathetic and timely manner.

We observed staff assisting patients with a wheelchair in a patient, caring and calm manner.

Patients were treated with kindness and compassion by all staff in the department. Patients we spoke with were happy with their care. Patients described the nursing staff as patient, respectful and knowledgeable.

We saw nurses introduce themselves and take their time when talking to patients to ensure they understood what was happening. Patients living with dementia were reassured and reoriented when they became confused and all patients we spoke to were kept informed during their time in the department.

We saw staff respected privacy when assessing a patient or delivering care by closing the door to the assessment room. Staff spoke to patients and their carers ensuring that both were included in the care plan and treatment.

Reception staff discretely identified vulnerable patients through the electronic patient record so that all staff treating the patient were aware. Staff made allowances for extra time for these patients while they were in the UCC.

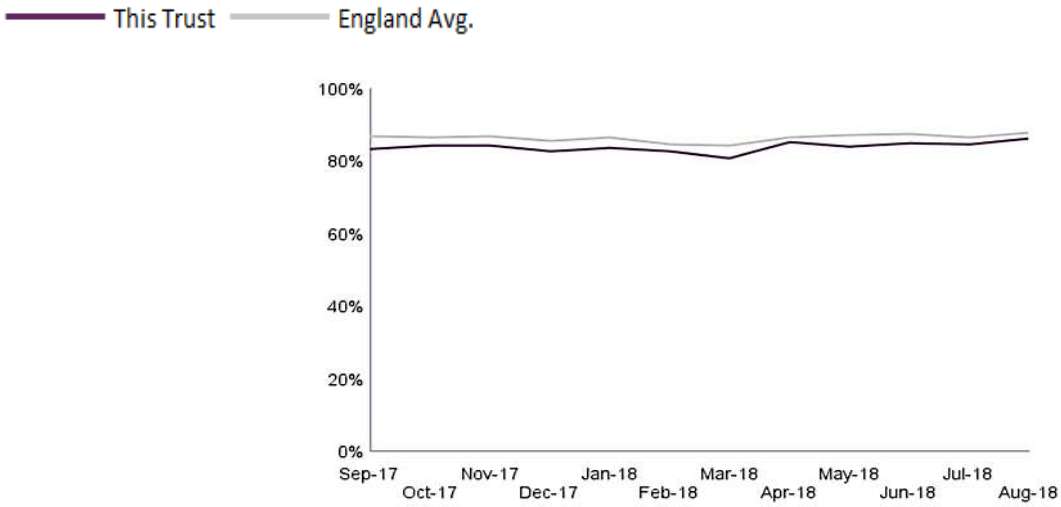
The reception area did not have any signage indicating where patients should stand while waiting to be booked in by the receptionist, for example a 'stop here' or 'wait here' sign. This meant that a patient's privacy could not always be ensured. However, reception staff told us they asked patients to step back to ensure people's privacy.

The UCC reception was at the back of the paediatric outpatient reception, which was separated using a folding screen. We saw that there was a risk of patients' conversations being heard on both sides.

While UCC reception staff mitigated the risk by speaking quietly, on occasions we could hear patients and reception conversation from the paediatric outpatients. Senior staff told us there were plans in place to divide both reception areas with appropriate walls.

The chaperone policy we viewed on the unit was out of date, however the trust supplied an up-to-date online chaperone policy. There were no signs in the waiting area prompting patients that they could ask for a chaperone. The trust policy required a chaperone in the case of intimate examinations, the examination of a child, young person or adult at risk, however, emergency care would take precedence over the request or requirement for a chaperone. Staff in the service received chaperone training within the safeguarding training; staff within the service met the trust standard for safeguarding adults and children levels one and two.

From September 2017 to August 2018, the trust's urgent and emergency care friends and family test (FFT) performance (% recommended) was slightly worse than the England average. In the latest period, August 2018 performance was 86.3% compared to the England average of 87.7%. NHS England recommends that FFT results should not be used to compare trusts.



(Source: NHS England Friends and Family Test)

Emotional support

Staff understood the impact of patients care, treatment or condition to their wellbeing and those close to them Staff provided emotional support to patients to minimise their distress.

We saw that all patients we treated with kindness, compassion, dignity and respect by staff while receiving care in the UCC.

We observed that staff discussed and explored patients' emotional well-being during consultation. Staff attended regular multidisciplinary psychosocial meeting to discuss and assess patients' emotional needs. Patients that required further emotional and psychological support were redirected to their GP and health visitors for referrals.

Staff responded to patient distress with kindness and spent time supporting them. Staff took time to answer questions and explain what was going to happen next to provide reassurance and help reduce their stress and anxiety.

There was a trust chaplaincy and spiritual care team which provided appropriate spiritual and religious care to patients, staff, families, visitors, friends/carers and volunteers. The chaplaincy and

spiritual care team offered one to one support and encouraged compassionate, non-judgemental care and respect of diversity. Included in the chaplaincy and spiritual team was a Muslim chaplain, Rabbi, Roman Catholic priest, Anglican priest and several volunteers from other faiths/backgrounds, including Humanist, Buddhist and Sikh.

There was a multi-faith room on-site for patient use. The multi-faith room had a weekly programme offering a quiet space for reflection and held services of mindfulness, meditation, holy communion, and the Muslim Friday prayer (Jumu'ah).

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Staff took time to talk to patients and ensured they understood their care, treatment and information given to them.

Staff consulted patients on their preference in discussing and sharing information with their relatives and we saw that this was respected and reviewed throughout patient care, which was in line with the NICE guidance.

We observed four patient's assessments and noted staff discussed at length with patients about their clinical condition and suggested treatment with emphasis on patient choice. Patients were not rushed during their appointments and staff answered all questions the patient and families had. Staff supported patients to make decisions. When necessary, staff used a mental capacity assessment tool. Staff gave follow up advice to patients and signposted them to the NHS choices for further information and some occasion printed leaflets.

The trust scored worse than other trusts for three of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 21 questions.

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	4.4	About the same as other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.1	About the same as other trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.2	About the same as other trusts
Q14. Did the doctors and nurses listen to what you had to say?	8.8	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.8	About the same as other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	8.4	Worse than other trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough	7.5	About the same as other trusts

Question	Trust 2016	2016 RAG
opportunity to do so?		
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?	8.3	About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	7.4	About the same as other trusts
Q22. Sometimes in a hospital, a member of staff will say one thing, and another will say something quite different. Did this happen to you in the emergency department?	8.8	About the same as other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.5	About the same as other trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	8.8	About the same as other trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.1	About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	5.5	About the same as other trusts
Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.4	About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests?	8.5	About the same as other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	8.8	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.4	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	4.6	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	4.5	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	2.9	Worse than other trusts
Q42. Did a member of staff tell you about what	4.3	Worse than other trusts

Question	Trust 2016	2016 RAG
danger signals regarding your illness or treatment to watch for after you went home?		
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	6.5	About the same as other trusts
Q45. Overall	7.7	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

Is the service responsive?

Service delivery to meet the needs of local people

The urgent care service was planned and delivered service in a way that met the diverse needs of the local and surrounding population. Patient's needs and preferences were considered and acted on to ensure services were delivered to meet those needs.

The service was commissioned to deliver urgent care to adults and children with minor, non-life threatening and short-term illnesses, which required prompt treatment or advice. Patients who attended the UCC were usually referred by their GP, 111 calls, walked in and brought in by an ambulance.

The UCC was open 8am to 10pm, seven days a week. Out of these hours the 111 and ambulance services would redirect patients to the nearest ED.

The service worked closely with stakeholders including their commissioners (Barnet and Enfield CCG), neighbouring trusts, and region network to improve the service provision. The service reported good and improved relationship with their commissioners and local Healthwatch and had received support on working with the primary care and prison service in delivering care to the local population.

The UCC had an agreement with paediatric outpatients to use one of their consulting rooms to see children and the room could be increased depending on capacity from 9am to 5pm. However, during out of hours and weekends the UCC could use all the paediatric outpatient rooms to assess patients.

If a patient was not registered with their local GP, the primary care liaison officer (PCLO) advised them on how to register and if required assisted with the paperwork. The PCLO also dealt with the patients who were not entitled to free NHS care. If patient's first language was not English, the PCLO used a telephone language service.

The design of the ambulance entrance area worked well. Ambulances could park and unload easily and there was a designated ambulance entrance. Patients brought in by ambulance were seen immediately by a senior nurse to assess if patients could be seen and treated in the service or to be directed to a nearest Emergency Department (ED).

The service undertook x-ray, electrocardiogram (ECG), vital signs, and urine testing to assess patient risk. At the time of our inspection there were no blood tests done in the service.

The hospital was well-signposted from the road and was on a regular bus route. We observed that there were two entrances into the UCC; one was before the hospital entrance and led straight to the service and while the second entrance was through the hospital entrance. While the entrance within

the hospital had clear signage of the UCC, the other entrance which was outside the hospital and lead straight to the UCC reception had no signage. This meant that patients and visitors that used the service were not aware of the direct entrance into the service and would come in through the main hospital entrance. It also meant that patients had a hard time finding the service's entrance as this was the entrance meant to be used out of hours. We observed that patients were not aware of the two entrances into the unit.

The hospital had adequate parking and while on site we did not notice any delayed parking or informed of delays by patient and relatives.

The premises of the urgent care centre were designed to meet the needs of the local population. Staff told us the hospital had designed the new UCC facilities to be dementia friendly. There was adequate seating and space in the reception and waiting areas.

Meeting people's individual needs

Although the needs and preferences of patients were considered when delivering and coordinating services including those with complex needs and vulnerable circumstances, services did not always meet the needs of people with visual and hearing impairment. Care and treatment were coordinated with other services and providers, to ensure the needs of patient and their families were met.

The UCC moved into the new hospital movement in September 2018 and the new environment was spacious and had a relaxed feel. There were adequate seats in three waiting areas which included the main waiting area, plaster room and x-ray waiting areas.

The department was designed to support people with disabilities, such as providing accessible toilets and having lowered counters at the reception for people with reduced mobility. There was wheelchair access to the service through the main entrance.

The UCC had a trolley and accessible wheelchairs at the entrance of the department for patient transfer during emergencies when needed.

Staff told us they usually triaged patients in a timely order however they would prioritise a patient with mental health, in pain or complex problems. Staff told us they supported patients in that manner as they knew the hospital setting could exacerbate their condition.

The service had improved service provision for patients living with a learning disability or dementia. For example, the service had introduced a dementia distraction pack in November 2018, which included items such as twiddle blanket, crayons and soft teddy bear.

Staff told us the distraction pack was implemented by the receptionists as they identified coming to the hospital could be stressful for people with dementia and the pack was designed to keep them active and stimulated whilst waiting to be seen by staff. Staff were planning to have a learning disability and dementia quiz night in March 2019 to increase staff and visitors' awareness.

The staff we spoke with had a good understanding of caring for people living with dementia and their needs. Staff had received dementia training at the trust induction and study days. The trust had introduced a guide to dementia, which was available in all clinical areas. We noted that the hospital's new electronic system had a flagging system for patients with additional needs. Staff we spoke to told us they have used to flag patients with additional needs such as hearing impairment.

The service had its own x-ray which ensured patients had their x-ray promptly and reduce the waiting time and trip to the general hospital x-ray department.

The service had a prescription payment machine where patients could pay for their prescription before collecting their medicine from the outpatient pharmacy from 9am to 5pm, Monday to Friday.

However, out of hours the medical and nursing staff dispensed the medicines following payment to ensure patient had prompt access to their medicine and ensured they did not have to travel to a community pharmacist.

However, the service did not follow best practice as adults and children shared the waiting areas and the designated children's play area had limited play facilities. We observed the UCC only had one toy to distract distressed children in the combined waiting area for both adult and children. The service had an arrangement with paediatric outpatients to share their waiting area for children waiting to be seen. Staff directed paediatric patients to sit in the paediatric outpatient which had more spacious play areas with toys. Staff told us that parents were offered the option of choosing to seat in the UCC or paediatric outpatient waiting area. However, most patients and their carers told us they were not always offered this option if the paediatric outpatient was busy but said they still felt safe in the main waiting area. Evidence shows that having a separate child waiting area helps to ensure that children are not exposed to potentially frightening experiences; and equally, so that adults feeling ill are not disturbed by noisy children.

Reasonable adjustments had not been made to the service so that people with visual, speech or hearing impairment could access the service on an equal basis as others. We noted there was no hearing loop (assisted listening device) in the service to support patient with hearing impairment. Staff told us the receptionist would have highlighted if a patient had hearing impairment and when they need to be seen they would approach and tap the patient. Also, during consultation or assessment they would speak slowly to ensure the patient understood what they were saying.

There were no leaflets or information for patients with visual impairment. When we highlighted our concerns to senior staff we were shown a printed 'choose the right place for treatment' leaflet which was designed in contrast colour and big text font and was suitable for patient with visual impairment. However, this leaflet was currently not in use and was being reviewed during inspection.

The safeguarding policy highlighted that the trust was committed to documenting the voice of the child including those with speech impairment who were unable to communicate their needs. The policy stated that staff would use PECS (picture exchange communication system (PECS) for children and young people with additional needs. During inspection there was no evidence of PECS or other aids used to communicate with patient with visual impairment.

We received mixed responses from staff on access to translation services. Staff we spoke with told us patients whose first language was not English often came with their relatives who would normally translate for the patients. Staff also told us they used online translators to convert text to speech. Most staff believed they did not have access to a telephone translation service since they moved to the new building. However, two staff told us there was access to a telephone translation services should these be required.

Information received from the trust showed that they offered British Sign Language interpreters, lip speakers and touch sign interpreters. However, staff we spoke to in UCC were not aware of this service provision.

We observed that there were no leaflets or posters on health promotion or condition in the service or displayed on the television. Staff we spoke to told us they were trying to be paperless and they would sign post patients to NHS choices or print out specific leaflets when necessary. The printed leaflets could include information on looking after your wound, dental treatment, hand injury, ankle injury, sexual health, 24h dental care, strain and sprains, and eye injury. There were also no available leaflets in other language or Braille text.

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

Question – Responsive	Score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	6.9	About the same as other trusts
Q11. Overall, how long did your visit to the emergency department last?	6.2	About the same as other trusts
Q20. Were you given enough privacy when being examined or treated?	8.9	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

Access and flow

Patients had access to timely treatment after arrival in the urgent care service, even when the department was receiving a higher number of attendances than expected.

Patients accessed the UCC via their GP, 111 calls, walk in or brought in by an ambulance.

The service provided treatment for patients with minor ailments and minor injuries and excluded any life threatening or acute conditions. Staff used a clinical pathway that advised them on the inclusion and exclusion criteria of patients seen in the service. Patients that could not be treated in the service were referred to their GP, emergency department or other services such as sexual health clinic. For example, patients with acute medical problems such as acute infection and heart failure were referred to the older person's assessment unit (OPAU) for rapid access to comprehensive geriatric assessment and admission avoidance. During inspection we saw the service had referred two patients to OPAU within 24 hours

For the period of December 2017 to June 2018, there were 4,888 referrals in the urgent care centre for patients that needed further input.

The hospital had a pathway for managing patient flow and early closure if there was no GP cover in the evening or at times of exceptional demand. For the period of December 2017 to November 2018 the UCC had not closed the service.

For the period of December 2017 to December 2018, there were 33,876 attendees in the service of which 71% of patients seen were adult and while 29% were children. The x-ray within the service saw approximately 20 to 30 patients a day.

The ambulance audit for the period of 22 March 2018 to 31 May 2018 showed 41 patients were transferred by ambulance to other service. The result showed 38 (93%) patients were not appropriate for the UCC service and redirected to a nearest ED. The audits showed an eight minutes response for 26 patients (63.4%), nine patients (22%) transferred within an hour and one patient (2.4%) transferred over an hour and no time recorded for five patients (9.8%).

The April 2018 triage audit showed 1,011 patients were seen over nine days and of which 54 (5.3%) were redirected to other hospital emergency department such as Barnet ED (1%) and North Middlesex Hospital ED (0.9%).

The treating clinician referral audit for the same period showed 824 patients were treated over eight days and of which 51 (6.2%) were referred to other service including Barnet ED (1.5%) and NMUH ED (1.7%). The overall result of the triage and referral audit showed 11.5% of patients were

redirected or referred to other services, which meant 89% of patients were solely managed and discharged by the service.

We observed that most patients who re-attended the service within seven days were related to wound dressings. Staff and patients, we spoke with told us some patients attended the service three to four times a week for their wound dressing. For the period of 1 December 2018 to 3 December 2018, 32 patients received wound dressing in the service as there GP were not opened or no available appointment.

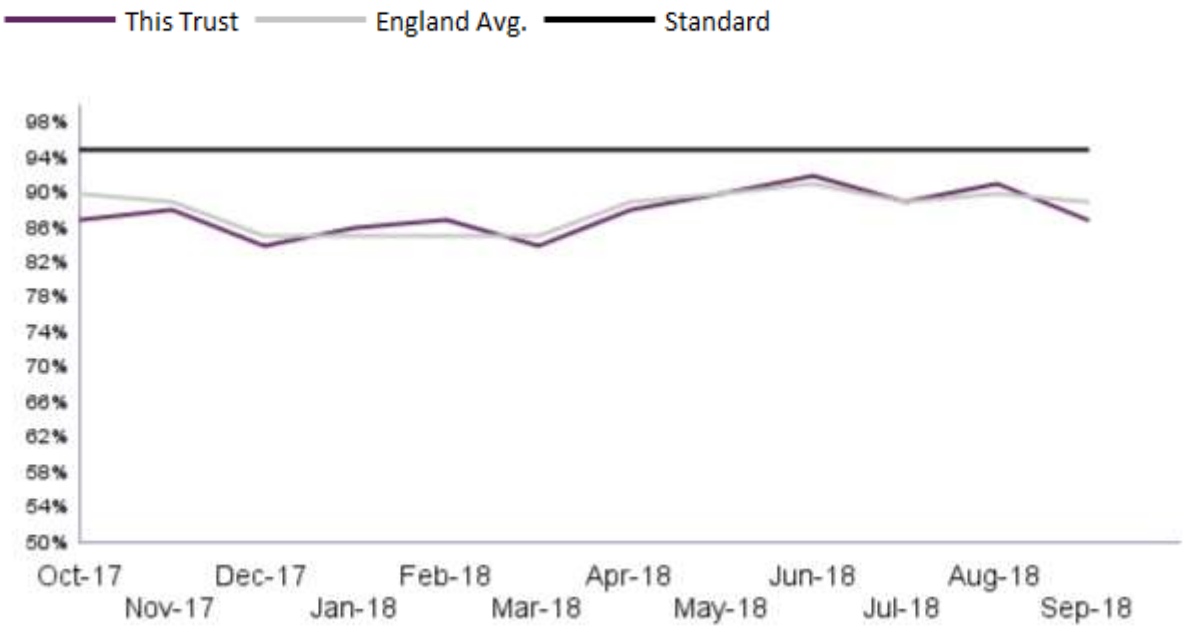
During inspection, there was no breach of the four hours target and the longest wait observed was 87 minutes.

The department only monitored patients seen and treated within two and four hours. The service did not monitor the number of patients receiving treatment in an hour as part of their key performance index. This was in line with the agreement with the commissioners.

The UCC used a nurse-led approach to streaming and triaging patients. After registering at the reception, a junior sister or emergency department assistant (EDA) would assess patients within 20 minutes of arrival. However, all children were triaged following their booking while adults were streamed following their booking before been triage if required.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From October 2017 to September 2018 the trust failed to meet the standard and performed about the same as the England average. Over the same period, performance against this metric showed a similar pattern to the England average.

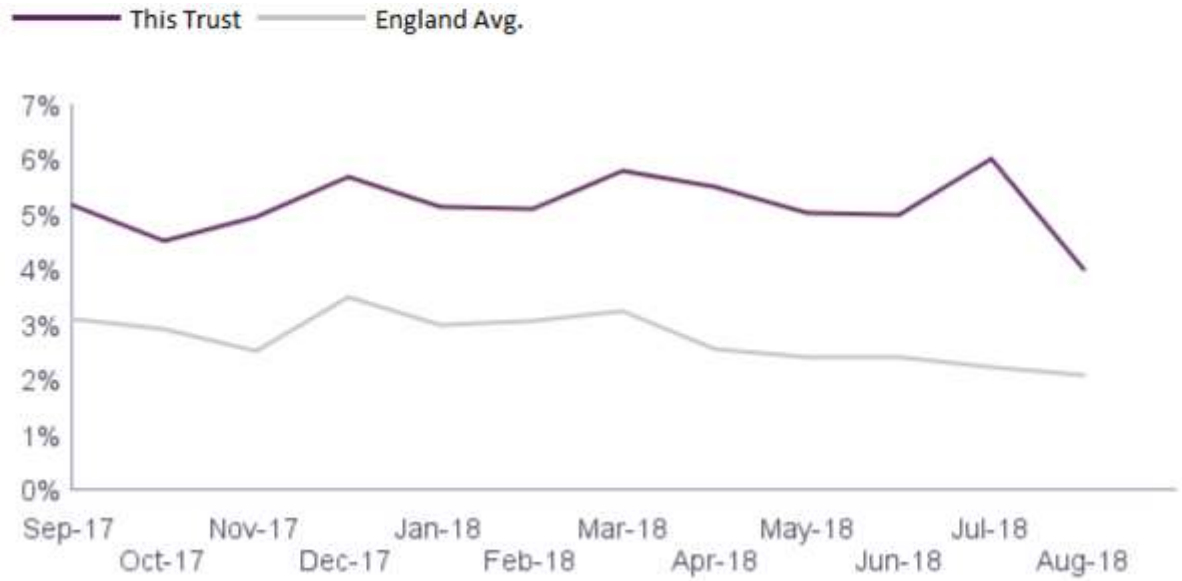


(Source: NHS England - A&E Waiting times)

From September 2017 to August 2018 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average with performance ranging from 4-6%.

Over the same period, performance against this metric showed a stable trend until July 2018 where performance worsened, with 6% of patients leaving the trust's urgent and emergency care services before being seen for treatment, compared to the England average which was 2.2%.

Performance showed an improvement in the latest period, August 2018 where the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 4.0%, compared to the England average which was 2.1%.



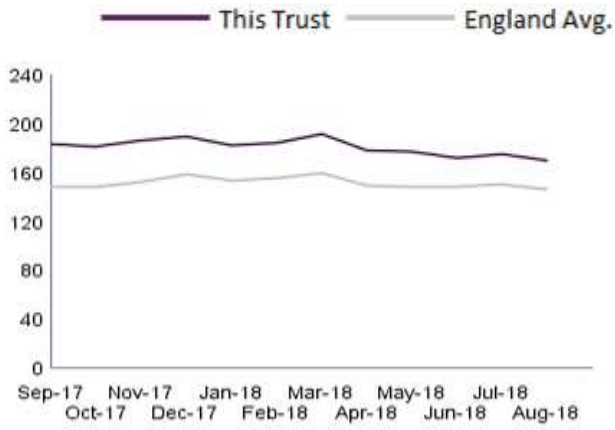
(Source: NHS Digital - A&E quality indicators)

The service did not audit the number of patients that left before being seen or the median total time these patients spent in the UCC. This meant there was lack of oversight and follow-up of patients including children and vulnerable adults. Staff told us most patients that left before being seen did so due to waiting times. During our inspection we observed that there was no displayed information on waiting times or patients being informed by staff. Staff told us the service was waiting for the two televisions in the waiting area to be connected.

Following inspection, the audited the number of patients seen in October 2018 which showed 140 patients left the service before been seen of which 42 patients were children and 11 were elderly patients between 70 to 87 years old.

From October 2017 to September 2018 the trust's monthly median total time in A&E for all patients was higher than the England average. In the latest period, August 2018 the trust's monthly median total time in A&E for all patients was 170 minutes compared to the England average of 146 minutes.

From October 2017 to September 2018, performance against this metric ranged between 172-192 minutes, compared to the England average of 146-160 minutes.



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

For the period of December 2017 to November 2018 the average length of stay in UCC was 108 minutes which was better than their 120 minutes discharge target and national average of 146-160 minutes.

For the period of December 2017 to November 2018, the service reported that 99.9% of patients were seen and discharged within four hours compared to 95% national target.

Learning from complaints and concerns

There were processes in place to ensure complaints were dealt with effectively however staff had limited understanding on the complaints' themes in the service and there was no displayed or accessible information on how to make a complaint, comment cards or how to give feedback about the service.

The trust complaints policy was available on the intranet to guide staff on managing and responding to concerns.

We noted that information on how to raise a complaint or concerns was on the trust website, however there were no leaflets or posters in the waiting areas or consultation room. This meant that people without access to smart phones or internet were unable to access how to make a complaint or give feedback.

We highlighted that there were no available leaflets or posters on how to make complaints or give feedback to senior staff. Staff told us they would print out a complaint leaflet to patients which was printed for us to review. Leaflets were only given to patients when they raised concerns or gave verbal feedback.

Not all patients that we spoke with knew how to make a complaint or give feedback.

We noted that complaints were discussed at various governance meetings. We saw two examples of complaints responses and saw that responses were detailed, and the executives were involved in these complaints investigation and response. The service had apologised for things that had gone wrong, provided explanations and provided information about who to contact if they were not happy with the hospital's response.

We saw examples of improvement made to the service in response to complaints or concerns raised which included the development of a leaflet on why staff asked sensitive paediatric safeguarding questions.

From September 2017 and August 2018 there were 156 complaints about urgent and emergency care services. The trust took an average of 34 working days to investigate and close complaints. This was in line with their complaints policy, which stated complaints should be completed and closed with 35 days.

The three most common subjects of complaints are shown in the table below:

Subject	**Number of Complaint**
All aspects of clinical treatment	84 (53.9%)
Attitude of staff	32 (20.5%)
Communication/information to patients (written and oral)	14 (9.0%)

Chase Farm UCC has the lowest number of complaints by site:

Site	Number of Complaint
Barnet Hospital	73 (46.8%)
Royal Free Hospital	67 (43.0%)
Chase Farm Hospital	16 (10.3%)

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

From September 2017 to August 2018 there were 101 compliments in urgent and emergency care.

- Barnet Hospital: 59
- Royal Free Hospital: 39
- Chase Farm: Nine

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

Is the service well-led?

Leadership

The urgent care service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The service had a clear management structure with defining lines of responsibility and accountability.

The urgent care service was led by the clinical lead and matron who reported to the senior clinical operation manager and medical director. Since the last inspection each hospital in the trust now had their own executive leadership team who were supported by divisional leadership teams and governance structures. The hospital board committees have changed to reflect new goals set by the board and to reflect the benefits of the group model.

At the last inspection the service was a nurse-led service and was led by the matron. Staff told us the service now had GPs embedded, which resulted in the appointment of a medical clinical leader who was available and offered support to the medical team. This was in line with Royal College of Emergency Medicine (RCEM) ED care QS14. The GPs, middle grade doctors, senior nurses and reception manager supported the senior management team.

The leaders had appropriate skills and experience to lead the service and had received further leadership training to lead the service such as lead the leaders training, coaching and mentoring. The service leaders (triumvirate) demonstrated knowledge of the service's performance, challenges they faced but had divided opinion on actions needed to address issues identified.

The triumvirate felt the leadership structure was now embedded in the service and they had made improvement to the medical staffing, nursing staff development programme and engagement with their stakeholders.

The leadership team had direct access to the hospital executives, reported good support and interest in the UCC. The matron and clinical lead had regular meetings with the chief executive, medical director and senior clinical operation manager in addition to other senior meetings. We saw from the minutes of governance meetings that the executives had oversight of the UCC and received presentation on the service.

Staff told us the senior leaders and local managers were visible, accessible and approachable. The UCC leadership team was based in the service and worked clinical and managerial shifts weekly, which ensured they were available to support staff when needed. Staff we spoke to told us the hospital executives also visited the service regularly and were visible.

Nursing, medical and receptionist staff we spoke to reported good support from colleagues and their managers.

At the last inspection we had concerns that UCC middle grade doctors and GPs did not have any regular meetings with other UCC staff and there was no formal teaching for middle grade doctors. During this inspection we saw there was an improvement and there were daily safety huddles held three times a day however there was no staff meetings or formal teaching sessions.

At our last inspection we noted the lack of oversight of the locum GP practice. During this inspection we found improvements and GPs were now employed by the trust and received support by the clinical lead who had oversight on their work and performance.

Vision and strategy

The trust and service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The urgent care service vision was to become a world class stand-alone urgent care centre and to be nurse-led within five years. We noted that this vision was underpinned by the trust vision.

The trust vision was to deliver world class expertise and local and friendly hospital care and represent the NHS at its best.

The service strategy focused on staffing development and developing the GP service. During inspection we noted that the service was working towards achieving this strategy and which reflected in the training of advanced clinical practitioner (ACP) and emergency nurse practitioner (ENP) staff.

The senior leaders and staff we spoke to were clear about their local vision and strategy for the service.

The trust values were welcoming, respectful, communicating and reassuring.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

All staff had a strong commitment to their job and were proud of their role, team working, morale and impact made to patient care and experience.

Staff felt valued and respected by department leads and colleagues said they were well-supported. Staff spoke highly of the chief executive and were impressed when she stayed overnight with staff to help their move into the new hospital building. Staff highlighted that the support they received ensured the UCC operated the day of the move and were ready in the morning to resume their service and see patients in the new building.

Specific comments received from staff about the culture of the service included: “good morale”, “no bullying and harassment anymore”, “love the job”, “very friendly and supportive team”, “good team spirit”, “cosy service” “I love and enjoy working here and working with patients”, “enjoy it- no problem with staff”.

Some staff had been working at the trust for years, for example an emergency department assistant had been working in the hospital for over 20 years because they were passionate about the care delivered.

The service and hospital celebrated staff successes and improvements made to the service. The hospital had a star awards programme in place and staff told us they had received nominations in the past. We noted and were told the UCC team celebrated each other's birthday.

The 2017 trust staff survey highlighted staff had experience bullying and harassment from colleagues, patients, relatives and public. Staff told us the trust executive leadership had worked with trade unions and staff on tackling reported levels of bullying and harassment in the trust. Staff we spoke to told us they had not been victim of bullying and harassment however a colleague had experienced this from a senior manager who no longer worked in the service.

The hospital had a freedom to speak up guardian and speaking up champions to support staff in raising concerns. Staff told us there was a no blame culture and they would be confident to raise a concern with their managers and were confident this would be investigated appropriately. Staff reported they had received feedback from concerns raised during daily meetings. The hospital had introduced a volunteer peer support to support staff involved in serious incidents and never events during the investigation process. Staff that been through the investigation process and attended the serious incidents review panel offered support to other staff and which could also encourage them to raise any concerns they had. This was an additional staff support process to the freedom to speak up team. Senior staff told us this was introduced by a band 5 staff supported by the governance team following identification of support needed for staff in incidents that have caused them anxiety or distress.

Although the service was open and honest with patients and their families involved in incidents when things goes wrong, there was no process in place to inform other patients and visitors visiting the department about safety incidents such as falls, complaints or clinical performance.

Staff were not encouraged to always report safety incidents. During inspection we, found a culture of low levels of incident reporting. We had mixed views from senior managers about reporting safety incidents such as inadequate staffing on a shift "as this was on their risk register and was discussed at their safety meeting and reporting such incidents served no purpose". This was not in line with the Royal College of Emergency Medicine (RCEM) Quality Standard. The senior managers also had mixed views on health promotions, written leaflets and meeting the needs of people with visual and hearing impairment.

Governance

There were effective systems of governance that looked at quality and performance. Staff understood their roles around governance and there were structures for reposting and sharing information from the department to the division and board and down again.

At the last inspection, there was shared management and governance across trust sites and the governance team covered the Chase Farm Hospital and Barnet Hospital. During this inspection, we noted that each hospital now had their own governance team since April 2018, which was a result of staff feedback and to ensure the governance team were more visible, offer timely support and have oversight on the governance in each division. The Chase Farm Hospital governance team was comprised of four staff members. They had governance oversight of areas such as patient safety risk, complaints, compliance, staffing and feedback from NHS Choices, Healthwatch and social services.

During our inspection we saw that assigned staff members conducted regular audits, which fed into the divisional and hospital governance meetings. Staff told us that if someone fell short of the expected standard, for example during a hand hygiene audit, they would address it immediately with the staff member to drive improvement.

The hospital departments had governance meetings that fed up to the hospital clinical performance and patient safety committee. The service sought through various governance meetings such as the clinical performance and safety committee, safety meetings, deteriorating patient meeting, nursing and midwifery committees and Serious Incident Review Panel (SIRPs). Most governance committee meetings were held monthly.

The nursing and midwifery committees covered areas such as recruitment and retention, appraisal, training and infection prevention and control. We noted that the managers and governance team regularly attended the NMC committee meetings to identify any staffing and safety issues.

The hospital SIRPs were held weekly and covered near misses, low and moderate levels of harm incidents. The committee used a multidisciplinary team approach and the meeting was open to all staff, who managers encouraged and invited to attend. Senior staff told us that serious incidents or never events could also be taken to other SIRPs panels at other trust sites if it needed to be reviewed urgently or to meet their target. The governance team also carried out a deep dive into past incidents across the hospital through observational study or reviews.

The trust had a sepsis lead who had an oversight on the service and during inspection we noted that the service had a nurse sepsis champions who had received additional sepsis training. There was plan in place to undertake sepsis audits in 2019. This was in line with National Institute for Health and Care Excellence (NICE) guideline 51.

The dementia strategy and governance were overseen by the dementia implementation group who also reviewed all complaints and incidents reported that relate to dementia or delirium to help identify any gaps in meeting patient's individual needs and contributed to the dementia action planning.

Clinical, quality and safety risks were presented and reviewed weekly at the clinical performance and patient safety committee meeting which was chaired by the medical director. We reviewed the minutes of the meetings between July 2018 and November 2018 and saw that discussions were held around quality improvement (QI) projects, compliance with NICE guidance, hospital open risk register, never events, safety incidents, central alerting system (CAS) report, quality safety board report and received reports from sub-committee. The meetings were usually attended by the medical director, infection prevention and control nurse, governance team, operations managers, consultants, and matrons. However, the minutes for these periods did not include performance around complaints and compliments received by the service. Staff provided limited evidence of knowledge of the service's complaint trends.

The clinical performance and patient safety committees formally reported to the local executive committees, which was chaired by the three site CEOs. There was also a formal link up to the monthly non-executives chaired clinical standards and innovation committee.

The local executive's committees reported to the group executive committee, (GEC) chaired by the group CEO where all site based integrated performance was monitored against the agreed trust goals to ensure consistent approach of governance.

Management of risk, issues and performance

The service had clear risk processes and systems in place for managing performance and identifying and mitigating risks. However, we found risks which had not been identified by managers and included in the risk register.

Risks and incidents were identified and reviewed at various governance meetings. The team bulletin showed that risks, incidents including SIs and never events were discussed and shared with staff.

The service had internal audits system in place to monitor quality performance and risks to identify where action should be taken.

The service had arrangements in place for identifying, recording and managing risks. The risk register included a description of each risk, with mitigating actions and assurances in place. An assessment of the likelihood of the risk recurring, possible impact and those responsible for review and monitoring were highlighted on the risk register. The risk register fed into the monthly clinical site and performance meetings and staff scrutinized and agreed or rejected all risks and developed action plans as a result. Staff told us the executives were informed of extreme and closed risks on the risk register and there were plans to start reporting the top three highest risks for each service to the executives.

There was a departmental risk register which was reviewed monthly with actions to mitigate risk updated by staff. The UCC had four risks against the divisional risk register:

- Current staffing of early shift nurse practitioner staffing levels to meet roster due to increased demands (moderate risk). This was mitigated using temporary staff and on-going recruitment and training for ENPs,
- The lack of use of trigger scores and risk of not identifying deterioration. Staff told us there was plans in place to roll out the national early warning score on paper and scan observation to the patient's electronic records.
- The centre was unable to communicate child attendance to the child protection team who were not on site (high risk). This was being mitigated by staff contacting the child protection team not on site via email and telephone. The risk register highlighted that the new electronic patient records may enable safeguarding information to be disseminated.
- Children currently waiting to be seen by UCC had to wait in the paediatric outpatient area (moderate risk) which had no CCTV, which meant staff could not observe the children and potentially a deteriorating child. There was also a risk of cross infection for vulnerable paediatric outpatient.

The November 2018 clinical performance and patient safety committee included other hospital wide risks which were applicable to the service. These relevant risks included delays of inter-hospital transfers by external ambulance providers (moderate). It also included the lack of assurance that paediatric patients with protection alerts were escalated to the safeguarding and child protection teams (high risk) for children who did not attend (DNA) their appointment. These patients may not be escalated to the safeguarding and children protection teams as the system was reliant on staff to alert and complete appropriate documentation. In November 2018, the paediatric outpatient service identified and added the escalation of DNA patients to their risk register.

During our inspection, we saw that the service did not audit nor have an oversight of the number of patients that left the department before been seen including children and vulnerable adult. Senior managers did not have an oversight of this and we were not assured staff had followed up and escalated to the safeguarding team and patient's GP for these patients to be followed up. This had not been identified as a concern by the service senior managers before inspection and therefore was not on their local register. However, senior managers told us they would start auditing this and review staff documentation on patients records to ensure escalation compliance.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service had clear performance measures such as key performance indicators (KPI), local and national audits which were reported and monitored. These included social media feedback and the two and four hours target of patient been seen and discharged in the service. Reports were used to advise on current standards, to track improvements and trends and which were used as points of discussion and analysis at governance meetings to improve care and patient outcome.

When required the department submitted reports through available systems such as the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) promptly to support shared learning and to share information with external bodies.

The electronic patient record dashboard was used in the service to monitor patients' treatment and pathway in the service.

The hospital had introduced the use of an electronic quality and performance monitoring tool to gather information on the PLACE audit and there were plans to roll this out to UCC.

In November 2018 the hospital launched new electronic patient record systems which improved data management in the service. The system had a health information exchange (HIE) which meant that providers could access patient data in real time. It also included a patient portal for patients to access key clinical information and transactional services online.

During our inspection we noted the service did not have adequate provision to provide relevant printed or visual information to meet the communication needs of people with visual and hearing impairment. Senior staff told us the hospital was now paperless and would normally direct people to various website for information. Specific information that could be printed out by staff when prompted were not in large print or contrast. The televisions in the waiting area were not displaying any information as there were overdue software developments and awaiting approval of information to be displayed. Information received from the trust highlight they recognised that the work to embed the Accessible Information Standard (AIS) had been slow and was in progress to improve access for people with information or communication needs. The trust had developed an AIS draft policy and booklet to provide guidance to staff on ensuring the identification, recording, flagging and sharing of patient information.

Engagement

The service engaged well with staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. Although the service acted on staff and people's views and experiences to shape and improve the services and their experience, improvement was needed on patient's engagement and gathering patients' feedback to shape the service and inform them of improvement made.

The service engaged well with the stakeholders such as commissioners and local Healthwatch. The service reported improvements in working relationships following feedback received from stakeholders. The service worked with their local Healthwatch on wordings of some informational leaflets. Managers worked with local stakeholders in attracting patients around local areas south of the service, such as in Tottenham and Edmonton.

Medical staff attended a 'keeping in touch GP forum' with other GPs in their network and had discussed topics such as winter pressures to improve service delivery for the local population.

Staff were encouraged to contribute their views and experiences to help shape the department. Hospital executives engaged with staff through the 'chase up weekly meetings' which was open to all staff and a group wide monthly newsletter from the safety director.

The Chase Farm Hospital had a magazine for staff, members and governors named 'Freepress'. The November edition included messages from the trust's social media account, information on flu vaccine, the new EPR system in place in November 2018, and staff awards.

The hospital had organised a Christmas raffle scheduled for the 14 December 2018 through the Chase Farm Charity where staff, patients and public could attend.

The trust also engaged with staff through staff surveys, listening events and exit interviews. Information received from the trust showed that the themes from staff feedback included: relationship with colleagues, equal opportunities for professional or career development, role of senior management and better involvement from them / acting on feedback, improving staff wellbeing, improved facilities and working environment for staff, staffing levels, bullying and harassment and physical violence from patients. The trust held various listening events that focused on black and minority ethnic (BME) staff experience and anti-bullying and harassment week following the 2017 staff survey to improve their experience.

The trust held a 'what matters to you day' event in June 2018 and all interested staff attended during their team meeting. The event focused on three key questions which included: what made a good day for staff, what makes staff proud to work in the trust and what does the trust or service best look like. Staff led local improvements to the service following the feedback received.

The service had planned a team Christmas party which was being held the following week of inspection. Staff were excited about the team Christmas party. The service had introduced away days for band 3, 6 and 7 staff to improve staff engagement following their feedback.

Although staff had regular contact with their line managers or senior staff, either informally or through face-to-face meetings and safety huddles, regular staff meetings were not held. The last staff meeting held in the service was in July 2018 and no consecutive meeting had been held due to the summer holidays for staff and the service relocation. Senior staff told us the reception manager planned and would be facilitate staff meetings in 2019.

Although the service made improvements based on staff feedback and complaints received by patients, there was no evidence of how this was cascaded to patients and staff in the UCC, such as through a newsletter, posters or a bulletin.

During inspection we observed there was no evidence of continuous patients' engagement and feedback such as complaints, compliment, friends, improvement made as a result of feedback and family test (FFT) result. The service relied on feedback from complaints, patient advice and liaison service, NHS Choices website and social media. We only saw one thank you cards from patients which was not displayed in the general areas but in the manager's office. We saw that the service had developed a patient questionnaire which was being used to feedback on written leaflets that had been reviewed and developed. During our inspection, we reviewed six recent patient feedback leaflets received. All patients found the leaflet useful and language clear to read, however 33% of the patient felt the size of the text was too small.

Following patient feedback, the service had developed a leaflet of the role of ENP to educate patients on their role and a paediatric leaflet explaining why staff asked parents sensitive safeguarding questions at reception, triage and consultation.

The service participated in the hospital open day in November 2018 and staff had a stall where they engaged with visitors and public about the service.

Learning, continuous improvement and innovation

There was a culture and focus of continuous learning, innovation and improvement in the service to improve patient outcome. Staff we spoke to told us their managers encouraged and supported them to contribute ideas towards quality improvement in the department.

The service was involved in a quality improvement (QI) project for the retention of emergency nurse practitioner (ENP) with the aim to reduce agency usage by 50% in the next two years. The service had applied to NHS England for funds for training and developing nurses to band 8A advanced nurse practitioners.

Staff felt they had opportunities to develop their career and this was evident in the on-going development of ACP and emergency care practitioner (ECP) staff. A programme of training pharmacists and paramedics to be ECPs was currently underway within the department during inspection as part of the QI project.

The service had improved the medical staffing provision and had moved GPs from their previous agency into the hospital temporary staffing with arrangement of indemnity insurance in place covered by the hospital. This had helped improved medical cover and fill rate.

The service had a band 6 sepsis champions who would be leading on a sepsis QI project following committee approval as part of their leadership programme as the service. This QI project was necessary as the service did not take or carry out blood tests and to support staff if a patient was identified with sepsis and awaiting ambulance transfer.

The service had applied to be an education faculty and received accreditation by the Royal College of Nursing on minor injury and minor illness.

The hospital had plans to set up a patient council in 2019 to improve patient engagement.

Medical care (including older people's care)

Facts and data about this service

Chase Farm Hospital is part of the Royal Free London NHS Foundation Trust group. The trust completed a new Chase Farm Hospital building in July 2018.

Medical care services at Chase Farm Hospital consists of Capetown ward, an older persons assessment unit (OPAU) and an endoscopy unit.

Two of the units including the OPAU and the endoscopy unit are located within the new building. Capetown ward is located within the old hospital building

Capetown ward is a 24-bedded rehabilitation ward with eight beds allocated for stroke rehabilitation and 16 beds for general rehabilitation. There were 36 beds on the ward during our previous inspection, however, the number of beds have decreased over time. There are ongoing arrangements to transfer the ward to Barnet, Enfield and Haringey Mental Health trust by April 2019.

There were 471 admissions to Capetown ward between December 2017 and November 2018. All admissions to Capetown ward were elective. During the same period, 25,562 patients attended the endoscopy unit and 1632 patients attended the OPAU.
The Older Persons Assessment Unit (OPAU) is an admission avoidance unit for patients who cannot wait for routine outpatient appointments. The service receives referrals from GPs, community matrons, urgent care centres and nursing homes amongst others. The service is funded by the local clinical commissioning group and accepts patients from the local authority area. The OPAU opens from 9am to 7pm, Monday to Friday.

The endoscopy unit is accredited by the Joint Advisory Group (JAG) on gastrointestinal endoscopy. The unit offers elective endoscopy including colonoscopy, flexible sigmoidoscopy, gastroscopy, feeding tube insertion/change, bronchoscopy, dilatation and stents.

The endoscopy unit opens from 7.30am to 8pm Monday to Friday. Sessions run from 8am to 11.30am, 12 noon to 3.30pm and 4pm to 7pm. At the time of our inspection, the unit was carrying out extra sessions at weekends to reduce waiting lists.

We visited Capetown ward, the endoscopy unit and OPAU during our announced inspection from 11 to 13 December 2018. We spoke with 19 members of staff including doctors, nurses, allied health professionals, administrative staff and domestic staff. We spoke with eight patients and five relatives. We reviewed 14 patient records and five prescription charts. We made observations of the environment, staff interactions and checked various items of equipment.

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff were required to complete mandatory training to ensure they remained competent in specific core areas. Staff spoke highly of their opportunities for training and said it enabled them to keep up to date with best practice.

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the medicine department at Chase Farm Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Basic Radiation Safety	45	45	100%	85%	Yes
Emergency Planning	45	45	100%	85%	Yes
Fraud & Security	45	45	100%	85%	Yes
Health & Safety Awareness	45	45	100%	85%	Yes
Infection Control L1	45	45	100%	85%	Yes
Resuscitation L1	45	45	100%	85%	Yes
Waste Management	45	45	100%	85%	Yes
BPAT	45	45	100%	85%	Yes
Moving and Handling	42	45	93.3%	85%	Yes
Infection Control L2	42	45	93.3%	85%	Yes
Information Governance	41	45	91.1%	85%	Yes
Blood Transfusion	40	45	88.9%	85%	Yes
Fire Safety	40	45	88.9%	85%	Yes
Resuscitation L2	39	45	86.7%	85%	Yes
RTT L1	11	13	84.6%	85%	No
Conflict Resolution	38	45	84.4%	85%	No
Equality, Diversity & Human Rights	33	45	73.3%	85%	No

At Chase Farm Hospital medicine department, the 85% target was met for 14 of the 17 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the medicine department at Chase Farm Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Blood Transfusion	7	7	100%	85%	Yes
Basic Radiation Safety	6	7	85.7%	85%	Yes
Infection Control L1	6	7	85.7%	85%	Yes
Infection Control L2	6	7	85.7%	85%	Yes

Information Governance	6	7	85.7%	85%	Yes
Resuscitation L1	6	7	85.7%	85%	Yes
BPAT	6	7	85.7%	85%	Yes
Conflict Resolution	5	7	71.4%	85%	No
Equality, Diversity & Human Rights	5	7	71.4%	85%	No
Fraud & Security	5	7	71.4%	85%	No
Health & Safety Awareness	5	7	71.4%	85%	No
Resuscitation L2	5	7	71.4%	85%	No
Waste Management	5	7	71.4%	85%	No
Moving and Handling	4	7	57.1%	85%	No
Fire Safety	4	7	57.1%	85%	No
Emergency Planning	3	7	42.9%	85%	No
RTT L1	3	7	42.9%	85%	No

At Chase Farm Hospital medicine department, the 85% target was met for seven of the 17 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy. Staff escalated safeguarding incidents to senior staff or the safeguarding team. Staff said could also report safeguarding incidents using an electronic system.

The trust had a policy for female genital mutilation (FGM) that set out the staff's responsibility for identifying and reporting known or suspected cases of FGM. This was available on the trusts intranet and was accessible for all staff. FGM was included in the trusts safeguarding training.

Staff had received safeguarding adult and children training and demonstrated a good understanding and knowledge of the types of abuse patients may experience. Staff could give us an example of a recent safeguarding concern they had reported and said they were working with community teams to provide appropriate package of care for the patient once discharged.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for qualified nursing staff in the medicine department at Chase Farm Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	44	45	97.8%	85%	Yes
Safeguarding Adults L2	44	45	97.8%	85%	Yes
Safeguarding Children L1	43	45	95.6%	85%	Yes

Safeguarding Children L2	43	45	95.6%	85%	Yes

At Chase Farm Hospital medicine department, the 85% target was met for all the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for medical staff in the medicine department at Chase Farm Hospital is shown below

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	6	7	85.7%	85%	Yes
Safeguarding Children L2	6	7	85.7%	85%	Yes
Safeguarding Adults L1	5	7	71.4%	85%	No
Safeguarding Adults L2	5	7	71.4%	85%	No

At Chase Farm Hospital medicine department, the 85% target was met for two of the four safeguarding training modules for which medical staff were eligible.

There was a safeguarding lead in post and we noted contact numbers for safeguarding issues were visible in clinical areas visited. Staff knew how to report safeguarding concerns and we reviewed some of the safeguarding incidents reported which showed staff escalated concerns appropriately.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Infection prevention and control had improved since our last inspection in 2016. Areas of poor practice identified during our last inspection had been addressed. Staff disposed of personal protective equipment appropriately and washed their hands in line with best practice guidelines.

All areas of the units visited were visibly clean including Capetown ward, the older people's assessment unit (OPAU) and the endoscopy unit.

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

There was easy access to PPE. Aprons and gloves were available in all areas we inspected and we observed staff using PPE as required. There was also sufficient access to antibacterial hand gels as well as handwashing and drying facilities. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. We observed bed space curtains were labelled with the date they were last changed. Senior staff informed us they changed the curtains every six months, if soiled or if an infectious patient had been in the bay. We noted the curtains in place had been labelled with a date within the last two months of our inspection.

Staff were ‘bare below the elbow’ and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients.

Waste management, including those for contaminated and hazardous waste was in line with national standards. A colour coded system was used on all units visited to prevent cross contamination between different areas. There were housekeeping staff for cleaning wards and cleaning staff understood cleaning frequency and standards. Green ‘I am clean’ stickers were used to identify which equipment staff had cleaned and were ready to be reused.

Where patients had a known or suspected infection, they were nursed in single side rooms. Isolation signs indicated which patients required barrier nursing and gave guidance about what types of precautions were needed.

Needle sharp bins were available on all units visited. All bins we inspected were correctly labelled and none were filled above the maximum fill line.

Staff in the endoscopy unit used an automated distribution system (machine) to disposed dirty uniforms. Staff picked clean uniforms from a separate distribution system.

Clean and dirty scopes were labelled and separated to avoid contamination. There was a separate clean scope store and a scope returns store.

Staff on Capetown ward completed the saving lives audit. This involved daily checks to audit whether infectious patients were safely isolated, patients had risk assessments completed for MRSA, invasive devices were well maintained and the environment was clean.

Information displayed on Capetown ward safety board indicated it had been 343 days since the last incident of clostridium difficile (C.diff) and 398 days since the last methicillin-resistant staphylococcus aureus (MRSA). The unit scored 100% for hand hygiene in the last month of our inspection.

Hand hygiene audits from August 2018 to October 2018, showed that staff in the endoscopy unit scored 100% during the period.

Environment and equipment

The service had suitable premises and equipment and looked after them well.
Wards were accessed by staff using swipe card and visitors pressed a buzzer to alert staff.

We noted the size and layout of Capetown ward was set out in a manner that ensured people were safe. The ward consisted of four bedded bays and eight side rooms which provided sufficient space between beds to eliminate infection risks.

We reviewed equipment checks on all units visited and we found staff maintained a documented programme of daily checks.

We observed resuscitation equipment was readily available on the units. We found the resuscitation trolley and difficult airway trolley was regularly checked. Equipment inspected had maintenance stickers showing they had been serviced in the last year. We checked a random sample of supplies on trolleys within the units and saw they were all in their original packs and in date.

Patients on Capetown ward had access to a gym within the ward. This was equipped with sufficient rehabilitation and mobility equipment including walking frames, corner steps and remedial panel bars amongst others.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
There was a trust wide policy for monitoring and responding to the deteriorating patient, which was available to staff on the intranet.

Ward staff used the national early warning score (NEWS) to identify patients whose condition was deteriorating. The NEWS system used clinical observations within set parameters to determine how unwell a patient may be. When a patient's clinical observations fell outside certain parameters, they produced a higher score, which meant they required more urgent clinical care than others.

The adult observation chart contained as section listing NEWS, frequency of monitoring for each score and the clinical response for each score. Staff were required to escalate patients with a NEW score of 5 or more to the 'patient at risk and resuscitation team (PARRT). In addition, staff were required monitor patients hourly and to follow trust guidelines in considering sepsis.

Capetown had clear admission criteria to admit patients who were medically fit. Senior staff informed us if patients became acutely unwell, they were transferred to other sites or referring hospitals. Senior staff informed us they recorded any such transfer from the ward as an incident as the admission criteria requires patients to be medically fit. Patients should not be having medical treatment or awaiting investigations or results that will impact on therapy interventions. Staff on Capetown ward monitored patients' vital signs and conducted observations twice daily. Doctors conducted a daily ward round and reviewed patients accordingly.

Staff had access to relevant information about patients to provide safe care. Staff used standardise indicator markers to identify patients with complex needs. This highlighted patients at risk of falls, pressure ulcer or patient living with dementia amongst others.

Staff completed comprehensive risk assessments and reassessed patients regularly throughout their stay on Capetown ward. These included risk assessments for falls, confusion, challenging behaviour, mental health, bed rails assessment and pressure ulcers.

Staff also used a risk assessment for guiding the level of enhanced supervision patients may need who are vulnerable due to falls, confusion and challenging behaviour or mental health. This was used to determine the skills level of the staff required to provided 1:1 supervision such as such as a health care assistant (HCA), nursing assistant or registered mental health nurse (RMN).

All staff within the endoscopy unit carried a monitoring screen which set out an alarm if a patient's heart rate goes up or if a patient otherwise needed assistance. Patients attending the unit for an endoscopy procedure were required to have completed a form listing all medications they were taking, dosage and frequency as well as their medical history. Patients were required to have discontinued certain medications such as anticoagulants before their appointment.

Endoscopy staff completed a pre-procedure checklist to ensure the required fasting time had been observed, escort and transport arrangements have been arranged following the procedure and checked for any contra-indications. Staff recorded patient observations on admission.

Staff completed a specific safety standards invasive procedure checklist prior to the procedure and after the procedure.

OPAU staff triaged phone calls from referring clinicians to determine patients' suitability for the unit. Triage was conducted by senior nurses with appropriate level of skills and experience.

Nurse staffing

The service had enough nursing staff with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.

A matron led medical care including OPAU and Capetown ward. The matron was assisted by senior sisters based on each of the two units.

A senior sister led the endoscopy unit on Chase Farm Hospital. The senior sister reported to the senior clinical operations manager for theatres and endoscopy at the hospital.

A breakdown of staffing numbers at Chase Farm Hospital was provided following further information request as shown below:

Department	Staff Group	Establishment WTE	Actual FTE	Vacant WTE	Vacancy %
CH Capetown Ward	Healthcare Assistants	0.00	19.47	-19.47	
CH Capetown Ward	Nursing and Midwifery Registered	0.00	18.02	-18.02	
CH Endoscopy	Healthcare Assistants	5.50	4.80	0.70	12.73%
CH Endoscopy	Nursing and Midwifery Registered	24.20	20.73	3.47	14.33%
CH OPAU	Healthcare Assistants	1.00	1.00	0.00	0.00%
CH OPAU	Medical and Dental	2.40	1.00	1.40	58.33%
CH OPAU	Nursing and Midwifery Registered	4.20	2.89	1.31	31.11%
CH:Endoscopy Medical	Medical and Dental	0.30	0.00	0.30	100.00%

(*Source: DR306 – staffing*)

However, during our inspection, senior staff informed us there were 13.2 work time equivalent (WTE) nurses and 17 WTE health care assistants (HCAs) on Capetown ward. They said they had one band 6 vacancy and four band 5 vacancy posts. These vacancies were filled with bank staff. We were informed some staff had left to fill other posts within the trust as the service was in transition to be taken over by another trust.

There were three nurses rostered on the day night shift on Capetown ward during our inspection. Four health care assistants (HCAs) were rostered during the day and three were rostered at night. Senior staff informed us they rostered four HCAs at night if they had a patient that required enhanced care.

The service used an electronic system to monitor staffing on inpatient wards. This systems linked with the electronic roster system and senior staff were able to access information about the number of patients on each ward, their acuity level and the number of staff rostered to care for patients. Senior staff could move staff around to maintain safe staffing levels.

The trust had implemented three endoscopy session lists by the time of our inspection. Staff

within the endoscopy unit informed us there were insufficient nursing staff for three endoscopy sessions. The trust told us that although there are not enough nurses to cover every session, this was identified when the rota was devised and sessions would be closed in order to maintain a safe service. There were always sufficient nursing staff covering the used sessions to support the endoscopy procedures and ensure that the service was safe. Senior staff within the endoscopy unit informed us they had three nursing vacancies with interviews set up to recruit staff. They informed us they covered vacancies with bank staff.

From September 2017 to August 2018, the trust reported a turnover rate of 20.5% in medicine. This was higher than the trust target of 13%.

- Barnet Hospital: 16.7%
- Chase Farm Hospital: 19.4%
- Royal Free Hospital: 22.4%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

A breakdown of turnover rates at Chase Farm Hospital was provided following further information request as shown below:

Department	Staff Group	Turnover Rate
CH Capetown Ward	Healthcare Assistants	8.25%
CH Capetown Ward	Nursing and Midwifery Registered	18.60%
CH Endoscopy	Healthcare Assistants	0.00%
CH Endoscopy	Nursing and Midwifery Registered	8.60%
CH OPAU	Healthcare Assistants	0.00%
CH OPAU	Medical and Dental	0.00%
CH OPAU	Nursing and Midwifery Registered	20%

(*Source: DR306 – staffing*)

From September 2017 to August 2018, the trust reported a sickness rate of 3.1% in medicine. This was lower than the trust target of 3.5%.

- Barnet Hospital: 2.7%
- Chase Farm Hospital: 5.2%
- Royal Free Hospital: 3.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

A breakdown of sickness rates at Chase Farm Hospital was provided following further information request as shown below.

Department	Staff Group	Sickness Rate
CH Capetown Ward	Healthcare Assistants	7.35%
CH Capetown Ward	Nursing and Midwifery Registered	4.37%
CH Endoscopy	Healthcare Assistants	6.80%
CH Endoscopy	Nursing and Midwifery Registered	7.07%
CH OPAU	Healthcare Assistants	0.00%

CH OPAU	Medical and Dental	0.00%
CH OPAU	Nursing and Midwifery Registered	1.54%

(*Source: DR306 – staffing*)

Medical staffing

The service had enough medical staff with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.

The trust has reported the following medical staff numbers in medicine from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	**Actual WTE staff**	**Fill rate**	**Planned WTE staff**	**Actual WTE staff**	**Fill rate**
Barnet Hospital	137.4	120.8	87.9%	140.7	115.3	82.0%
Chase Farm Hospital	7.7	11.0	Over-established by 42.9%	7.3	8.0	Over-established by 9.6%
	164.1	196.8	Over-established by 19.9%	174.0	192.5	Over-established by 10.7%
Total	**309.2**	**328.6**	**Over-established by 6.3%**	**321.9**	**315.8**	**98.1%**

From April 2017 to March 2018, the trust reported an over-established staffing level of 6.3% for medical staff in medicine. This had decreased to 98.1% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Capetown ward was staffed by two consultants and two junior doctors (one speciality doctor and one junior clinical fellow) during the day. There was one consultant and one junior doctor for stroke rehabilitation and another consultant and junior doctor for general rehabilitation. Out of hours, a senior house officer (SHO) grade doctor provided cover from 5pm to 10pm and a registrar provided cover from 9.30pm to 9.30am. During the weekend, a SHO grade doctor provided cover from 9am to 10pm and a registrar provided cover from 9.30pm to 9.30am.

There was a clinical lead for medical staff on the endoscopy unit. The endoscopy unit had 22 consultants working across site. The endoscopy unit operated three session lists (from 8am to 11.30am, 12 noon to 3.30pm and 4pm to 7.30am) across four theatres during week days. Staff said the third list did not match working patterns for gastroenterologist working between Barnet and Chase Farm Hospitals.

(Source: DR307 – Medical staffing)

Following our inspection, data provided by the trust showed a significant number of endoscopy sessions in October and November 2018 did not go ahead.

October 2018:	
Total number of sessions available:	**276**
Job planned	**146**
Vacant	**130**
Total number of sessions that went ahead:	
Job planned	**121**
Vacant	**52**
TOTAL number of weekday lists:	**173**

November 2018:	
Total number of sessions available:	**264**
Job planned	**133**
Vacant	**131**
Total number of sessions that went ahead:	
Job planned	**109**
Vacant	**26**
TOTAL number of weekday lists:	**135**

(Source: DR774 - Endoscopy list cover)

From September 2017 to August 2018, the trust reported an over-established vacancy rate of 3.0% in medicine. This was lower than the trust target of 12%.

- Barnet Hospital: 12.2%
- Chase Farm Hospital: 2.0%
- Royal Free Hospital: Over-established by 15.8%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 7.3% in medicine. This was lower than the trust target of 13%.

- Barnet Hospital: 16.7%
- Chase Farm Hospital: 0.0%
- Royal Free Hospital: 5.5%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 0.6% in medicine. This was lower than the trust target of 3.5%.

- Barnet Hospital: 0.4%
- Chase Farm Hospital: 0.0%
- Royal Free Hospital: 0.8%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 7% of medical shifts in medicine were filled by bank staff and 1% of shifts were filled by locum staff.

The breakdown by site is shown in the table below:

Site	Total hours available	Bank Usage		Locum Usage		NOT filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Barnet	249,402	27,659	11%	5,598	2%	1,063	0%
Chase Farm	4,387	789	18%	0	0%	341	8%
Royal Free	306,336	10,188	3%	568	0%	Over-filled by 49,259	Over-filled by 16%
Total	**560,125**	**38,636**	**7%**	**6,165**	**1%**	**Over-filled by 47,854**	**Over-filled by 9%**

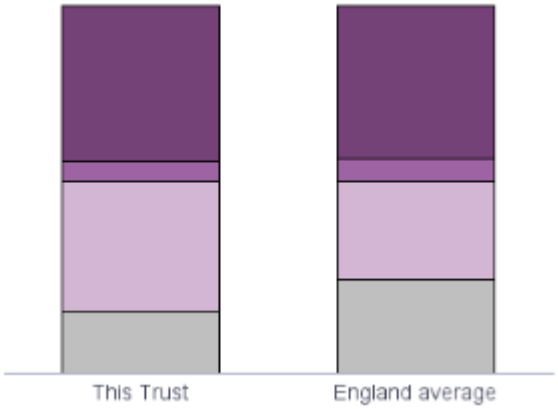
The trust reported an over establishment in bank and agency usage, they explained the negative values are for areas where total hours plus agency and bank hours have exceeded the establishment (effectively unfunded hours) this will need to be investigated further as fully understand why.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In July 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 442 whole time equivalent staff working in medicine at Royal Free London NHS Foundation Trust

	This Trust	England average
Consultant	42%	42%
Middle career^	6%	6%
Registrar group~	35%	27%
Junior*	17%	25%



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital - Workforce Statistics - Medical (July 2018))

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Electronic patient records (EPR) had recently been implemented in the hospital and staff on the OPAU and endoscopy unit used the EPR system. The EPR had not been implemented on Capetown ward and staff recorded patients' assessments on paper records.

Staff within the endoscopy unit informed us there were hitches using the new system as patients' previous records were not yet accessible on the EPR. Endoscopy staff informed us they were having to search old systems to make sure they did not miss information and this had an impact their time.

The electronic system was password protected and we noted staff log out once they had finished using the system. Staff informed us the system also timed out after a certain period of inactivity.

Patient records were securely stored in keypad locked trolleys on Capetown ward. Staff ensured the trolleys were secure after removing or replacing relevant notes.

We looked at a random sample of 14 patient records across all units visited and noted records were clear, legible and the name and grade of staff reviewing the patient was clearly documented. At this inspection, we found that assessments for VTE, pressure areas, nutrition and pain had been completed using national risk assessment tools. The records also included evidence of the daily ward round review and completed care plans. This was an improvement from our previous inspection when we found gaps in several care plans and risk assessments on Capetown ward.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Medicines (including controlled drugs) were stored securely in locked cabinets and fridges. Controlled drugs (CD) were managed appropriately. CDs were checked twice a day by two qualified nurses. Pharmacy staff conducted quarterly controlled drugs audits.

Whilst staff monitored fridge temperatures, they did not initially monitor the ambient temperature of medicines storage areas. We raised this with senior ward staff they installed a temperature gauge to monitor the ambient temperature of medicines storage areas the following day.

Staff had access to medicines disposal facilities including sharps bins and this was managed appropriately. Medicines and equipment for use in emergencies were readily accessible to staff and was checked regularly. Most oxygen cylinders were full and within date. We saw one oxygen cylinder which was empty. Staff immediately arranged the removal of the empty cylinder.

Robust systems, using tamper evident seals, were in use to ensure emergency medicines were readily available when needed and fit for use. Regular checks of emergency medicines and equipment were carried out by staff.

Staff returned unwanted medicines (including CDs) to the pharmacy for disposal.

Pharmacy staff visited wards each day and conducted medicines reconciliation. Medicines reconciliation is the process of ensuring that the list of medicines a person is taking is correct. Staff could access medicines supplies and advice out of hours. Pharmacists and pharmacy technicians counselled patients on their medicines.

A new system for producing electronic discharge summaries was recently implemented. Pharmacists and doctors worked together to ensure that discharge prescriptions were processed correctly via the new system.

We checked five prescription charts and saw that information on patient demographics and allergy statuses were complete. Prescription charts were signed after each dose was administered and there were no unexplained gaps in the administration of medicines.

Venous thromboembolism (VTE) risk assessment was documented on the prescription chart, and if relevant, medicines for VTE prevention were prescribed. The prescription chart was designed in such a way that ensured that antibiotics were reviewed in line with the trust policy.

Discharge summaries were sent to patient's own GPs electronically.

Incidents

The service generally managed patient safety incidents well.

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

There were no never events or serious incidents reported in the 12 months prior to the inspection

Staff knew how to report incidents and informed us senior staff discussed learnings from incidents during staff meetings and by email. They told us they received feedback from incidents they reported. Meeting minutes we reviewed showed that learning from incidents across the trust were discussed and disseminated to staff.

Staff on Capetown ward reported 60 incidents between August 2018 and November 2018. The most commonly reported incidents were slip, trips and falls (22), access, transfer, admission and discharge (15) and safeguarding (seven). 46 of the incidents resulted in no harm caused, 11 resulted in low harm and one resulted in moderated harm. Staff reported 18 incidents in relation to endoscopy between July 2018 and October 2018. Staff recorded actions taken to in relation to the incidents.

The duty of candour requires providers of health and social care services to notify patients (or

other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with were aware of their responsibility to apologise and be open and honest and share the information with the patient and their carer’s.

The service held monthly mortality and morbidity meetings within medical specialities for Barnet and Chase Farm Hospitals. We reviewed the notes of mortality and morbidity (M&M) meetings in the last six months before our inspection and found that they were informed by a deceased patient summary.

(Sources: DR309, DR311 – Mortality and morbidity meetings)

Safety thermometer

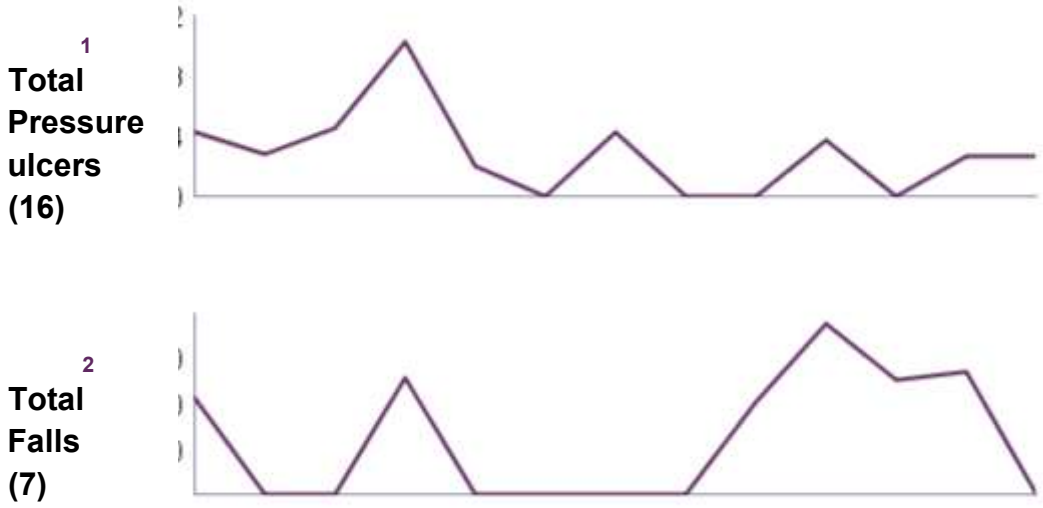
The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 16 new pressure ulcers, seven falls with harm and 12 new urinary tract infections in patients with a catheter from September 2017 to September 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Royal Free London NHS Foundation Trust



Total CUTIs (12)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

The service displayed safety thermometer data on its safety board within Capetown ward. During our inspection, information on the ward showed it had been 29 days since the last fall and 68 days since the last pressure ulcer incident.
Our review of patients' notes showed that all patients had their level of risk assessed for venous thromboembolism (VTE), falls and pressure ulcers. Staff informed us tissue viability nurses reviewed patients with pressure ulcers.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff had access to guidelines on the trust's intranet system. We reviewed a sample of this and saw they were mostly up to date and in line with best practice. This included the National Institute for Health and Care Excellence (NICE) recommendations. However, one of the (ten) policies reviewed, the infection control policy was out of date since January 2014.

During our last inspection, the endoscopy unit was not accredited by the Joint Advisory Group (JAG) for Endoscopy. The unit was accredited by the time of our inspection and the accreditation had been renewed for another year from August 2018.

Nursing and medical staff assessed the needs of patients on admission and throughout their stay. Treatment and care was planned and delivered in line with evidence based guidance, standards and best practice. Staff on Capetown ward conducted monthly audits to ensure staff complied with best practice standards. These included pressure ulcer audit, slips, trips and falls audits and rounding audits. We reviewed audits between August 2018 and November 2018 which showed staff achieved over 90% compliance rate during the period in line with the trust target.

Our review of patient records showed staff completed Venous thromboembolism (VTE) risk assessments for each patient.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Our review of eight inpatient records on Capetown ward showed staff completed nutrition and hydration assessments for each patient. Nutrition plans and food charts were in use and these had been completed. Staff completed nutrition assessments for all patients within 24 hours of admission and weekly after admission. In addition, patients' weight were documented on admission and weekly thereafter. Patients weight were documented weekly.

Staff confirmed they had access to dietitians and could refer patients to them when necessary.

Patients at risk of malnutrition had a nutrition score chart in place and were referred to a dietitian.

Staff completed monthly nutrition screening audits for patients admitted on Capetown ward. We reviewed the audit for November 2018, which showed the unit scored 100% for achieving the trust's standards for nutrition screening.

Staff conducted monthly meal time audits on Capetown ward. The audit from November 2018 showed the unit scored 98% in line with trust standards assessing how staff prepared patients, prepared the environment, assisted patients to eat, food preparation and clearing away plates after patients had eaten.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Our review of patient records showed that patients on the unit had been assessed in regard to pain management. Staff used a pain scoring tool alongside observing for the signs and symptoms of pain. Staff used pictorial tools to communicate with patients who were non-verbal to determine whether they were in pain and their level of pain.

Pain management was led by the ward medical teams who reviewed pain level as part of their daily ward round.

Patients we spoke with told us they received pain relief when they required it and that it was reviewed regularly.

Staff had access to a pain specialist team who they could refer patients too.

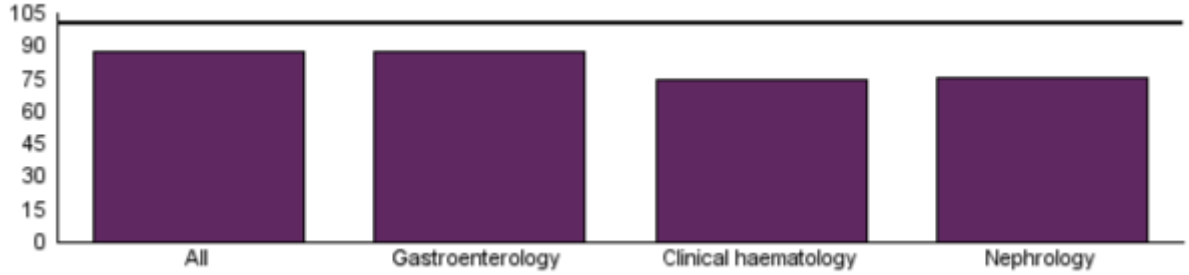
Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

From June 2017 to May 2018, patients at the trust had a lower than expected risk of readmission for elective admissions and a similar to expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions – Trust Level

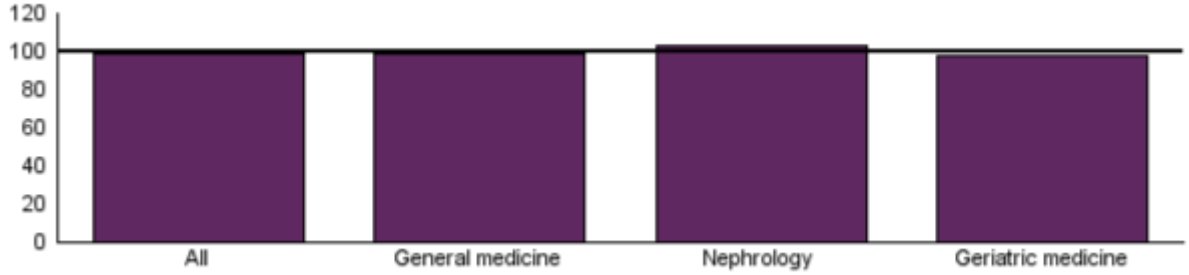
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in nephrology had a lower than expected risk of readmission for elective admissions



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

Non-Elective Admissions – Trust Level

- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in nephrology had a similar to expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a similar to expected risk of readmission for non-elective admissions



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

(Source: Hospital Episode Statistics - HES - Readmissions (June 2017 – May 2018))

Data from the trust showed the percentage of deaths within 30 days of an endoscopy was 0.3% (2 out of 789) for Chase Farm Hospital. Percentage of emergency re-admissions within eight days of an endoscopy was 0.8% (6 out of 789). This was lower than the trust average. Three of the six patients were readmitted for other reasons not related to their endoscopy procedure.

The endoscopy unit held regular audit meetings. Notes of the meeting from June 2018 showed staff discussed results of audits carried out in line with JAG standards. Safe sedation audit was within the median guidance for patients over 70 years and under 70 years. The Colonic biopsy for chronic diarrhoea audit showed 20% of biopsies were not taken. Staff discussed recommendations and the minutes identified action plans for improvement.
(*Source DR315 Endoscopy Audit*)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

All staff went through an induction period and orientation. New starters were allocated a mentor

for a specified period to help them settle into their role. New nurses completed competencies which had to be signed off by their mentor. Staff within all units visited had opportunities to attend relevant study days and formal teaching sessions when available. Staff informed us they had been provided with relevant training required to carry out their role.

Medical staff received an orientation and induction programme following their employment. Junior doctors we spoke with reported the hospital provided good teaching and regular learning opportunities and were given time for training. They also felt they had good support from consultants who also provided clinical supervision.

From April to September 2018, 75% of staff within medicine at the trust received an appraisal compared to a trust target of 85%. Nursing staff had a 77.8% completion rate and medical/dental staff had an 82.8% completion rate.

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Medical and Dental	128	106	85%	82.8%	No
Healthcare Assistants	238	193	85%	81.1%	No
Estates and Ancillary	10	8	85%	80.0%	No
Nursing Registered	445	346	85%	77.8%	No
Healthcare Scientists	9	6	85%	66.7%	No
Administrative and Clerical	83	45	85%	54.2%	No
Allied Health Professionals	61	33	85%	54.1%	No
Additional Clinical Services	23	12	85%	52.2%	No
Add Prof Scientific and Technic	6	3	85%	50.0%	No
Total	**1,003**	**752**	**85%**	**75.0%**	**No**

At Chase Farm Hospital, nursing staff had a 76.7% completion rate and medical/dental staff had a 100% completion rate.

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Estates and Ancillary	1	1	85%	100%	Yes
Medical and Dental	5	5	85%	100%	Yes
Healthcare Assistants	28	26	85%	92.9%	Yes

Nursing Registered	43	33	85%	76.7%	No
Administrative and Clerical	10	5	85%	50.0%	No
Total	**87**	**70**	**85%**	**80.5%**	**No**

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

By the time of our inspection, appraisal rate for nursing staff on Capetown ward and OPAU was 90%.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff reported good working relationships with other teams. Our review of patient records on the Capetown ward showed there was input from therapists, dietitians, nurses and doctors. Patient records reviewed on the OPAU and endoscopy unit also showed inputs from nurses, doctors and consultants.

Staff in the OPAU liaised effectively with community teams including the intermediate care team, Parkinson's clinics, falls prevention team and community nurses to keep older people healthy at home.

Staff began discharge planning from the first day of a patient's admission on Capetown ward. This involved identifying how independent the patient was prior to their hospital admission and goals to enable their discharge home. Staff liaised with community teams to ensure patients received the right packages of care and were discharged accordingly.

Physiotherapists and occupational therapists (OT) assessed all patients on admission to the Capetown ward to ensure to ensure appropriate mobility and personal care support was provided during their admission. There were two physiotherapy teams on Capetown ward including a core physiotherapy team and a neurology physiotherapy team. Senior therapy staff informed us they've been unable to recruit occupational therapists for the neurology team as the service was in transition and they were not allowed to recruit. OT cover for the neurology team had been provided by bank staff, two days a week. This meant there were insufficient OT cover to consider cognition issues and manage complex discharge for neurology patients.

Staff held daily board rounds and this was attended by therapy staff, doctors and nursing staff. This involved a quick overview of patients on the ward and any immediate issues or problems were highlighted. We observed a MDT board round meeting attended by the nurse in charge, lead therapists and doctors on shift. The meeting was robust with a detailed review of each patient on the ward. Each patient was reviewed for their level of need, progress against rehabilitation goals, mobility issues, and social care issues with regard to discharge planning and home care packages. Staff discussed their treatment plan, skin integrity, changes in medication, equipment required for mobility, home visits and any safeguarding issues amongst others. Therapists discussed progress against each patient's needs, plans and goals.

Staff in medical care had easy access to a social worker based on the unit. Staff informed us it helped to facility packages of care and discharge.

Discharge summaries were sent to the patients' GPs and relevant community teams on discharge from the hospital. Patients were provided with a printed copy of the discharge summary including medicines information to take home with them.

Seven-day services

Medical and nursing staff provided cover on Capetown ward 24 hours a day, seven days a week. Consultant cover was available seven days a week, including on call outside normal working hours.

Physiotherapists and occupational therapist were available Monday to Friday to support rehabilitation on Capetown ward. Speech and language therapist (SALT) and dieticians were available on a bleep referral system.

The OPAU opened from 9am to 7pm, Monday to Friday.

The endoscopy unit open from 7.30am to 8pm Monday to Friday. At the time of our inspection, the unit was carrying out extra sessions at weekends to reduce waiting lists.

The pharmacy opened from 8am to 8.30pm, Monday to Thursday and 8am to 5pm on Friday.

Health promotion

The trust had implemented several programmes to support national priorities and improve the health of the local population. The trust has a 'no smoking policy' across all sites and actively promoted no smoking for patients and staff. Staff were being trained to embed smoking cessation across the trust and to increase referrals to community based smoking cessation services. There were similar programmes in place to tackle other priorities including obesity, drug and alcohol dependency, dementia and domestic abuse amongst others.

A team of physiotherapists and occupational therapists assisted patients with rehabilitation on Capetown ward until they are fit for discharge. These included activities which helped patients achieve their independence such as exercise programs and social activity groups like cooking, backing and arts and craft.

Staff on Older Persons Assessment Unit (OPAU) liaised with community teams such as the intermediate care team (ICT) to help patients recover and achieve their independence. The ICT provide short term nursing and therapy input in the patient's home environment in line with an agreed care plan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff had access to mental health and deprivation of liberty safeguards guidelines on the trust intranet. Staff could talk about the deprivation of liberty safeguards (DOLS) and how this would impact a patient on the unit. Staff were aware of their responsibilities under the mental capacity act.

Staff were aware of the concept of shared decision-making with patients. The sample of patient records we reviewed demonstrated consent for treatment was completed. We saw consent forms completed by patients attending the endoscopy unit. Patients told us staff explained treatment and care and sought their consent before proceeding.

Our review of patient notes showed staff followed trust policy in line with DOLS. We reviewed a patient record which showed DOLS was assessed by medical staff with the involvement of the patient's family. We saw that staff completed all necessary documentation including discussion with patients' relatives.

The trust reported that from April 2018 to August 2018 Mental Capacity Act (MCA) training and deprivation of liberty (DOLS) training was completed by 79.3% of staff in medicine compared to the trust target of 85%. Nursing staff had a completion rate of 90.1% and medical/dental staff had a completion rate of 48.4%.

A breakdown of completion rates by site and staff group is below:

Site	Nursing staff	Medical/dental staff	All staff
Chase Farm Hospital	97.8%	85.7%	93.8%

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We spoke with eight patients and five relatives on all units visited. Patients were positive about their care and said staff were professional, polite and treated them with dignity. Both patients and their relatives confirmed staff were “nice”, “caring” and “helpful”. They also described their care as “fantastic”, “good” “excellent”. One relative at the OPAU informed us reception staff helped to register their car for parking.

All the observations of care we made were positive, with staff showing kind and compassionate care. Staff were courteous, professional and engaging. We saw staff maintaining patient privacy and dignity by drawing curtains around patient areas before completing care tasks. Patients undergoing a procedure in endoscopy were allocated individual en-suite pods/suites which protected patient’s privacy and dignity.

Staff were confident about the care they provided to patients and informed us they received positive feedback from patients.

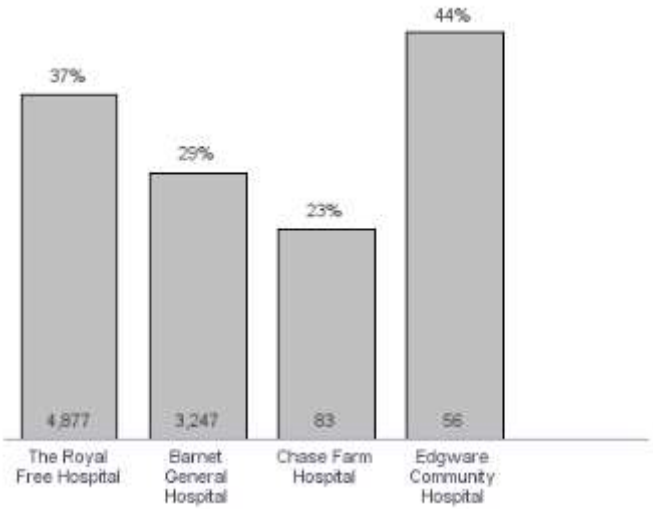
We observed patients had call bells within reach. The trust target was for 90% of call bells to be answered within 10 rings. Call bell audits were completed monthly and results for November 2018 showed 100% of call bells on Capetown ward were answered within 10 rings.

Privacy, dignity and respect observational audits were also completed monthly. Results from November 2018 showed Capetown ward achieved 97.5% in November 2018.

We saw many thank you cards displayed within Capetown ward from patients and their families. The cards described the kindness and diligence of staff and how staff had helped them achieve their rehabilitation goals.

The Friends and Family Test response rate for medicine at the trust was 33% which was better than the England average of 25% from September 2017 to August 2018.

Friends and family Test – Response rate from September 2017 to August 2018 by site



Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	
BH-CDU	791	33%	85%	89%	83%	82%	87%	86%	82%	92%	88%	91%	96%	89%	87%
BH-MSSU	739	26%	81%	92%	82%	87%	78%	83%	73%	90%	83%	91%	90%	86%	86%
10 SOUTH A	692	47%	96%	92%	93%	85%	89%	82%	77%	86%	94%	88%	88%	75%	88%
10 WEST	651	44%	100%	95%	90%	98%	98%	90%	93%	98%	97%	98%	94%	88%	95%
8 NORTH	605	35%	89%	86%	85%	91%	84%	90%	83%	87%	77%	95%	86%	83%	86%
9 NORTH	564	47%	88%	87%	91%	85%	94%	86%	88%	90%	90%	91%	87%	80%	88%
11 EAST	467	44%	98%	97%	91%	93%	97%	91%	92%	98%	98%	100%	91%	95%	95%
BH-ROWAN	340	38%	94%	84%	100%	92%	97%	96%	78%	85%	96%	83%	94%	89%	91%
11 WEST	339	35%	97%	95%	94%	85%	96%	88%	86%	93%	96%	90%	89%	100%	93%
10 EAST	325	33%	78%	93%	88%	72%	89%	85%	90%	89%	88%	90%	78%	83%	86%
8 EAST	319	34%	93%	96%	97%	91%	96%	87%	93%	87%	88%	87%	81%	95%	91%
BH-WALNUT	319	35%	68%	100%	87%	91%	85%	91%	84%	83%	82%	94%	96%	85%	87%
10 NORTH	243	24%	86%	100%	100%	62%	82%	89%	100%	80%	78%	87%	84%	93%	88%
8 WEST	236	23%	71%	90%	82%	86%	79%	72%	89%	91%	89%	85%	96%	69%	84%
BH-CCU	235	52%	88%	100%	95%	93%	94%	100%	100%	95%	100%	100%	100%	94%	97%
BH-	226	31%	91%	82%	91%	88%	91%	73%	67%	89%	86%	85%	75%	77%	84%
6 SOUTH	220	31%	90%	92%	94%	89%	82%	94%	86%	58%	93%	90%	88%	88%	88%
BH-OLIVE	184	26%	94%	94%	88%	92%	100%	94%	100%	92%	87%	100%	88%	78%	92%
6 EAST	184	27%	100%	100%	100%		80%	90%	81%	86%	96%				82%
11 SOUTH	128	44%	87%	87%	96%	88%	91%								90%
BH-JUNIPER	118	20%	86%	79%	100%	100%	58%	78%	87%	56%	88%	77%	100%		81%

Highest score to lowest score

Key 100% 50% 0%

[1] The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).

[2] Sorted by total response.

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

Note: sorted by total response

Ward BH–CCU (coronary care unit) had the highest response rate with 52% and ward 8-West had the lowest response rate with 23%. The average response rate during the period was 19%.

(Source: NHS England Friends and Family Test)

Data received from the trust showed between November 2017 and October 2018, 83% of patients indicated they would recommend Capetown ward.

(*Source: DR318*)

Emotional support

Staff provided emotional support to patients to minimise their distress.

Patients and their relatives informed us they could speak to staff about their concerns.

Patients on Capetown ward said staff went the extra mile to take care of their needs and engaged with their families.

Staff within the endoscopy unit informed us they helped patients relax when nervous or anxious about their care and had received positive feedback from patients about this.

Patients and relatives had access to the hospital's multi-faith chaplaincy team for spiritual, religious and pastoral support.

Staff also referred patients and their carers to external organisations for support.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients and relatives we spoke to confirmed they received good information from staff and they were regularly updated. They informed us staff introduced themselves, explained procedures and obtained their consent before conducting them.

Patients at the endoscopy unit informed us they were provided instructions regarding what happened next and were given details of the nurse that would take care of them.

Patients were involved in setting goals with their therapist and patients were happy about their progress against rehabilitation goals.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The new Chase Farm Hospital was completed in July 2018 and features modern facilities to meet the needs of the local people. Two of the units we inspected including the Older Persons Assessment Unit (OPAU) and the endoscopy unit were located within the new building.

The OPAU provided consultant led same or next day appointment to elderly patients who could not wait for routine outpatient appointments. Patients attending the unit had their vital signs checked and other investigations such as x-tray, bloods and electrocardiogram (ECG) conducted. Patients were able to see a geriatrician before discharge.

The endoscopy unit consisted of 16 individual pods or suites for admission, recovery and discharge. The pods are equipped with en-suite facilities to protect the privacy and dignity of patients as well as their convenience. Senior staff informed us en-suite toilet facilities were provided in response to patient feedback on the need for privacy when changing for the procedure. This showed feedback from patients were considered when planning locations for services. The endoscopy unit had a quiet room where doctors could discuss sensitive information within relatives.

On arrival to the hospital, patients could use interactive self-service kiosks to check in for their appointments.

Capetown was located within the old hospital building. At the time of our inspection, there were arrangements to transfer the ward to another healthcare provider by April 2018. Relative visiting time on Capetown wards was between 2pm and 8pm every day.

Staff commence discharge planning on Capetown ward from when patients were admitted to the unit. Patients were accommodated in single rooms or in single sex bays. Data from the trust showed there were no mixed sex accommodation breaches on Capetown ward in the 12-month period to our inspection.

(*Source: DR323 – Mixed sex breaches*)

Meeting people's individual needs

The service took account of patients' individual needs.

Visitors had access to a variety of information leaflets on all units visited. These included relevant information for the elderly and various ailments or conditions. There were also leaflets signposting people to relevant charities. There was a large pictorial banner explaining the endoscopy journey in the waiting area within the endoscopy unit.

Staff confirmed they could access interpreting services for patients through a help line or face-to-face.

Patients attending the OPAU had access to books in waiting areas. Some of the books included creative communication tools for patients living with dementia, cards for sharing and enjoying memories from another time, and active minds jigsaw puzzles amongst others.

Patients attending the OPAU and the endoscopy unit had access to a water dispenser within the unit. We also noted patients in the OPAU had access to beverages kept on a trolley within the waiting area. Staff in OPAU informed us they also offered patients a hot meal or sandwiches and we overhead staffing offering patients refreshments.

Patients on Capetown ward informed us they were provided food of their choice and they informed us the food was good.

OPAU staff informed us they considered patients' individual circumstances when triaging calls, including if patients could attend unit. Where patients had difficultly attending the unit, staff arranged hospital transport to pick up patients and drop them back at home.

Staff had access to dementia and learning disability nurses from the trust. There was no patient with learning disability on admission during our inspection. However, staff informed us patients with learning disabilities were assessed and reviewed by the learning disability team on admission.

A hospital passport was used for patients with complex needs including dementia and learning disabilities. The passport provided the opportunity for family, carers and health professionals to document important things about the patient, including their preferences and dislikes.

Patients admitted on Capetown ward had access to a well-maintained dementia garden with water features and sitting areas. Senior staff informed all plants in the garden where edible and they had visited a dementia village in Holland for inspiration to design the garden. Patients also had access to a therapy garden located within Capetown ward. Staff informed us the gardens helped to aid patient recovery.

Staff used standardise indicator markers to identify patients with complex needs. For example, patients living with dementia were highlighted on the with a blue forget me not flower next to their name on the main patient details board on Capetown ward.

Inpatients on Capetown ward had access to several activity groups which aided their rehabilitation, these included exercise group, gardening group, and social activity groups (including cooking and baking). Patients had attended a carol service organised for inpatients in the hospital just prior to our inspection.

Patients on Capetown ward were particularly complimentary about the care provided by staff, including their rehabilitation care. Patients were happy about their use of the gym and activities including arts and crafts to improve dexterity. Patients informed us the sessions were engaging. Staff could refer patients or carers for psychological support or to societies caring for specific groups of people.

There were facilities in place for disabled patient access. Patients could access the endoscopy unit on the lower ground floor via a lift. The OPAU and Capetown ward were on the ground floor with ease of access for patients with disabilities. Each unit had disabled toilets and we noted Capetown ward had assisted toilet and shower facility for wheel chair users.

There was a separate notice board within Capetown ward for carers. Information on the board signposted carers to counselling services, the local carers centre and various other services targeted towards carers. There was also information about the community stroke service and Alzheimer society.

Visitors had access to a multi-faith room within the hospital.

Access and flow

People could access most services when they needed it, however, waiting times from referral to treatment for endoscopy was not in line with national standards.

The OPAU received referrals from GPs, community matrons, urgent care centres and nursing homes. Patients attending the unit were deemed not to require accident and emergency appointment but could not wait for routine outpatient appointments.

The OPAU arranged same day appointments for patients provided the referral was received by 3.30pm or next day afterwards. Senior staff informed us urgent cases after 3.30pm would be referred to an acute hospital.

Senior nurses at the OPAU triage all calls to the unit to determine if referrals were appropriate for the unit. Patients informed us staff promptly attended to them when they arrived on the OPAU and they did not have to wait.

Patients were admitted to Capetown ward for rehabilitation once they were assessed by staff to be medically fit. Staff used a decision making tool to determine if patients were suitable for admission on the ward. Staff reviewed key questions considering whether patients were medically fit, patient function level, expected discharge destination, progress with therapy and whether rehabilitation goals have been identified amongst others.

However, we noted a few cases where staff were awaiting further information from the referrer to admit patients. For example, there were four cases by 12 December 2018 where insufficient information was provided for staff to determine if patients were suitable for admission on the ward.

Staff informed us there were sometimes occasions when patients had to be transferred back to acute hospital settings on arrival because they were not medically stable. Senior staff informed us they raised an incident every time a patient is transferred out of the ward. Incidents recorded by staff showed there were three occasions when patients were transferred back following their admission between August 2018 and December 2018.

Staff held a daily board round with a detailed review of each patient on the ward. This enabled staff to rapidly assess the progress of each patient and address any delays to treatment or

discharge.

Data received from the trust showed between November 2017 and October 2018, the average bed occupancy at Chase Farm Hospital was 87%. These occupancy rates were slightly higher than the recommendation of 85% bed occupancy in line with national standard.

(*Source: DR310- Capetown incidents, DR322 – Average bed occupancy*)

Patients were referred to the endoscopy unit for elective cases within the trust.

Staff informed us the endoscopy unit was experiencing delays to the two-week cancer wait and routine cases. Staff informed us waiting times at the time of our inspection was six weeks for cancer waits and 16 weeks for routine cases contrary to national guidelines which recommends two weeks for cancer cases and six weeks for routine cases.

Following our inspection, the trust provided the data below in relation to two week waiting times for endoscopy:

avg_week_wait	**27.897606**	
Modality_final	avg_week_wait	
Colonoscopy	25.991277	
Flexible Sigmoidoscopy	21.00742	
Gastroscopy	31.048597	
Site	avg_week_wait	
Barnet & Chase Farm Hospital	27.582564	
Royal Free Hospital	28.392103	
Modality_final	Site	avg_week_wait
Colonoscopy	Barnet & Chase Farm Hospital	27.105126
Flexible Sigmoidoscopy	Barnet & Chase Farm Hospital	23.169172
Gastroscopy	Barnet & Chase Farm Hospital	29.024442

The service had implemented several solutions to reduce waiting times for appointments at the endoscopy unit. These included the use of an insourced endoscopy provider to carry out additional eight sessions on weekends. Patients were also referred to a private unit within the trust.

In addition, the trust had increased the number of daily lists from two sessions in four rooms a day to three sessions a day. However, staff informed us there was insufficient nursing capacity to

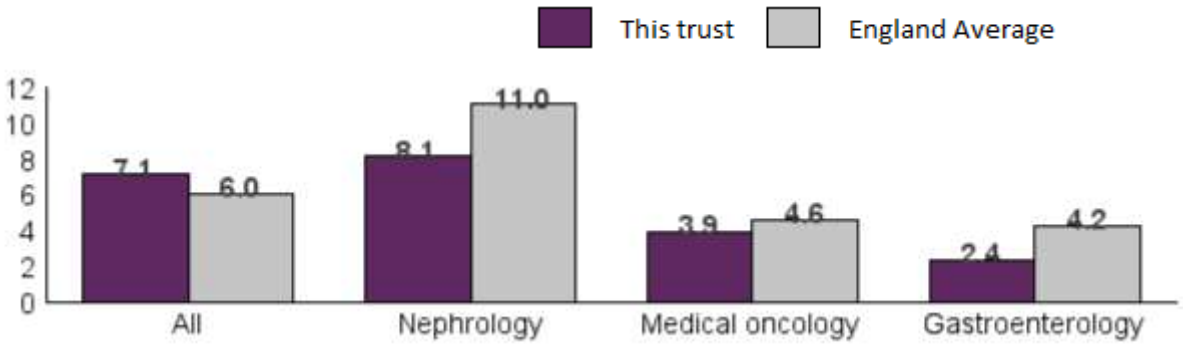
cover three lists. Staff said the third list did not match working patterns for gastroenterologist working between Barnet and Chase Farm Hospitals. In addition, patients were often unwilling to attend the last list (from 4pm to 7.30pm) which meant they would have to endure longer fasting periods. These often resulted in DNAs for the last list and under-utilisation of the unit.

Staff informed us 'did not attend' (DNA) rate was 6% as at September 2018. Staff said they sometimes had DNAs because patients were informed about their appointments with little notice. In addition, appointments were booked by administrative staff who failed to obtain relevant information about any medication patients were taking. This meant patients sometimes attended the unit for their appointment only for staff to realise they were on a medication that needed to have been stopped seven days before the procedure.

One of the incidents recorded by endoscopy staff was in relation to DNA by seven patients on a Sunday in October 2018. The patients were contacted to rebook appointments. One of the patients said they had cancelled the appointment two weeks prior but never received a new appointment. Another patient said they had not received any information regarding the appointment and did not know an appointment had been scheduled for them.

From July 2017 to June 2018 the average length of stay for medical elective patients on a trust wide level was 7.1 days, which is higher than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 7.7 days, which is higher than the England average of 6.3 days.

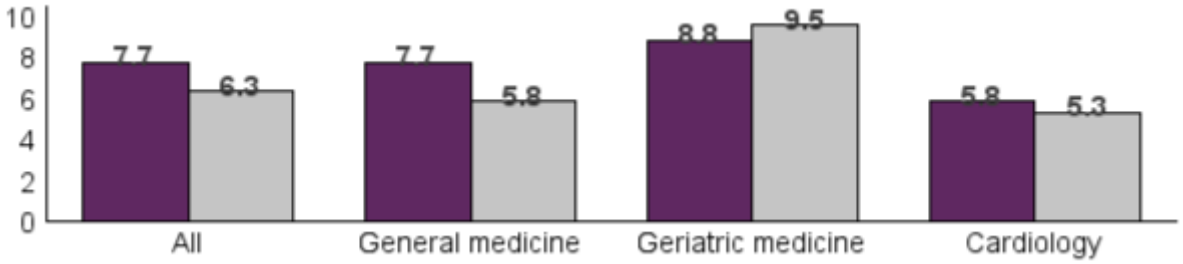
- Average length of stay for elective patients in nephrology is lower than the England average.
- Average length of stay for elective patients in medical oncology is lower than the England average.
- Average length of stay for elective patients in gastroenterology is lower than the England average.



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

- Average length of stay for elective patients in general medicine is higher than the England average.
- Average length of stay for elective patients in geriatric medicine is lower than the England average.
- Average length of stay for elective patients in cardiology is higher than the England average.

This trust England Average

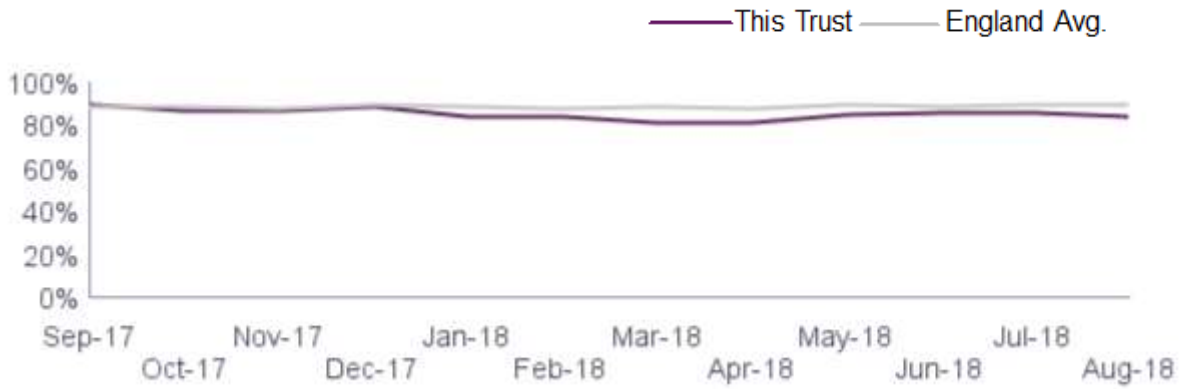


Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Capetown ward was the only inpatient ward for medical care at Chase Farm Hospital and admitted only elective patients for rehabilitation. Data obtained during our inspection showed between December 2017 and November 2018 the average length of stay for patients on Capetown ward was 30 days.

From September 2017 to December 2017 the trust's referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average. However, from January 2018 to August 2018, performance was slightly worse. In the latest period, August 2018, the RTT rate was 84.2% compared to the England average of 90.0%.



(Source: NHS England)

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

Specialty grouping	Result	England average
Geriatric medicine	100%	97.0%
Thoracic medicine	98.8%	93.0%
General medicine	98.0%	96.4%
Neurology	97.1%	91.1%
Dermatology	82.9%	82.2%

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

Specialty grouping	Result	England average
Gastroenterology	91.3%	93.7%
Rheumatology	88.0%	94.5%

Cardiology	77.7%	82.1%

(Source: NHS England)

The trust did not provide a date range for patients moving wards per admission, shown below.

Patient moves	Number of patients	% share of all patients
1	18,452	67%
2	7,524	28%
3	1,045	5%
4+	273	1%
Total	**23,545**	**100%**

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Staff told us they would try to manage complaints informally at ward level and would involve senior staff to support if this is need. Staff told us they would refer patients and their relatives to the Patient Advice and Liaison Service (PALS) if the complaint could not be managed at ward level.

We saw leaflets in all clinical areas visited providing visitors with information about how to make a complaint. This included information about the PALS.

From September 2017 to August 2018 there were 399 complaints about medical care. The trust took an average of 30.4 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 35 working days.

The most prevalent types of complaints were those relating to all aspects of clinical treatment (183, 45.9%), appointments, delay/ cancellation (out-patient) (65, 16.3%) and communication/ information to patients (written and oral) (57, 14.3%).

A breakdown of complaints by site is below:

Site/location	Number of complaints	Proportion of total complaints
Chase Farm Hospital	39	9.8%

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

From September 2017 to August 2018 there were 13 compliments within medicine at Chase Farm Hospital.

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

Is the service well-led?

Leadership

Managers had the right skills and abilities to run a service providing sustainable care.

Medical care for Capetown ward and the Older Peoples Assessment Unit (OPAU) was managed across site by the medicine and urgent care division based at Barnet Hospital. The division was led by the divisional director, divisional director of operations, and the divisional director of nursing. A matron led nursing staff on Capetown ward and OPAU. The matron was supported by senior sisters for each unit.

The endoscopy unit was led by a clinical lead, senior sister and assistant operations manager for gastroenterology services. Staff informed us endoscopy was previously managed across three locations by the trust Transplant and Specialist Services (TASS) based at Royal Free Hospital but there was a move to place the unit under the local leadership of Chase Farm Hospital. By the time of our inspection, nursing staff were managed by Chase Farm Hospital. The senior sister for endoscopy reported to the senior clinical operations manager, theatres and endoscopy. Medical and operations staff were managed by TASS and medical staff were rostered across site.

Staff on all units visited were generally positive about the leadership team and felt the local leadership team were visible and approachable. They felt well supported by the local leadership. However, one staff in the endoscopy unit felt different management structures for nursing and medical staff was ambiguous. Nursing staff within the endoscopy unit felt being managed by Chase Farm Hospital management was better as they were easily accessible.

Staff within the endoscopy unit felt they were not always involved in the decision-making process by the executive team.

Vision and strategy

The trust had a vision for what it wanted to achieved and workable plans to turn it into action.

There was a clear vision and strategy for the trust which was to ‘deliver world class expertise and local care’. The trust had governing objects which set out how they will achieve their mission to be world class in terms of healthcare treatment, clinical research and teaching excellence.

Most staff were aware of the trust’s vision and we found the trust values (‘welcoming, respectful, reassuring and communicative’) were well embedded on the units visited.

During our last inspection we found a strong vision for developing services for patients living with dementia. At this inspection, we found that plans for a therapy and dementia garden had been implemented. The new Chase Farm Hospital which was in the planning stage at the time of our inspection in 2016 opened in Summer 2018. The OPAU and endoscopy unit were located within the new Hospital.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff were generally positive about the culture within medical services. Staff felt they had opportunities to develop in their role and felt they worked in a friendly environment. We noted some of the staff we spoke to had trained at the hospital and risen through the ranks to senior

positions. Staff felt part of the team and said they were well supported by their line managers. Staff informed us they enjoyed their job, liked dealing with patients and making a difference.

Notwithstanding the positive culture on the unit, some staff on Capetown ward felt the pending transfer of the ward to another trust had an impact on morale within the unit. Staff often left the unit to fill other substantive post within the trust. In addition, staff within the endoscopy unit were unhappy about the trust decision to implement three session lists during the week. They felt concerns about the unit's capacity to carry out the sessions were ignored.

Governance

The trust used a systematic approach to improve the quality of its services and care.
Medical care (including the OPAU and Capetown ward) sat under Barnet Hospital medicine and urgent care division.

Endoscopy was managed by Chase Farm Hospital management team, Barnet Hospital Surgery and Associated Services (SAS) and Royal Free Hospital Transplant and Specialist Services (TASS).

Regular cross-site governance meetings took place with staff from Barnet Hospital. These were attended by medical staff as well as senior nursing staff. A range of governance and quality issues were discussed such as risks, incidents, complaints, staffing and operational issues.

The endoscopy unit held bi-monthly audit meetings and reviewed results of audits in line with Joint Advisory Group (JAG) on endoscopy standards. Minutes of the meeting from June and September 2018 showed recommendations were made and action plans identified to address non-compliance with standards.

Cross-site governance meetings also included the gastroenterology and endoscopy directorate meeting. The OPAU held bi-monthly operational meetings attended by nursing and medical staff as well as social workers and operational staff.

There were monthly clinical performance and patient safety committee meeting for Chase Farm Hospital attended by senior medical and nursing staff as well as operational and governance leads. We reviewed notes of the meetings from July to November 2018 and noted staff discussed quality improvement projects for the hospital, CQC action plan from the last visit, risks, incidents and policies amongst others.

Management of risk, issues and performance

The trust had systems for identifying risks and planning to eliminate or reduce them. **However, not all risks we found were on the risk register**.

There was one risk on the risk register for medical care. This was the risk of unauthorised entry into Highlands wing of Chase Farm Hospital which houses Capetown ward, a stand-alone unit within the hospital. As at the time of our inspection, there was open access to the front sliding door to Highland wing enabling entry to anyone. The risk level was recorded as high but the consequence was recorded as minor. There were controls in place to mitigate the risk. Access to the ward was via secure entry and there was a camera at the door for staff to see visitors at the door. The ward was in consultation with estates to secure building between 9pm and 7am.

One of the risks on the risk register for endoscopy was the risk of endoscopy patients not being triaged prior to their procedure. The summary of actions planned to address the gaps indicted patients were admitted via the pre-admission team if they required a bed before the procedure.

Some of the risks we found during our inspection were not included in the risk register, in particular, nursing and therapy staffing on Capetown ward and the impact of the ongoing transition on staff morale. Therapy staff informed us they were not allowed to recruit due to ongoing transition to another trust. As a result, there were insufficient therapy staff, in particular occupational therapists (OT) to support neurology patients. Staff said they were unable to take some neurology patients due to lack of OT.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff informed us they could access information they needed to provide safe and effective care. Patient records were held on electronic systems in the OPAU and endoscopy unit, and staff used electronic password protected systems effectively.

The intranet was available to all staff and contained links to guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained therein.

All staff had access to their work email and senior staff informed us they provided organisational information and updates to staff on regular basis. Relevant information was displayed on notice boards in all clinical areas visited.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
Staff within the endoscopy unit informed us they were involved in designing the new unit. The estate management team received input from staff regarding the preferred location for pods and equipment and staff informed us this was mostly adhered to. Staff within the OPAU also confirmed they were involved in designing the unit within the new hospital.

The service engaged patients through feedback forms. Feedback from patients were used to improve the service. For example, in endoscopy, each pod included an en-suite toilet facility in response to patient feedback requesting for privacy when they undressed for the procedure.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning, promoting training, and innovation.

The endoscopy team received the outstanding staff celebration and rewards (OSCAR) award 2017/18 for being Chase Farm Hospital clinical team of the year.

A new digital patient check in system (In Touch) has been implemented which allowed patients to check in themselves when they arrived at the hospital and guided them to where they need to go to.

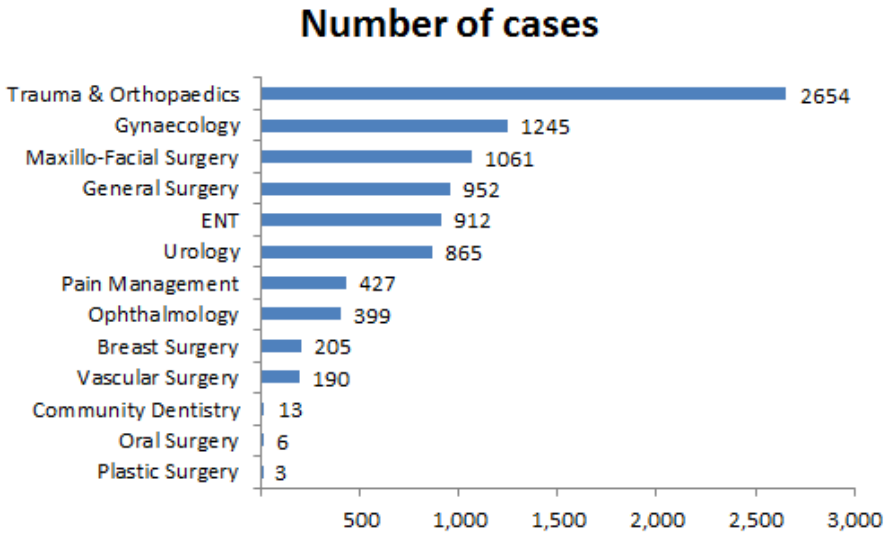
Most of the trust’s plans from our last inspection had been implemented. This included completion of the new Chase Farm Hospital and a dementia and therapy garden on Capetown ward.

Surgery

Facts and data about this service

Between November 2017 and October 2018, 9,019 surgical procedures took place at Chase Farm Hospital. Almost all of these were elective (planned) procedures. Patients requiring emergency surgery were seen at other hospitals within the trust.

Between November 2017 and October 2018 the trust reported the following breakdown of elective surgical procedures were carried out at Chase Farm Hospital:



At our previous inspection, in 2016, we rated surgical services at Chase Farm Hospital as good.

Shortly before this current inspection the service had re-located into a new, purpose-built hospital building. Whereas previously there were two surgical wards, Canterbury (18 beds) and Wellington (39 beds), at the time of this inspection there was now a new surgical ward with 50 beds. The surgical ward had 42 single en-suite rooms and two four-bedded single-sex bays for short-stay patients. There were eight operating theatres and a separate day surgery unit on the second floor.

At the time of the inspection, the surgical service was not yet operating at full capacity. The trust told us that although the new surgical ward had 50 beds only 40 were workforce commissioned and that one of the eight theatres was not yet workforce commissioned.
We spoke with 35 staff including doctors, nurses and allied health professionals and with four patients.

Is the service safe?

Mandatory training

Although the service provided mandatory training in key skills to all staff, not all staff had completed it.

The trust set a target of 85% for completion of mandatory training. The 85% target was met for 10 of the 17 mandatory training modules for which qualified nursing staff were eligible and six of the 17 mandatory training modules for which medical staff were eligible. Most staff told us they did not get time to complete training and had to do it in their own time. The service's clinical nurse educator told us there had been some challenges with staff completing face to face

training, including fire safety, as they were unable to pre-book slots.
We were told there were also issues with the trust's training system which did not always accurately reflect training that had been completed in real-time.
A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the surgery department at Chase Farm Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	89	90	98.9%	85%	Yes
Infection Control L1	87	90	96.7%	85%	Yes
Resuscitation L1	87	90	96.7%	85%	Yes
Fraud & Security	85	90	94.4%	85%	Yes
Basic Radiation Safety	84	90	93.3%	85%	Yes
Health & Safety Awareness	84	90	93.3%	85%	Yes
Waste Mgt	83	90	92.2%	85%	Yes
Emergency Planning	82	90	91.1%	85%	Yes
Moving and Handling	81	90	90.0%	85%	Yes
Resuscitation L2	77	90	85.6%	85%	Yes
Fire Safety	76	90	84.4%	85%	No
Infection Control L2	76	90	84.4%	85%	No
Information Governance	75	90	83.3%	85%	No
RTT L1	35	42	83.3%	85%	No
Equality, Diversity & Human Rights	69	90	76.7%	85%	No
Conflict Resolution	68	90	75.6%	85%	No
Blood Transfusion	62	89	69.7%	85%	No

At Chase Farm Hospital surgery department the 85% target was met for 10 of the 17 mandatory training modules for which qualified nursing staff were eligible.
A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the surgery department at Chase Farm Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Moving and Handling	14	21	66.7%	85%	No
Basic Radiation Safety	17	21	81.0%	85%	No
Blood Transfusion	18	21	85.7%	85%	Yes
Conflict Resolution	15	21	71.4%	85%	No
Emergency Planning	18	21	85.7%	85%	Yes
Equality, Diversity & Human Rights	17	21	81.0%	85%	No
Fire Safety	17	21	81.0%	85%	No
Fraud & Security	18	21	85.7%	85%	Yes
Health & Safety Awareness	18	21	85.7%	85%	Yes
Infection Control L1	19	21	90.5%	85%	Yes
Infection Control L2	15	21	71.4%	85%	No
Information Governance	17	21	81.0%	85%	No
IRR17			0.0%	85%	No

Resuscitation L1	16	21	76.2%	85%	No
Resuscitation L2	7	21	33.3%	85%	No
RTT L1	12	21	57.1%	85%	No
Waste Mgt	15	21	71.4%	85%	No
BPAT	19	21	90.5%	85%	Yes
WRAP			0.0%	85%	No

At Chase Farm Hospital surgery department the 85% target was met for six of the 17 mandatory training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had completed training on how to recognise and report abuse and they knew how to apply it.

The trust had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. Staff we spoke with knew how to escalate safeguarding concerns.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for qualified nursing staff in the surgery department at Chase Farm Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	88	90	97.8%	85%	Yes
Safeguarding Children L2	87	90	96.7%	85%	Yes
Safeguarding Adults L1	80	90	88.9%	85%	Yes
Safeguarding Adults L2	77	90	85.6%	85%	Yes

At Chase Farm Hospital surgery department the 85% target was met for all of the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for medical staff in the surgery department at Chase Farm Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	18	21	85.7%	85%	Yes
Safeguarding Adults L1	17	21	81.0%	85%	No
Safeguarding Children L2	17	21	81.0%	85%	No
Safeguarding Adults L2	15	21	71.4%	85%	No

At Chase Farm Hospital surgery department, the 85% target was met for one of the four safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Additional data provided by the trust following the inspection for December 2018 showed that compliance rates for medical staff met the trust target.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The environment was clean and staff followed infection control policies and procedures. There were visible cleaning schedules on the wards and operating theatres.

The infection prevention and control (IPC) team had carried out audits across all clinical areas prior to the opening of the new hospital building. Detailed feedback had been provided to staff following these audits and more recent audit results showed good staff compliance with hand hygiene and other IPC procedures.

We saw evidence that the new theatre areas had undergone a deep clean in July 2018 to ensure they were ready to be used when the service relocated into the new hospital building.

Staff complied with the trust's policy on being 'bare below the elbows' in clinical areas. Audit data provided by the trust, showed 99.4% staff compliance with hand hygiene between December 2017 and August 2018 on Canterbury ward and 100% on Wellington ward.

Staff had access to handwashing facilities, hand gel sanitisers and personal protective equipment (PPE), including gloves and aprons and we saw that staff used these appropriately.

We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal and staff followed appropriate waste segregation procedures.

All trusts that carry out orthopaedic surgery are required to submit data on surgical site infections (SSIs) to Public Health England (PHE). At Chase Farm Hospital, SSI data was collected on a year round basis in the categories of knee and hip replacement and submitted quarterly to PHE. The data included patients who had their surgery at the hospital and were subsequently admitted to another hospital site with an SSI. Data provided by the trust showed that infection rates at Chase Farm Hospital for knee and hip procedures were comparable with the national rate. Between July 2017 and June 2018, the service reported an infection rate of 0.6% (two cases) against the national average of 0.7% for knee replacement and 1.0% (three cases) against the national average of 0.9% for hip replacement.

The new surgical ward had been designed to reduce the risk of infection. Each patient had their own private en-suite room. Staff followed a standard operating procedure (SOP) to ensure orthopaedic patients were admitted to a dedicated area of the ward, furthest away from patients who had undergone gastro-intestinal (GI) procedures.

Staff used green 'I am clean' labels on equipment to indicate that it had been cleaned and was ready for use. All items of equipment we checked were visibly clean.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

During our previous inspection, we were concerned that many areas of the clinical environment were in need of repair or unfit for purpose, for example there were issues with the ventilation system in theatres. As the service had recently moved into a new, purpose-built hospital building these issues had now been addressed.

The surgical service had a comprehensive record of equipment which allowed for monitoring of servicing and maintenance. We saw evidence of annual maintenance and revalidation checks carried out on the operating theatres ventilation systems.

We saw daily checks of equipment such as oxygen cylinders, resuscitation equipment and suction machines were completed and documented by staff. Staff checked emergency trollies daily.

We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Decontamination and sterilisation of instruments was managed in a dedicated facility at Barnet General Hospital. The service had reported a large number of safety incidents related to issues with sterilisation of surgical instruments, primarily due to incorrect return of instruments from theatres. Senior staff told us that this issue was caused by staff in theatres returning instruments to the wrong trays. Although we were told about a new process of cross-referencing instrument trays which had been introduced to address this issue, we did not see this was happening in practice. However, we did observe staff carry out instrument and swab checks appropriately with two members of staff present. We heard there were plans in place for the SSD to move outside of the trust to an external provider, where all instruments would be cleaned, sterilised and returned off site.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. However, safety checks in theatres were not fully documented. The brief and de-brief steps of the safer surgery checklist were not fully compliant with national guidelines. Not all staff attended the brief and therefore not all staff were aware of key safety information relating to patient risk.

The hospital ensured that only patients who could be safely cared for post-operatively were admitted for surgery. The hospital had an admissions policy which listed clearly the types of procedures which were not suitable to be carried out at the hospital under any circumstances. The list included patients with specific risk factors or conditions for example, sickle cell disease. This admissions policy had recently been reviewed and some higher-risk procedures, including thyroidectomy no longer took place at the hospital.

All elective patients underwent a pre-operative assessment to assess their suitability for surgery at Chase Farm Hospital. A nurse reviewed the patient's general health and medical history and carried out tests to assess the patient's physical status. Patients identified as having additional risk factors (such as a body mass index over 40) were also seen by an anaesthetist to check whether it was safe for them to have a general anaesthetic or sedation.

The hospital had processes in place to ensure that patients were kept safe during their procedure. Theatre staff used the five steps to safer surgery, which included the three stages of the World Health Organisation (WHO) surgical checklist as well as a brief and de-brief, before and after the surgical list was completed.

The hospital governance team carried out observational audits of these safety steps and provided feedback to staff where opportunities for improvement were identified. A summary of observations from June and July 2018 highlighted that staff were not always fully engaged in the time-out and sign-out stages as these started before staff had finished what they were doing.

We saw that the three WHO stages of, 'sign in', 'time out' and 'sign out' were generally completed to a high standard. We observed several procedures where these checks were thoroughly completed with all staff engaged appropriately in the process. However, although we saw that the brief and de-brief stages were completed by staff these were not consistently structured in-line with national safety standards for invasive procedures (NatSSIPs). For example, there was no confirmation of the post-operative destination for each patient or patients' infection risk. We also observed some poor practice when a member of staff missed the brief and again when there was a staffing change to the surgical team post-brief. On both occasions, not all staff were present at

the brief, and key information, such as staff introductions, was not repeated. Although we also observed some good examples of brief and de-brief discussion between staff, these were not documented and therefore it was unclear how good practice or problems were recorded and fed back into any governance process. Therefore, opportunities to learn from incidents and share good practice were missed.

We saw some good examples of where staff had developed additional local safety checks including an additional time out check to ensure the brakes had been applied to the operating trolley. In response to a recent patient safety incident, staff were reminded to 'stop at the shop' which meant they must carry out additional checks to ensure they had the correct implant before continuing with the operation.

The hospital used the national early warning score (NEWS) to identify deteriorating patients. This is a basic set of observations such as blood pressure, respiratory rate, oxygen saturation, temperature and pulse rate, which are then used to calculate a score indicating the severity of a patient's acute illness. This system helped staff to identify patients who were deteriorating and provide them with increased support. Staff we spoke with understood how to escalate patients appropriately and told us that they were well supported by the ward's resident medical officer (RMO). Patients with a NEWS score of five or more were immediately escalated for review by the RMO and senior nursing staff. If necessary the patient was then moved to the enhanced surgical care unit (ESCU) for enhanced monitoring. Out of hours, the RMO had access to support from an on-call consultant team based at Barnet General Hospital.

The hospital did not carry out high risk or complex surgery as it did not have an intensive care or high dependency unit and therefore was unable to provide care to patients who were acutely unwell. This meant that patients who deteriorated post-operatively and were too unwell to be cared for on the ESCU would be transferred by ambulance to Barnet General or Royal Free Hospitals. All unexpected patient transfers were reported as patient safety incidents and investigated to identify causes, areas for improvement and shared learning.

Staff had access to a sepsis care bundle (sepsis 6) for identifying and managing sepsis. Any patients with suspected sepsis would be escalated immediately to the RMO and nurse in charge for review.

The hospital carried out a monthly audit of NEWS to measure staff compliance the trust's policy for identifying and escalating a deteriorating patient. Data provided by the trust for October 2018 showed 100% compliance with both accuracy and completeness of NEWS.

Although there was no on-site mental health support, staff could access support from the team at Barnet General Hospital who offered telephone advice or could come out to see patients if required.

The service had tested arrangements in case a patient experienced a life-threatening haemorrhage. Staff told us that they had recently taken part in a simulation which identified several key areas for improvement including communication between staff and access to blood for transfusion. We saw that guidance for staff was readily available both on the staff internet system and in paper form within a key documents folder on the surgical ward. As a result of the learning from the simulation a 'grab bag' of essential items had been introduced to help staff respond quickly in an emergency.

The hospital had processes in place to ensure patients were assessed for their risk of developing complications following surgery including, venous thromboembolism (VTE). VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis) and travels in the circulation, lodging in the lungs (known as pulmonary embolism). It

is important that VTE assessments are undertaken prior to surgery so as to reduce the occurrence of an embolism.

The trust electronic clinical system was designed to promote the completion of the VTE risk assessment within 24 hours. Reminders flagged up to medical staff to prompt them to complete the VTE risk assessment. Data provided by the trust showed that VTE screening rates were consistently above 90% in the six-months prior to our inspection.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

During the inspection, staffing levels were appropriate in all areas we visited. Staffing in theatres was based on national guidance. On the surgical ward, staffing levels were planned to meet patient acuity levels, with one nurse usually providing care for up to six patients. If there were any unexpected staffing requirements the department was authorised to use bank or agency staff.

The trust reported their nurse staffing numbers for surgery for March and August 2018 below.

	August 2018			March 2018		
Site	**WTE Scheduled**	**WTE in post**	**Fill rate**	**WTE Scheduled**	**WTE in post**	**Fill rate**
Royal Free Hospital	335.4	282.6	84.0%	343.6	307.4	89.5%
Barnet General	134.8	118.2	87.7%	144.5	124.9	86.4%
Chase Farm	94.7	77.5	81.9%	86.5	81.6	94.3%
Total	583.1	495.4	88.6%	589.6	528.8	85.0%

(Source: Routine Provider Information Request (RPIR) –Total staff tab)

This data shows that at Chase Farm Hospital, the nursing staff fill rate fell from 94% in March to 82% in August. This was due in part to the increase in planned staffing numbers in advance of the new hospital opening (an increase of 8.2WTE). During the same period the number of nurses in-post dropped by 4.1WTE. However, the service leads told us that at the time of the inspection the service was staffed for only 40 of the 52 ward beds and as they were only operating at 30% capacity, current staffing levels were adequate. We were also told that more recently the service had recruited additional nursing staff to accommodate the anticipated increase in demand, including six additional band 5 nurses due to start on the surgical ward before March 2019.

Previously, there had been two Band 7 ward managers, however following the re-location this had reduced to one. The structure of the ward environment made it challenging for one ward manager to keep effective visual oversight of all staff. We were told with the planned increase in activity this would be reviewed. The ward matron told us about plans to recruit two ward-based clinical navigators which would allow Band 6 nurses to provide additional support to the ward manager.

From September 2017 to August 2018, the trust reported a vacancy rate of 11.6% in surgery. This was lower than the trust target of 12%. The vacancy rate for nursing staff at Chase Farm Hospital was better than both the trust target and the trust average, at 10.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 21.4% in surgery. This was higher than the trust target of 13%. The turnover rate for nursing staff at Chase Farm Hospital was better than the trust average, at 16.3%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 4.7% in surgery. This was higher than the trust target of 3.5%. The sickness rate for nursing staff at Chase Farm Hospital was worse than the trust average and target, at 6.6%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported a bank usage rate of 12% and an agency usage rate of 1.4% in surgery. There were 4.2% of hours available unfilled by either bank or agency staff. Bank and agency staff use was lower for nursing staff at Chase Farm Hospital than the trust average, at 6% and 1% respectively. The proportion of unfilled shifts was higher, at 9%.

Site breakdown can be seen below:

Site	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Barnet	278,100	26,727	10%	6,398	2%	14,674	5%
Chase Farm	198,808	11,661	6%	1,034	1%	18,280	9%
Royal Free	735,248	108,225	15%	10,179	1%	18,988	3%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Resident medical officers (RMOs) provided medical cover on the surgical ward. RMO cover was provided 24-hrs a day, seven days a week, with two RMOs covering the day shift and one at night. Nursing staff told us that there was always sufficient medical support available and RMOs responded quickly to any request for support

Surgeons carried out procedures at both Barnet General and Chase Farm Hospitals and therefore data provided by the trust below did not accurately reflect our findings on inspection. We were told that medical staff rotated between the two hospitals, ensuring theatre lists were always appropriately staffed. Staff we spoke with told us there were no issues with the medical staffing rota at Chase Farm Hospital.

Data provided by the trust for August 2018 showed that the surgery service at Chase Farm Hospital was scheduled to have 36 WTE medical staff, however only 20.3 WTE were in post at that time. The hospital's medical director told us that as the new theatres were not operating at full capacity yet they were only budgeted for 30 WTE and they had recently recruited some new clinical fellows to cover any gaps in rotas. We were told that a further medical staffing establishment review was planned to support the planned expansion of the orthopaedic service.

The trust has reported their staffing numbers below for the period September 2017 to August

2018. Fill rate in August 2018 was 94% a slight reduction compared to the March 2018 fill rate.

	August 2018			March 2018		
Site	**WTE Scheduled**	**WTE in post**	**Fill rate**	**WTE Scheduled**	**WTE in post**	**Fill rate**
Royal Free Hospital	213.3	214.6	101.4%	208.4	214.0	103.7%
Barnet General	84.7	79.6	94%	84.7	78.4	93.0%
Chase Farm	36.0	20.3	56%	42.0	28.9	69%
Total	333.9	314.4	94%	335.1	321.1	95.8%

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Medical staffing fill rate at Chase Farm Hospital was much worse that the trust average (94%) and had declined from 69% to 56% between March 2018 and August 2018.

From September 2017 to August 2018, the trust reported a vacancy rate of 2.4% in surgery. This was better than the trust target of 12%.

Site breakdown can be seen below:

- Chase Farm Hospital surgery department: 55.7%
- Royal Free Hospital surgery department: -4.9%
- Barnet General Hospital surgery department: 8.3%

The negative value indicates that there were more WTE in post than originally scheduled.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The medical staffing vacancy rate at Chase Farm Hospital was much worse than the trust target and trust average.

From September 2017 to August 2018, the trust reported a turnover rate of 9.2% in surgery. This is better than the trust target of 12%

Site breakdown can be seen below:

- Royal Free Hospital surgery department: 11.9%
- Barnet General Hospital surgery department: 2%
- Chase Farm Hospital surgery department: 0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

The trust reported there had been no turnover in medical staff at Chase Farm Hospital between September 2017 and August 2018. However, data provided by the trust on medical staff fill rate showed that the number of in-post medical staff had declined from 28.9WTE to 20.3WTE.

From September 2017 to August 2018, the trust reported a sickness rate of 0.7% in surgery. This is better than the trust target of 3.5%.

Site breakdown can be seen below:

- Royal Free Hospital surgery department: 0.9%
- Barnet General Hospital surgery department: 0.3%
- Chase Farm Hospital surgery department: 0.7%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

The sickness rate for medical staff at Chase Farm Hospital was better than the trust target and in line with the trust average.

From September 2017 to August 2018, the trust reported a bank usage rate of 3.1% and a locum usage rage of 1% in surgery. There were 0.8% of scheduled hours which remained unfilled by bank or locum staff.

Site breakdown can be seen below:

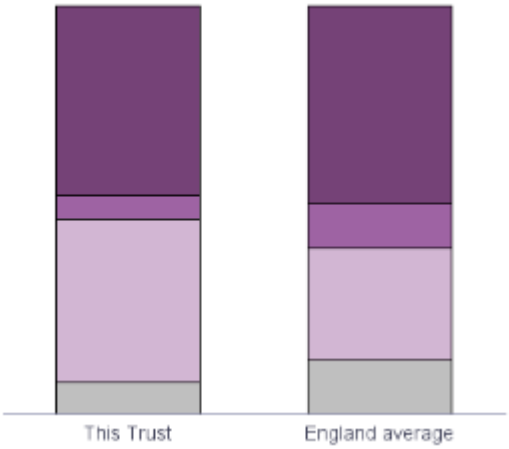
Site	Total hours available	Bank Usage		Locum Usage		NOT filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Barnet	165,647	4,415	3%	3,616	2%	12,547	8%
Royal Free	409,219	13,343	3%	2,011	0%	-8,063	-2%

The trust told us that the negative values are for areas where total hours plus agency and bank hours have exceeded the establishment (effectively unfunded hours). This will need to be investigated to understand why.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

From July 2018 to July 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at Royal Free London NHS Foundation Trust



	This Trust	England average
Consultant	46%	48%
Middle career^	6%	11%
Registrar Group~	40%	27%
Junior*	8%	13%

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

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The hospital had recently introduced a new electronic patient records system (EPR) which had been operational for approximately three weeks prior to our inspection. Staff were generally positive about the new system and were able to demonstrate how they could find and update relevant sections of the patient's records.

However, not all staff were aware of the contingency procedures should there be problems with the electronic system. We saw an example of where problems with accessing the anaesthetic record on EPR in theatres, led to the delay of a procedure in theatres as staff were unsure of the process.

Nursing staff recorded their routine patient observations (blood pressure, temperature etc.) directly into the electronic system along with assessments such as fluid balance and venous thromboembolism (VTE). We looked at three sets of patient's notes; these were comprehensive and well documented and included appropriate risk assessments of falls, pressure areas and nutritional status. We saw care plans had good evidence of multi-disciplinary input.

Audit data provided by the trust, showed 100% compliance with documentation between December 2017 and August 2018 on Canterbury ward and 94.5% on Wellington ward. More recent audit results for the new surgical ward for September and October 2018 were 93% and 94%.

Consent forms were completed appropriately on the day of surgery, however evidence of information provided to the patient prior to the day of surgery was not documented. This was not in line with the trust's consent policy. Senior staff told us that this was currently under review. Once completed, consent forms were scanned in and uploaded to the electronic system to ensure that all information relevant to the patient was available to staff.

We saw that the WHO checklist was completed electronically for all patients but the additional brief and de-brief steps were not documented. The trust provided evidence of observational audits of the five steps to safer surgery and WHO checklist.

Medicines

Although the service generally followed best practice when prescribing, giving and recording medicines, we found some medicines were not stored in line with trust policy.

Although medicines (including controlled drugs) were generally stored securely, we saw an intravenous (IV) fluid store on the surgical ward without a lock; therefore access was not restricted appropriately. This was on the trust's risk register and staff told us that they were working towards rectifying this.

Staff monitored temperatures of medicines storage areas. When temperatures were found to be outside of the required range, staff did not always take action to safeguard the stability and effectiveness of medicines.

Medicines and equipment for use in emergencies were readily accessible to staff and were checked regularly. Pharmacy staff visited wards each day and conducted medicines reconciliation. Medicines reconciliation is the process of ensuring that the list of medicines a person is taking is correct. Staff could access medicines supplies and advice out of hours. Pharmacists and pharmacy technicians counselled patients on their medicines. There was a satellite pharmacy dispensary for the surgical ward; this reduced waiting times for patients needing medicines to be dispensed.

Other than the IV fluid store room, we found medicines were stored securely in locked cabinets and fridges within locked clinical treatment rooms. Only relevant clinical staff could access them. This was usually via swipe card access.

Certain medicines fridges had their temperatures monitored automatically by the pharmacy department with the use of a data logger (e.g. the big pharmacy fridge in day surgery). Other medicines fridges were monitored manually by staff. We saw evidence staff monitored and recorded this information. Staff also recorded ambient room temperature readings in most areas where medicines were stored.

In the areas we visited, we saw these temperatures were within the required range. However, records showed that where temperatures had exceeded the required range, staff had not documented any action taken. Staff were not always sure what to do if fridge, or ambient room temperatures, fell outside the normal range.

Controlled drugs (CD) were stored and managed appropriately. CDs were checked at least once daily by two members of staff. Pharmacy staff conducted quarterly controlled drugs audits. Staff accessed national medicines guidelines and trust policies from computers on the ward.

There were various emergency trollies containing resuscitation equipment (including oxygen cylinders and an automated external defibrillator). They were checked regularly. We saw tamper evident seals were in place for emergency drug boxes. Oxygen cylinders were full and within date.

In theatres, medicines for emergency use were stored together in a readily accessible tray. We did not see emergency medicines drawn up in advance. We were told that anaesthetists drew up their own emergency syringes for use. If not, the operating department practitioners drew them up under the direct supervision of the anaesthetist who wanted to have them available.

Blood glucose monitors were calibrated at least every 24 hours. We saw that only trained staff could use them. Any concerns were reported to the ‘point of care’ testing team.

Staff had access to sharps bins which were managed appropriately. All unwanted medicines (including CDs) were returned to pharmacy.

Staff could access medicines out of hours via the on-call pharmacist and the site manager. There was also an emergency drug cupboard located within the hospital.

Staff could access a stock list for each ward to assist when looking for medicine stock.

We saw that irrigation fluids stored in warming cabinets for use in theatres were labelled with the date that they had been placed inside the warming cabinets. Staff told us that irrigation fluids were kept in the warming cabinet for a maximum of 30 days before being disposed of, in line with the trust’s policy. However, the manufacturer recommendations are that certain fluids be kept for no longer than 14 days. We saw two bags of irrigation fluid had been in the warming cabinets for

longer than the recommended 14 days. We asked to see a copy of the trust's policy on warming fluids but they did not provide this. We were not assured that the trust had a policy in line with manufacturers' recommendations on the management of IV fluid bags being warmed in theatres.

All patient demographics and allergy statuses were recorded on the prescription charts. Electronic prescription charts were signed after each dose was administered. The electronic prescription chart was designed in such a way that prompted a review of antibiotics after 48 hours in line with trust policy. Staff could also access a microbiology team for advice on the use of antibiotics. A pharmacist visited the wards each day and screened prescription charts and spoke to the multidisciplinary team. Of the electronic prescription charts that we saw, we did not see any unexplained gaps in the administration of medicines.

Staff in day surgery could access pre-labelled medicines to give to patients on discharge. Staff had to be trained to do this process, and a witness had to sign to say that they had double checked what had been dispensed in accordance with the discharge summary.

Patients could discuss any medicines queries with the ward based pharmacy staff. Patients being discharged on new medicines were given counselling by nurses, pharmacy technicians or pharmacists.

Incidents

We were not assured that there was a robust process in place to prevent incidents from reoccurring. Evidence of completed actions in response to serious incidents, was not robust. Staff told us they reported incidents infrequently and therefore opportunities to learn from near-misses were lost. We were not assured that there was a robust culture of incident reporting.

Staff used a trust-wide electronic incident reporting system to record and report incidents.

Data provided by the trust showed the staff had reported 481 incidents between November 2017 and October 2018. Of these, 432 were 'no harm', 36 were 'low harm' and three were 'moderate harm'. Only ten 'near misses' were reported. Of the moderate harm incidents, one related to a patient fall and two were patients who deteriorated and required an unplanned transfer to Barnet General Hospital. Almost half (204) of all incidents were related to issues with sterilisation of surgical instruments, primarily due to incorrect return of instruments from theatres (143). Staff told us that this issue was due to instruments becoming lost after they were returned to the sterile services department (SSD) rather than being lost in theatres. Senior staff told us that this issue was caused by staff in theatres returning instruments to the wrong trays. Other staff told us that the issue was caused by staff in the SSD misplacing instruments. Although we were told about a new process of cross-referencing instrument trays which had been introduced to address this issue, we did not see this was happening in practice.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported eight incidents classified as never events for surgery. Two of which occurred at Chase Farm Hospital. Both related to wrong site surgery and both occurred in April 2018.

Both serious incidents were investigated by the hospital's quality governance lead with evidence of appropriate senior clinical input. Root causes identified included, human error in transferring information about the procedure between systems and failure to carry out all appropriate safety checks effectively in theatre in line with the five steps to safer surgery. We saw that detailed action

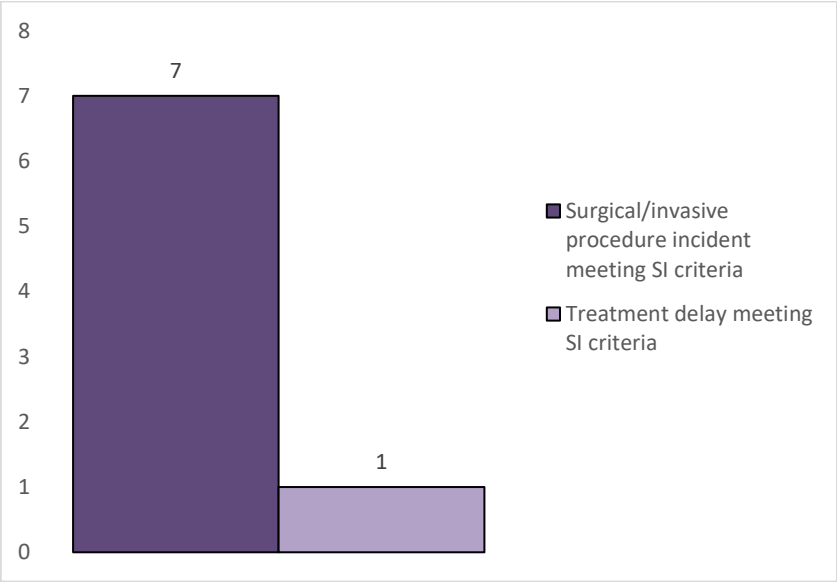
plans had been developed to achieve recommendations for improvement with the aim of preventing incidents from reoccurring.

At the time of our inspection, all actions other than trust-wide roll-out of the new electronic patient record (EPR) system were recorded as complete. However, some of the evidence provided by the trust as evidence of completed actions was not robust. For example, we saw that spot checks had been carried out in theatres to observe safety checks were being completed appropriately by staff; however, these checks were inconsistent and did not review the brief and de-brief stages. Additionally, evidence of conversations with surgeons about the incidents and their root causes was limited, with only one of the 11 surgeons interviewed having their responses documented.

During the inspection, although we saw evidence that some recommendations had been implemented, including removal of staggered patient arrival times, we also saw examples of poor practice in theatres where not all staff were fully briefed on important patient safety information.

We were told that local governance staff were responsible for making the final decision as to whether actions had been completed. We were not assured there was sufficient senior clinical oversight of this process to ensure consistency across the trust.

During our previous inspection, staff told us they did not always have time to report incidents as they were too busy and did not always receive feedback. During this inspection, some staff told us they had worked at the hospital for several years but reported only one or two incidents, if any. Some medical staff we spoke with told us they had never had to report an incident. Aside from unexpected patient transfers and surgical instrument issues, most staff were unable to share examples of where they had reported a patient safety incident or near miss. Junior doctors had limited knowledge of incidents and RMOs told us they rarely reported any incidents. This was reflected in the low number of ‘near miss’ incidents reported over the 12-month period prior to our inspection. Therefore, we were not assured that there was a robust culture of incident reporting.

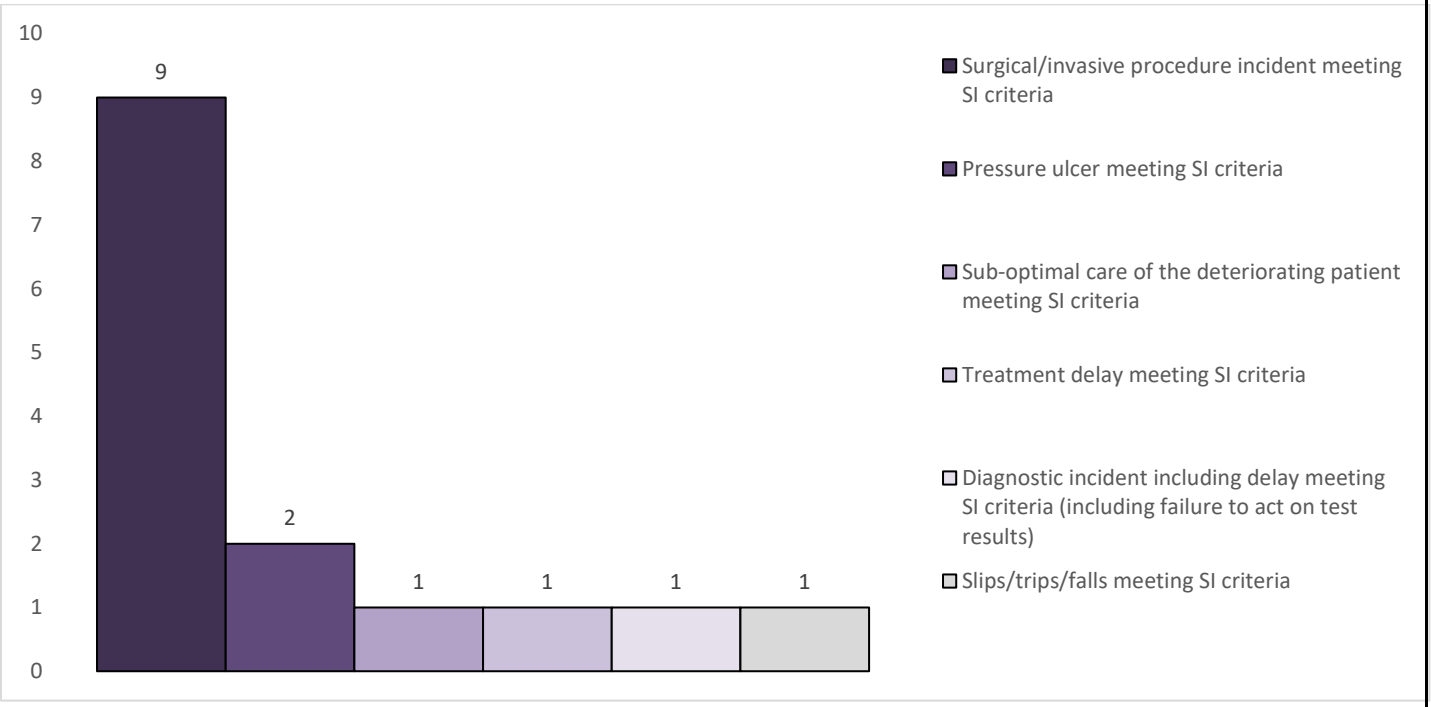


(Source: Strategic Executive Information System (STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2017 to September 2018.

The breakdown of the different types of incident reported were

- Surgical/invasive procedure incident meeting SI criteria with nine (60% of total incidents)
- Pressure ulcer meeting SI criteria with two (13.3% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (6.7% of total incidents)
- Treatment delay meeting SI criteria with one (6.7% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (6.7% of total incidents)
- Slips/trips/falls meeting SI criteria with one (6.7% of total incidents)



(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 18 new pressure ulcers, two falls with harm and eight new catheter urinary tract infections from September 2017 to September 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Royal Free London NHS

Foundation Trust

1 **Total Pressure ulcers (18)**

2 **Total Falls (2)**

3 **Total CUTIs (8)**

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Safety thermometer data was displayed for staff, in the ward's staff meeting room, but was not visible to patients or visitors. The ward matron said this was because they were still awaiting the boards needed to display this information.

Data displayed on the ward during the inspection showed that there had been no pressure ulcers for 91 days, no falls for 69 days and no hospital acquire infections for 91 days. Staff compliance with hand hygiene was 100%.

We saw "Please call, don't fall" signs had been place in each patient room. Staff told us that since they introduced these signs, two months ago, they had not had any patients fall.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff were able to access national and local guidelines through the trust's intranet. On the ward, we saw that paper copies of key documents, including the ward's safe operating procedure (SOP) and the hospital's escalation and transfer policies, were accessible to staff in case of IT downtime.

We saw there was a comprehensive policy review schedule which categorised policies by clinical priority and documented their target review date and person responsible.

Staff provided care and treatment in line with National Institute for Health and Care Excellence (NICE) guidelines. For example, we saw that patients assessed to be at risk of venous thromboembolism (VTE) were offered appropriate VTE prophylaxis in accordance with NICE guidance.

The trust had a clinical audit programme to support and monitor care and treatment and ensure NICE guidelines were followed. Surgical specialities held regular audit days to share the outcomes of any audits and review best practice. Ear, nose and throat (ENT) audit meeting minutes from June 2018 showed this meeting was well attended and included a review of patient outcomes. General surgery audit meeting minutes from November 2018 included topics such as managing patients with learning difficulties.

Across the trust, the surgical division had initiated a clinical practice group (CPG) to develop clinical pathways for a variety of specialisms such as; vascular surgery, pre-operative assessment, epistaxis (nose bleeds), acute tonsillitis, benign breast pathway, lower gastro-intestinal disorders and elective hip and knee replacements.

The aim of the clinical pathway development was to reduce any variation in clinical practice and process by implementing evidence-based standardisation in clinical practice to improve patient outcomes.

At Chase Farm Hospital, CPGs for hip and knee procedures were built in to the electronic patient record (EPR) system. This provided a comprehensive care pathway for patients in three phases, the first being immediately after their procedure, followed by daily mobilisation goals and then finally the day of discharge. These pathways had been developed by clinicians with input from allied health professionals and patients. There were plans to introduce similar standardised care pathways for patients having gynaecology procedures.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff used a five-step malnutrition universal screening tool (MUST) to identify patients who were malnourished or at risk of malnutrition. Audit data for December 2017 to August 2018 showed compliance rates were consistently high at 93% and 98% for surgical wards.

Prior to surgery patients were required to fast for six hours and drink only clear liquids until two hours before their operation. Until recently, the times patients were asked to come in for their surgery were staggered across the day however to improve patient safety all patients were now asked to come in at either 7am for the morning list or 12pm for the afternoon list. This meant that if lists over-ran, as staff told us they frequently did, some patients were waiting for up to eight hours before their procedure. Staff told us that if there was a delay they would ensure patients were informed and that they were able to have a drink of water.

The trust told us that there had been no audit of patient fasting time carried out within the last 12 months however one was scheduled to be completed in 2019 by the anaesthetic department.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We found patient’s pain continued to be managed well, with staff giving consideration to the most appropriate pain management methods. Patients told us they were assessed regularly for pain

and provided with additional pain relief when they needed it. We saw staff responding quickly to patients who reported pain.

Staff used a trust-wide pain assessment tool which incorporated a pain score and an algorithm for prescribing pain relief. These pain tools were integrated in to the electronic patient record system. Patient's pain was scored on a 0-10 scale and was assessed at rest and on movement. These were captured as two separate scores to monitor and support the patient's recovery.

If patients were unable to communicate verbally, staff used a pain assessment tool based on non-verbal cues including facial expression and movement.

Staff told us that patient controlled analgesia (PCA) was no longer used regularly as it restricted the patient's mobility and therefore did not support the patient's recovery. Instead, alongside pain medication other less invasive techniques were used including ice therapy which the patient was supported to apply themselves.

Staff on the ward had support from the trust's pain nurse specialist team who would assist with training and giving expert advice where necessary.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

There were a number of ongoing quality improvement projects which focussed on improving patient outcomes and the effectiveness of service delivery. For example, CPGs for hip and knee procedures were built in to the electronic patient record (EPR) system which provided a standardised approach to patient care and better patient outcomes. The trust was using CPGs to redesign patient pathways based on best practice and outcome data.

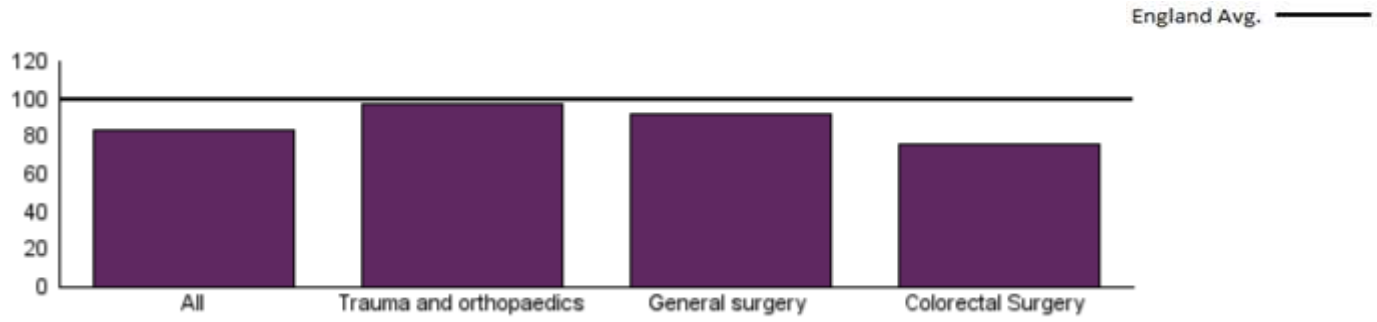
The trust told us that during the 12 months prior to our inspection, of the 9,019 procedures that had taken place at Chase Farm Hospital; there had been only eight unplanned returns to theatre.

From June 2017 to May 2018, all patients at Chase Farm Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Of the top three specialties based on number of admissions:

- Trauma and orthopaedics patients at Chase Farm Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Chase Farm Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at Chase Farm Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - *Chase Farm Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive

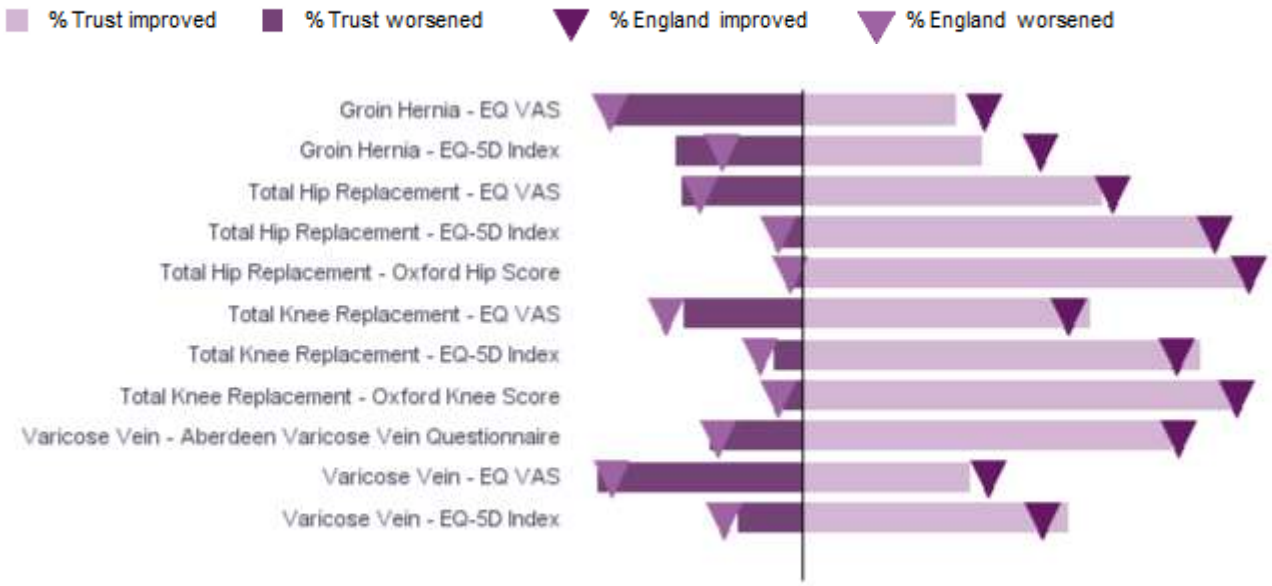
finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

(Source: Hospital Episode Statistics)

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.



In 2016/17 performance on groin hernias was worse than the England average.

For Varicose Veins, performance was about the same as the England average. Performance in the EQVAS indicator was worse than the England average but in the EQ-5D index performance was better.

For hip replacements, performance was about the same as the England average.

For knee replacements was better than the England average for both the EQ VAS and EQ-5D Index indicators.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.

The service had a dedicated Band 7 nurse practice educator who was responsible for ensuring nursing staff had completed the appropriate training and competencies for their role. They had also organised several clinical simulation training events to raise awareness of risks and identify areas for learning. Recent simulations included a major haemorrhage (severe bleeding) simulation in theatres and a patient with anaphylaxis (a serious allergic reaction) simulation on the ward.

Staff told us they had found these simulations useful in identifying gaps in knowledge and areas for improvement.

As well as structured training for staff, via workbooks and face to face sessions, the nurse practice educator carried out informal 'knowledge checks', for example to ensure staff knew the location of emergency equipment.

Data provided by the trust showed that all staff had completed the appropriate level of resuscitation or life support training, with all staff having completed level 1 and 93% completed level 2. Nursing staff assigned to the enhanced surgical care unit (ESCU) had received additional life support training (ILS 4). The practice educator had a background in high-dependency care and had therefore been able to provide additional training to staff on-site to ensure they were competent to deliver safe care to patients in the ESCU.

As part of the trust-wide service re-organisation, patients for elective gynaecology procedures were now seen at Chase Farm Hospital. The ward matron had a background in this speciality and had delivered additional training for nursing staff to improve knowledge and expertise in this specialism. We were told about plans to introduce an advanced nurse practitioners (ANP) role for both gynaecology and orthopaedics as the two main specialisms seen at the hospital. ANPs would be able to prescribe medicines and would work along-side the RMOs on the ward. This was part of the hospital's strategy to become 'nurse-led' through a 'grow your own' approach to developing competency and expertise in nursing staff.

There were several other examples of where staff were being supported to develop, including health care assistants (HCAs) supported to become nurses via the trust's internal apprenticeship programme and several leadership programmes including 'step up to lead' and 'license to lead'.

Junior doctors told us they were generally well supported by consultants and had appropriate access to training and supervision.

Most staff told us they told us they felt support to develop in the role and they had regular appraisals and one to one meetings with their managers.

From September 2017 to August 2018, 75.8% of staff within urgent and surgery care at the trust received an appraisal compared to a trust target of 85%. At Chase Farm Hospital appraisal completion rate was 83.3% which was better than the average for the surgical division.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We saw numerous examples of excellent multidisciplinary team working (MDT) between different groups of staff. On the ward, staff held a daily morning MDT meeting which we was well attended by nursing, medical and allied health professional staff. In theatres, we observed good team-working and communication between staff at all levels. Staff at all levels were actively engaged during clinical simulations and feedback on team-working in response to emergency incidents was positive.

The new CPG pathways had been developed with extensive MDT input including clinicians, nurses, allied health professionals and patients. Therapies staff told us they had been consulted on the design of the new surgical ward, to ensure the environment would meet patient needs and support the delivery of effective care.

The new hospital had been designed to encourage closer multidisciplinary team working, for example, hot desking was encouraged with staff of different levels working alongside each other. In theatres, there was now one combined staff room for all staff. Staff told us that the shared space helped to improve teamwork by removing barriers to communication. Staff told us it helped with creating the sense of them being part of 'one team'.

Nursing handovers were completed at the start and end of each shift. Handovers we observed included all relevant patient information. The ward matron attended the weekly transfer review meeting in order to review any patients who had been transferred out to another hospital and provide feedback to staff.

Chase Farm Hospital had introduced a new mobile intercom across the new hospital site. As well as allowing nurses on the surgical ward to speak to the patient directly via a mobile intercom system, the system supported more efficient communication between staff who could contact each other directly using the mobile devices.

Seven-day services

At Chase Farm Hospital, patients admitted to the surgical ward were reviewed by resident medical officers (RMOs) on admission. Nursing staff told us that there was always sufficient medical support available and RMOs responded quickly to any request for support.

The hospital had a team of 10 (8.52WTE) physiotherapy and occupational therapy staff who provided services for elective orthopaedic patients. Staff worked one weekend in four to ensure there was cover available seven days a week.

There was no provision for speech and language therapy (SLT) or dietetics for the surgical ward as the trust told us these services were very rarely required. However, if a patient did require either SLT or dietetics, the ward staff contacted the therapy service lead who was able to arrange to provide support on an ad-hoc basis.

The trust told us a review of allied health professional services was underway and they were continuing to gauge the requirements for all four professions since the hospital had opened to general surgical patients.

Pharmacy staff visited wards each day and conducted medicines reconciliation. Staff could access medicines supplies and advice out of hours via the on-call pharmacist and the site manager. There was a satellite pharmacy dispensary for the surgical ward. This reduced waiting times for patients needing medicines to be dispensed.

Health promotion

Patients were supported and encouraged by staff to take ownership of their recovery which helped to improve patient outcomes.

Enhanced recovery was well embedded into the patient pathway for orthopaedic patients. This included initiatives throughout the patient journey to help achieve the best outcome for the patient. All patients having a hip or knee replacement procedure were offered a place at 'joint school' which provided them with information on how to prepare for surgery and what to expect during their recovery. The service planned to introduce a similar approach for other specialities, including gynaecology.

We saw examples of various patient information leaflets given to patients at their pre-assessment appointment to help them understand the potential complications of their procedure and what they could do to help minimise these risks. For example, we saw a brief guide for patients on prevention of blood clots which encouraged patients to do leg exercises and drink plenty of fluids whilst in the hospital and after they had been discharged home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Although staff understood how and when to assess whether a patient had the capacity to make decisions about their care, they did not consistently follow the trust policy to ensure the consent process was appropriately documented.

The trust's policy on consent was under review at the time of our inspection. The current consent policy recommended a two-stage consent process for all surgical procedures. The first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead with the procedure. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

The two-stage process was not documented on any of the consent forms checked during the inspection. Consent was done on the day of surgery in all cases. Senior nursing staff told us that currently the two-stage process was only completed for spinal surgery but this was under review with plans to expand this to all elective procedures.

The trust's policy also stated that patients receiving elective treatment or investigations for which written consent was appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process. We did not see evidence that this was happening in practice.

The trust reported that from April 2018 to August 2018 Mental Capacity Act (MCA) and DOLS training was completed by 81.8% of staff in surgical care compared to the trust target of 85%. However, at Chase Farm Hospital 90% of staff within the surgery department had completed this training which was better than both the target and trust average.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patients we spoke with were generally very positive about the care they had received from staff. One patient told us that they, "could not have asked for better care" and that staff had treated them with "kindness and understanding." We saw several cards which had been sent by patients to thank staff following their stay. One thanked staff for supporting them with, "kindness and care" and another said, "Wonderful care, great team." Staff were repeatedly described as, "kind" and

“cheerful.” Another patient thanked staff for the support they had received and said, “I felt very reassured in your gentle hands.” We saw that staff treated patients with kindness and compassion, taking time to ask them ask how they were and listening to any concerns.

We saw that staff made an effort to ensure the patient’s privacy and dignity was maintained as much as possible at all times. In theatre, patients were left covered for as long as possible. We saw that additional screens were used in the barn theatres which helped maintain patient privacy.

The trust took part in the NHS Friends and Family Test which asked patients whether or not they would recommend the services to friends and family. Between September 2017 and August 2018, the percentage of patients recommending the surgical wards at Chase Farm Hospital varied from 89% and 99%. The overall response rate of 61% was significantly better than the trust and England averages. The Friends and Family Test response rate for surgery at Royal Free London NHS Foundation Trust was 45% which was better than the England average of 27% from September 2017 to August 2018.

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	
CF-WELLING	723	59%	99%	96%	96%	96%			95%		94%	96%		97%	91%
5 EAST B	708	45%	92%				84%	95%					85%	98%	89%
7 NORTH	585	53%								88%				88%	87%
CF-CANTER	576	61%	100%					98%		98%				89%	78%
9 WEST	542	52%	91%	89%		81%		73%					91%	82%	86%
BH-DAMSON	518	45%	88%	89%	84%	90%	72%	78%	94%		91%		84%	87%	86%
5 NORTH A	444	38%	97%	88%	95%	78%		90%	90%	74%	92%			80%	89%
7 WEST	405	43%	96%		88%	86%	91%	95%		87%	93%	93%	89%	81%	90%
BH-CEDAR	391	38%	84%	85%	93%	94%	97%	81%	89%	89%	76%	88%	89%	80%	87%
7 EASTB	210	62%	87%	97%	88%	88%	87%		91%	67%	100%	83%	100%		90%
BH-BEECH	196	30%	91%	100%	76%	71%	89%	95%	80%	80%	81%	95%	79%	91%	86%
7 EAST A	178	33%	80%	94%	71%	75%	100%	79%	81%	90%	88%	87%	100%		85%

Key — Highest score to lowest score: 100% | 50% | 0%

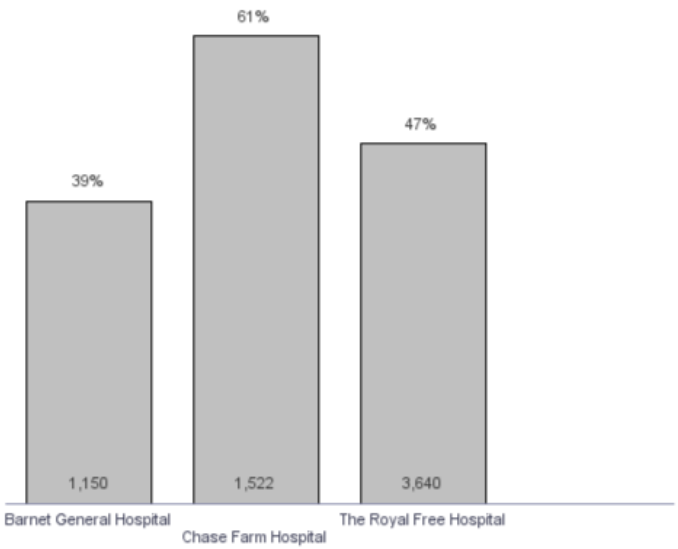
[1] The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).

[2] Sorted by total response.

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

Note: sorted by total response

Friends and family test response rate at Royal Free London NHS Foundation Trust, by site.



(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress.

We saw that where staff were preparing a patient for surgery they included the patient in all conversations about their care. Staff explained what would happen next, answered any questions and offered reassurance.

One patient told us that they had initially been “very worried” about what to expect but that staff had put them at ease by taking the time to explain what would happen.

Patients and visitors had access to a multi-faith room which was a quiet space which could be used for reflection and prayer. The room was accessible seven days a week and a multi-faith team of chaplains was available to provide additional support if needed.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We saw that staff in the pre-assessment clinic made sure that patients understood the procedure they were going to have and had an opportunity to ask questions.

The therapies team supported patients to take an active role in their treatment and recovery. Patients who were undergoing a hip or knee replacement were able to attend a half-day ‘joint school’ which provided them with information about how to prepare for their procedure. Patients told us they had been involved in planning their discharge home and how the equipment they needed to help them mobilise once home was already in place before they had their operation.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The new Chase Farm Hospital building had been designed and developed to improve efficiency in service delivery and to meet the needs of the local population.

As part of the trust’s new operating model Chase Farm Hospital was now where the majority of the trust’s planned (elective) surgery took place. The hospital offered extended outpatient opening hours until 8pm, Monday to Thursday, which allowed patients attending for a pre-assessment appointments greater choice and flexibility.

The opening of the new hospital building had seen the opening of four new ‘barn theatres’ specifically designed for orthopaedic procedures such as hip and knee replacements. This new theatre suite was one of only three in use across England and the only one in use in the London area. The barn theatre’s open-plan design allowed for safer and more efficient staffing with increased ability for senior supervision and a more effective use of space.

To help patients and visitors find their way around there was a concierge service in the main lobby. Each floor of the hospital was broken down into zones with clear signage indicating where services were located. Each floor was themed with a separate colour based on the trust values. Staff and volunteers were readily available to help provide directions if needed.

The design of the service allowed the majority of patients to be discharged home after their procedure without having to be admitted to the ward. Data provided by the trust showed that 96%

of patients were discharged home on the day of their procedure. The day surgery unit was open until 10pm at night to help facilitate this.

The hospital had recently started providing a maxillo-facial fracture pathway which allowed patients waiting for surgery at Barnet General Hospital to be transferred to Chase Farm Hospital and therefore seen more quickly.

Meeting people's individual needs

The service took account of patients' individual needs. The service made adjustments for patients' religious, cultural and other preferences.

All patients admitted overnight were given a private room. Each room had its own en-suite bathroom with a toilet and shower. Adaptations were in place to ensure the facilities were accessible to patients with limited mobility, including handrails and double-doors that could accommodate a wheelchair. Chairs in the sitting room areas had arm-rests which made it easier for patients to sit and stand.

There was a welcome mat on each bed's tray table which included key information about the ward, including meal times and staff uniforms and roles.

If patients needed assistance and rang the call bell, staff were able to speak to the patient directly via a mobile intercom system. This provided nurses with the ability to reassure patients prior to attending their room and ensure that their needs were addressed quickly. However, not all patients we spoke to were aware of this function.

Patients we spoke with were very impressed with the facilities and the ward environment. They told us it was very quiet on the ward at night which meant they were able to sleep without disturbance. Privacy blinds allowed staff to check on patients without having to enter the room.

Visiting hours were 11am to 8pm although staff were flexible with this and visitors could attend outside of these hours if needed.

Although patients and visitors had access to free Wi-Fi, staff and patients told us that this was sometimes unreliable. As phone signal was also poor at the hospital's location, patients told us this sometimes made it challenging to keep in touch with relatives.

The surgical ward had two designated sitting rooms which could be used by patients and relatives. These provided comfortable seating, including recliner chairs, televisions, magazines and a water fountain. In the main day surgery waiting area there was also a TV and mobile phone charging facilities provided free of charge.

Patients were able to choose meals from a menu which included vegetarian and gluten-free options. Separate choices were available for patients with cultural or religious preferences. Most patients were positive about the food choices available although one patient, who had been on the ward for longer than average, told us they did not like the food.

Staff and patients told us there were no facilities on the ward for patients or their relatives to make food or a hot drink. One patient we spoke with who had been on the ward for several weeks told us that they found this very frustrating as they often woke early and had to wait until breakfast after 8am for a cup of tea.

The trust had initiatives in place to support patients with additional support needs including those living with dementia or with learning disabilities. Information about patient preferences was used recorded on a patient passport and used to inform staff about the patient's likes and dislikes. Staff told us that they were able to contact their link nurse for support if needed and that they could access additional tools and key documents via the trust's intranet.

We saw the ward had some dementia-friendly facilities, for example differently coloured toilet seats, however the ward was very large and lacked clear signage which made it difficult to navigate.

Staff told us the signage at the ward entrance could be better as it was not immediately obvious to visitors that it was a reception area. The ward was still waiting for boards to be put up which would display information for visitors and patients including friends and family test, IPC and staffing.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Patient waiting times from referral to treatment (RTT) for surgical specialities at Chase Farm hospital were generally better than the England average.

Patients coming into the day surgery unit arrived at 7am for the morning list and those having surgery in the afternoon arrived from 12 noon. Previously, patient arrival times had been staggered throughout the day however, to improve patient safety in response to recent never events at the trust this had changed. Staff told that this meant that sometimes patients had to wait several hours before having their procedure. To address this staff tried to keep patients updated. If knew patients would be waiting a long time they made sure they received a drink of water.

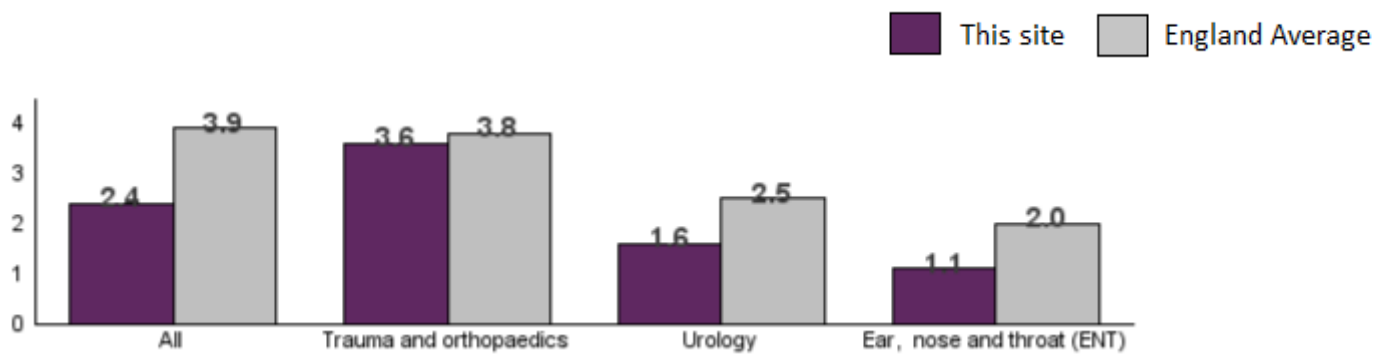
The trust told us there have been no audits of patient waiting times on the day of surgery undertaken in the 12 months prior to our inspection but that an audit on this was planned for 2019.

From July 2017 to June 2018 the average length of stay for all elective patients at Chase Farm Hospital was 2.4 days, which is lower when compared to the England average of 3.9 days. This meant patients were generally able to be discharged home sooner.

Of the top three specialties by number of admissions, the average length of stay for:

- Trauma and orthopaedics elective patients at Chase Farm Hospital was 3.6 days, which is similar when compared to the England average of 3.8 days.
- Urology elective patients at Chase Farm Hospital was 1.6 days, which is lower when compared to the England average of 2.5 days.
- Ear, nose and throat (ENT) elective patients at Chase Farm Hospital was 1.1 days, which is lower when compared to the England average of 2.0 days.

Elective Average Length of Stay - Chase Farm Hospital



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

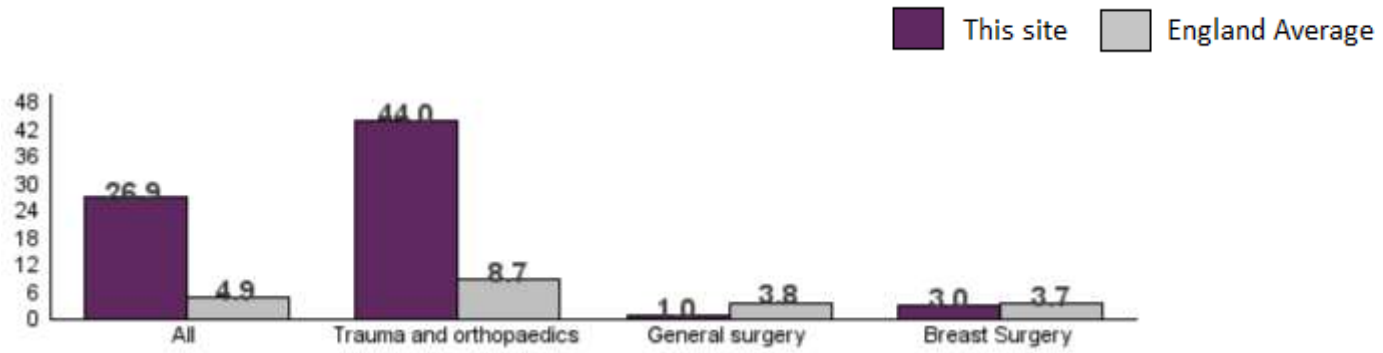
The average length of stay for all non-elective patients at Chase Farm Hospital was 26.9 days, which is higher when compared to the England average of 4.9 days. However, this was based on

a very small number (10) of non-elective patients seen at the hospital during the 12-month period.

Of the top three specialties by number of admission, the average length of stay for:

- Trauma and orthopaedics non-elective patients at Chase Farm Hospital was 44.0 days, which is higher when compared to the England average of 8.7 days.
- General surgery non-elective patients at Chase Farm Hospital was 1.0 days, which is lower when compared to the England average of 3.8 days.
- Breast surgery non-elective patients at Chase Farm Hospital was 3.0 days, which is higher when compared to the England average of 3.7 days.

Non-Elective Average Length of Stay - Chase Farm Hospital

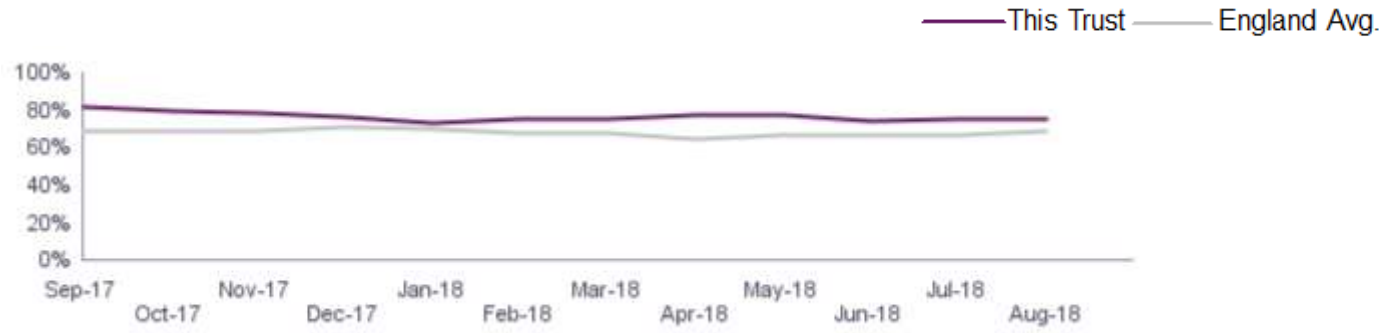


Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was better than the England average.

In the latest month, August 2018, the trust scored 75.7% compared to the England average of 68.5%.



(Source: NHS England)

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Cardiothoracic surgery	100.0%	79.6%
Ophthalmology	92.2%	68.2%
Urology	85.3%	76.7%
General surgery	76.0%	72.6%
Oral surgery	65.1%	59.4%
ENT	64.6%	63.1%

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Plastic surgery	80.9%	81.1%
Trauma & orthopaedics	45.1%	60.0%

More recent data provided by the trust for surgical specialities at Chase Farm and Barnet General Hospitals, showed that RTT for trauma and orthopaedics had been consistently above 80% between April and September 2018 but had dropped to 69% in October 2018. Several other specialities had seen a decline in RTT performance in October 2018 which coincided with the re-location of the service into the new hospital building.

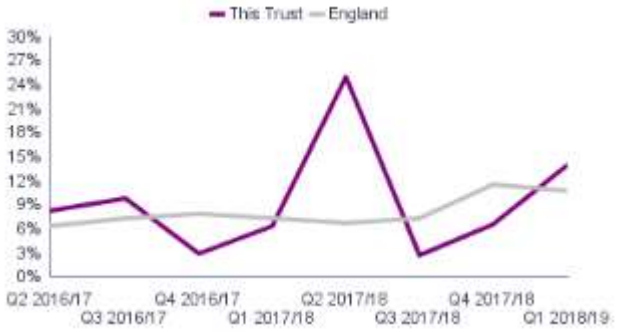
Specialty	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Anaesthetics	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Hepatobiliary & Pancreatic surgery	0.00%	50.00%	0.00%	0.00%	100.00%		100.00%
Thoracic surgery	100.00%	100.00%	100.00%	100.00%	85.71%	100.00%	100.00%
Breast surgery	96.65%	98.47%	98.68%	99.53%	99.24%	98.94%	98.24%
Ear, Nose and Throat	98.15%	97.90%	97.80%	97.70%	96.28%	94.54%	86.87%
Ophthalmology	98.28%	98.06%	95.30%	93.37%	94.70%	94.17%	83.23%
Vascular surgery	87.02%	89.96%	87.82%	90.44%	88.83%	92.87%	79.33%
Maxillo-facial surgery	98.82%	98.61%	99.43%	99.07%	98.88%	98.27%	76.48%
Colorectal surgery	87.92%	88.39%	90.18%	84.55%	86.43%	86.14%	72.79%
Plastic surgery	88.14%	83.33%	74.36%	64.86%	67.57%	65.79%	70.59%
Urology	94.21%	94.38%	92.78%	87.87%	82.62%	90.56%	69.98%
Trauma & orthopaedics	83.08%	84.24%	85.59%	86.17%	84.74%	84.75%	68.67%
Orthodontics	83.55%	73.16%	55.56%	63.16%	80.95%	91.18%	63.64%
General surgery	66.62%	63.75%	67.68%	71.33%	71.04%	73.72%	63.34%
Oral surgery	85.41%	82.77%	84.46%	86.72%	85.15%	80.91%	33.73%
Transplantation surgery	100.00%	100.00%	100.00%	100.00%	78.95%	47.06%	16.67%
Cardiothoracic surgery		100.00%	100.00%	100.00%	100.00%	100.00%	0.00%
Upper Gastrointestinal surgery	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

Over the two years, the percentage of cancelled operations at the trust has been similar to the England average. The only exception is in Q2 2017/18 (July 2017 – September 2017) where the trust had 25% of cancelled operations not treated within 28 days.

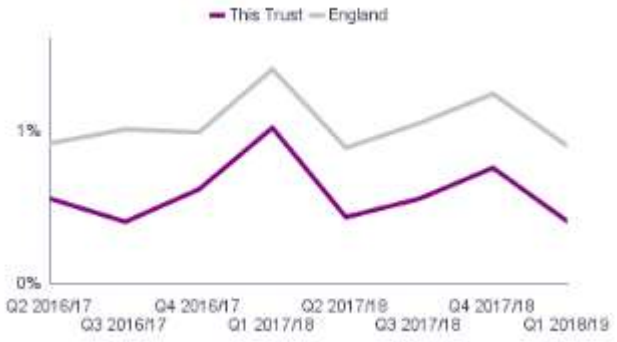
In the most recent quarter, Q1 2018/19 (April 2018 – June 2018), this trust cancelled 78 surgeries. Of the 78 cancellations 14% weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Royal Free London NHS Foundation Trust



Cancelled Operations as a percentage of elective admissions - Royal Free London NHS Foundation Trust

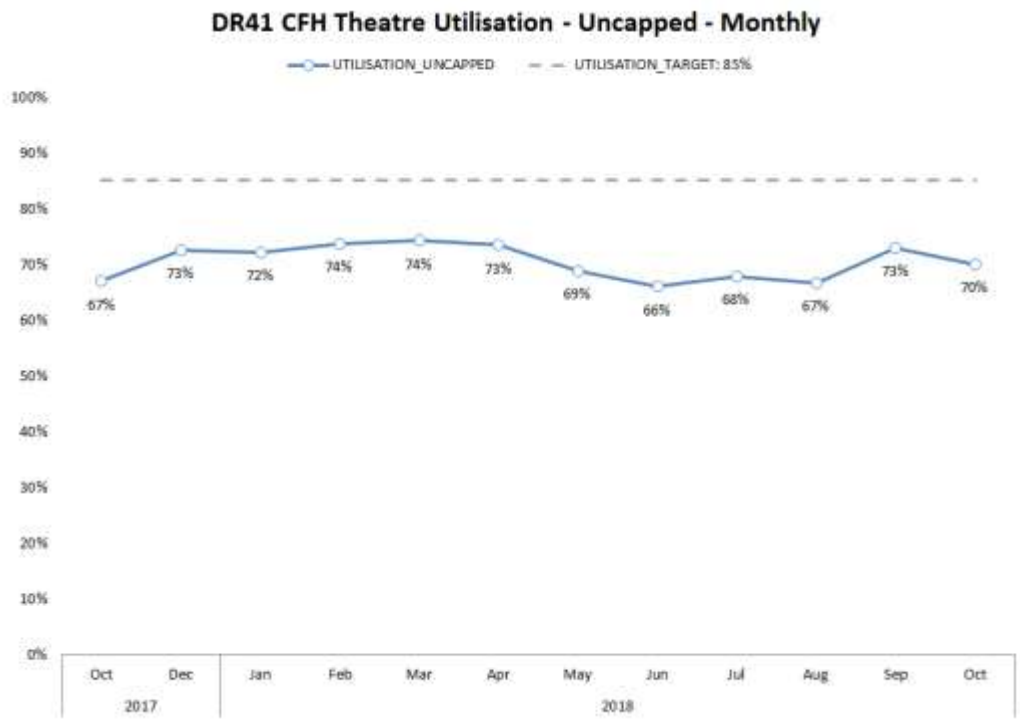
Over the two years, the percentage of cancelled operations at the trust was similar to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.



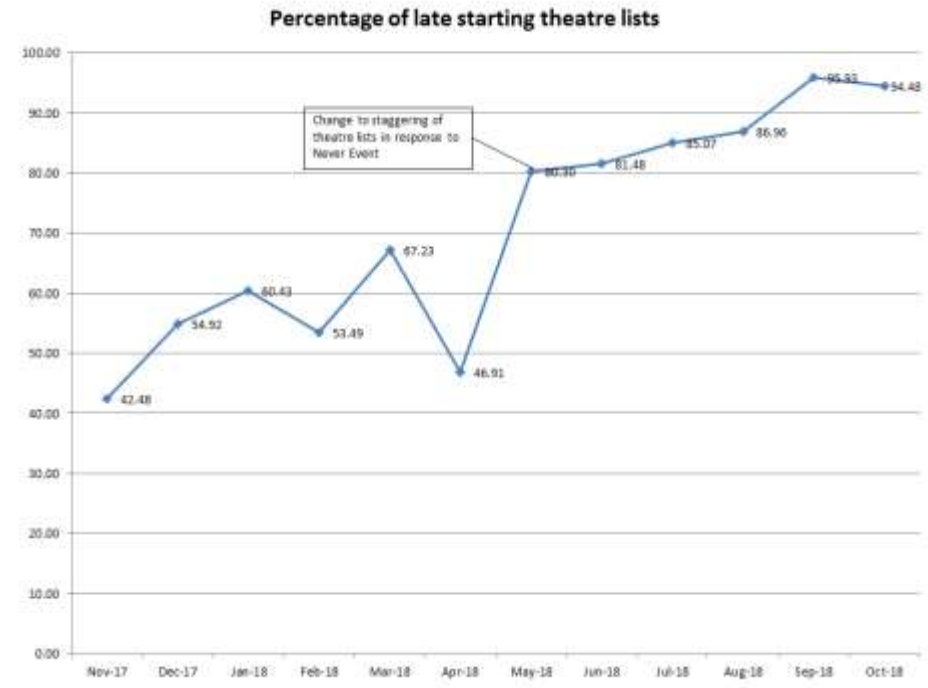
(Source: NHS England)

Data provided by the trust showed that between November 2017 and October 2018 the hospital had cancelled 163 (1.6%) elective surgical procedures on the day for non-clinical reasons. This was similar to the England average. The main reasons were theatres lists overrunning (50), equipment issues (24), administrative error (20) and the surgeon being unavailable (15). Of these 163 cancelled procedures, nine (5.5%) patients had not been treated within 28 days of the last minute cancellation. This was slightly better than the England average.

Between December 2017 and October 2018, theatre utilisation rates varied between 66% and 74% against the trust target of 85%.



Data provided by the trust in the chart below showed that the percentage of late starting theatre lists had increased from 42% in November 2017 to 94% in October 2018. We requested data on reasons for late starting lists but this was not provided. During the inspection, we observed that lists started late due to equipment issues, an over-running previous list due to a complex case and the surgeon arriving late from their morning list at Barnet General Hospital.



Service leads told us they were committed to improving efficiency and patient flow and had introduced several initiatives to review performance and identify areas for improvement. We observed a WHY (What Happened Yesterday) meeting. This was a multidisciplinary team of senior staff reviewed the prior day's performance to identify any issues as close to real time as possible. We saw the meeting was well attended and focussed on key issues, for example patients who had been transferred out. There was also a "Good to Go" meeting which checked

patient records for patients attending the following day to ensure all results and reports were in place.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From September 2017 to August 2018 there were 383 complaints about surgical care. The trust took an average of 36 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 35 days, however there is an option to extend the deadline if previously agreed with complainant.

The top four subjects of complaint were:

Subject	Total
All aspects of clinical treatment	217
Appointments, delay/cancellation (out-patient)	58
Communication/information to patients (written and oral)	40
Attitude of staff	39

Breakdown at the three main sites was as follows:

Site	Total
Royal Free Hospital	213
Barnet Hospital	108
Chase Farm Hospital	56

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

Between September 2017 and August 2018, there were 25 complaints about surgical services at Chase Farm Hospital. Themes included cancellations and delays and poor communication.

The trust told us that in response to complaints about waiting times and communication on the day surgery unit, nursing staff now completed a ward round every 90 minutes to ensure that every patient is aware of when they can expect to go to theatre. However, patients we spoke with said that they were not sure when they would be having their procedure. One patient said they had arrived at 7am and had to wait eight hours for their procedure. They told us it had been frustrating as they had not been kept updated by staff and due to poor phone reception and a broken television there had been very little to distract them in the waiting room.

We saw that patient information leaflets on how to complain and how to access the trust's patient advice and liaison service (PALs) were available throughout the hospital. Patients told us that they felt comfortable raising concerns with staff directly.

Is the service well-led?

Leadership

Managers had the right skills and abilities to run a service providing high-quality sustainable care.

Since our last inspection, a new management structure had been introduced across the trust. Clinical leadership for the surgery service at Chase Farm Hospital was based off-site, at Barnet General Hospital. Clinical service leads for the different surgical specialities reported to one of four clinical directors, who were overseen by the divisional director for the surgery and associated services (SAS) division.

At Chase Farm Hospital, the surgery service was managed locally by two senior clinical operations managers who reported directly to the hospital's chief executive and director of nursing. Both senior clinical operations managers were also senior nurses, with combined responsibility for both nursing and operational oversight of surgical services at the hospital. The hospital's medical director provided local senior clinical oversight of the service. The local leadership team were experienced and demonstrated a good understanding of the performance challenges and risks within the surgical services.

Within the service there were separate senior nursing leads for theatres, pre-assessment and the surgical ward, who all reported to the senior clinical operations managers.

Staff spoke positively about the service and site leadership teams. We heard that senior staff were visible and supportive and that the site leadership team including the chief executive were very approachable. Senior managers had an open-door policy and encouraged staff to speak directly with them about any concerns or suggestions for improvement. We saw this in action through the weekly 'Chase it up' meeting; a forum with the chief executive, open to all staff. Staff told us they could attend these meetings and that they provided an opportunity for a two-way conversation with the site leadership about current issues and updates.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The service's local leadership team told us that the vision for the surgery service was to provide 'nurse-led, patient-centred and consultant-delivered' care and to be in the top 10% of services for patient outcomes. This supported the trust's vision to 'to deliver world class expertise and local care' and it's values of welcoming, respectful, reassuring and clear communication.

The trust had a number of objectives to help it achieve its vision based around patient safety, outcomes, leadership and research. These objectives were supported by goals with measurable performance targets, included targets for improving referral to treatment time performance to 90%, avoidance of never events and embedding clinical pathway groups (CPGs).

Chase Farm Hospital was leading the way on the trust's objective of becoming a digital exemplar. In addition to the recently introduced electronic patient records (EPR) system, we saw a number of examples of where technology was being used to improve service delivery, including the interactive self-check-in kiosks, the design of the new operating theatres and the mobile intercom system. These developments were designed to help improve patient experience and flow through the hospital, as well as both safety and efficiency of service delivery.

Short-term goals for the service at Chase Farm hospital were focused on embedding the new EPR system and improving theatre utilisation and capacity to meet the anticipated increase in demand in early 2019.

Longer-term plans included focus on research, teaching and innovation, with plans to embed quality improvement (QI) methodology into business as usual. This included developing standardised care pathways to improve patient outcomes

The long-term aim for the service was to become a regional centre of excellence for elective surgery. Service leads had already begun work towards this and were liaising with other regional centres to identify opportunities for shared learning.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There was a strong culture of openness, transparency and teamwork within the organisation. Senior leaders modelled positive behaviours, including honesty and integrity. Staff felt well supported by managers and told us that they encouraged effective team working across the hospital.

Staff told us that Chase Farm Hospital was a friendly place to work. One member of staff said, “It feels like a family. We have gone through a lot of changes within a short space of time, but we all stick together.” Most staff told us that they had been well supported through the recent changes and the communication around these changes had been good. Although some staff told us that the recent changes had been challenging, most were optimistic that these were short-term issues and told us they were positive about the future.

The new hospital had been designed to encourage closer multidisciplinary team (MDT) working, for example, hot desking was encouraged with staff of different levels working alongside each other. In theatres, there was now one combined staff room for all staff. Staff told us that although room was a bit too small for its purpose, they liked the idea and told us the shared space helped to improve teamwork by removing barriers to communication. Staff told us it helped with creating the sense of them being part of ‘one team’.

The trust took part in the NHS staff survey which took place between October and December 2017. The response rate for staff within surgical services at Chase Farm Hospital was 49% which was slightly higher than the trust response rate at 47.1%. However, overall staff engagement was lower at 3.75 compared to the trust at 3.81.

The service leads told us about numerous initiatives which had been introduced to improve staff engagement and address concerns raised via the staff survey. These included the weekly ‘Chase it up’ forum with the chief executive and events and initiatives focused on staff wellbeing.

A small room had been set aside to be used as a dedicated wellbeing space for staff, with a team of trained volunteers on hand and available to provide emotional support. Known as the ‘SISOS’ room (serious incident SOS room) the initiative had been introduced to provide support to staff following a serious incident and provided a quiet environment for staff to sit and reflect.

Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Clinical governance of surgical specialities at Chase Farm Hospital sat within the trust’s surgical and associated services (SAS) division. There was a clear quality governance structure in place which demonstrated how governance was discussed and reported through the quality governance managers for the SAS up to the head of quality and governance and the hospital medical director.

Surgical specialities within the SAS division, held their own audit days and mortality and morbidity meetings. Meeting minutes showed that where complications had occurred patient outcomes were

reviewed and areas identified for improvement, recommendations for learning or best practice were captured and shared.

The SAS division held a monthly board meeting which alternated between focusing on performance and quality and safety. Meeting minutes we reviewed demonstrated that issues relating to patient safety, outcomes and experience were discussed. Safety incidents, complaints and risks were reviewed to identify areas of concern and opportunities for improvement.

At Chase Farm Hospital, the surgery service's local leadership team told us they contributed to these wider divisional governance meetings as well as holding their own local safety meetings.

The hospital held a twice monthly theatres safety group meeting where patient safety issues including incidents and never events were discussed and learning outcomes and action plans reviewed. We reviewed three sets of meeting minutes and saw these meetings were well attended by a range of clinical and non-clinical staff, including consultants, staff nurses and managers.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Divisional risks were reviewed at the monthly divisional board meeting. Minutes of the September 2018 board meeting noted that there were 58 open risks on the divisional risk register. New risks were identified by clinical leads at the speciality meetings and then escalated to the divisional board for review. Older risks were reviewed and closed if no longer relevant.

The local leadership team told us that local risks were reviewed weekly at the serious incident review panel (SIRP) which aimed to proactively identify risks from near misses and other incidents. We reviewed minutes for the five meetings held between 31 October 2018 and 5 December 2018, and saw examples of where issues had been recommended for escalation to the risk register, including issues related to implementation of the new electronic patient record (EPR) system.

They told us top risks for the surgical service at Chase Farm Hospital included staffing, especially the skill mix of medical staffing within the orthopaedic service and never events. Many of the service's previous risks were environmental however these had been addressed by the new hospital building.

The hospital had a never event assurance plan which was designed to monitor the progress of actions identified as required to reduce the risk of further never events occurring. Of the original 60 actions, 52 had been closed and the remaining eight outcomes were still in progress with deadlines for completion ranging from December 2018 to December 2019, with the majority due to completed by April 2019.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Chase Farm Hospital had recently moved to a new EPR system and was now almost completely paper-less. Only the patient's consent form needed to be completed manually and then scanned into the system.

The trust had started to use 'a perfect ward programme' approach for the surgical divisions to audit its safety when caring for patients. At Chase Farm Hospital, a new electronic audit application allowed staff to access and update perfect ward using their handheld monitor devices.

Perfect ward provided a comprehensive approach to the audit of the environment, hand hygiene, medicines management, documentation, as well as patient and staff experience.

Engagement

The trust ensured that patients, and their relatives and carers, the public, staff and external partners were actively engaged and involved in identifying and driving improvements in services.

The hospital used various means of engaging with patients and their families. These included surveys, such as the NHS 'Friends and Family Test', inpatient surveys and 'You said We Did' initiative.

Patients, staff and the public had been involved the development and design and development of the new hospital building. Stakeholder meetings had been held to communicate updates and listen to the views of the local community. Staff, patients and local residents were able to access information about the redevelopment and share their views.

Regular updates on service changes had been provided throughout the project on the trust website and via the trust newsletter. New patient information leaflets had been produced with detailed information for patients visiting the new hospital, including what to expect, how to prepare and how to find the services they needed.

Patients and staff had also been involved in the development of the new patient care pathway for hip and knee replacements. Service leads for the therapies team provided a number of examples of where feedback from patients had been used to improve service delivery. For example, feedback from patients was used to help develop the information available to patients prior to surgery.

The trust held a regular incident forum known as 'SNAIL' (Safety Needs and Incident Learning) which was attended by senior management but open to all staff to attend to encourage learning. The trust had recently introduced a SNAIL newsletter and online forum as a result of the number of never events that had occurred over the previous year. Weekly updates included key areas of learning from incidents and near misses. This was circulated to medical, nursing and other staff across the organisation. A Safety Lesson of Week newsletter was also sent out to all staff.

Learning, continuous improvement and innovation

There were robust systems and processes for learning, continuous improvement an innovation.

We saw numerous examples of innovation within the surgical service at Chase Farm Hospital. The design of the new barn theatres, the introduction of the new EPR system and the new electronic nurse calling system were just some of the ways technology and new developments were being implemented to improve patient safety, drive efficiency and improve patient experience.

The trust-wide clinical pathway group (CPG) work aimed to standardise clinical pathways using evidenced based practice. With the introduction of the EPR system the CPG pathways for pre-operative assessment and elective hip and knee procedures had been digitalised at Chase Farm Hospital. This ensured effective MDT input as all staff had access to the relevant information. The development and implementation of this standardised approach was being used to drive improvements in patient outcomes.

New initiatives introduced as a result of learning from patient safety incidents included 'stop at the shop' where staff completed an enhanced prosthesis check to prevent the wrong implant being used during a procedure. Simulation training provided staff with an opportunity to learn for patient safety incidents in a safe environment.

Royal Free Foundation Trust

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Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

- Royal Free Hospital emergency department
- Barnet Hospital emergency department
- Chase Farm urgent care centre

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

The trust has two emergency departments one at the Royal Free Hospital and another at Barnet Hospital. In addition, there is an Urgent Care Centre at Chase Farm Hospital.

(Source: Routine Provider Information Request (RPIR) – Acute context)

The department comprised of a rapid assessment and triage (RAT) area. This had six bays which primarily received patients brought in by ambulance. The majors area (ATA - adult treatment area) opened in June 2018 and had 16 cubicles and one isolation cubicle, as well as two close observation rooms for patients who presented with mental health problems. Patients from this area still in receipt of active treatment such as intravenous fluids could be moved to an adjacent area which had eight chairs and was known as ‘care in a chair’. The resuscitation area had six bays including one designated for use with children. This had full facilities for resuscitating critically unwell patients, for example a patient with a serious injury or heart attack. The paediatric ED (PED) treated patients up to the age of 18 and was a fully separated paediatric area. There were five cubicles, a four-bed close observation bay and a triage room. There was a waiting area and 24-hour reception cover.

Patients that self-presented registered with a receptionist and were then seen by a nurse who directed (streamed) them to different areas including the urgent care centre which was staffed by emergency nurse practitioners and other nursing staff from the emergency department twenty-four hours a day, as well as GPs who were in clinic until 10:00pm.

The ambulatory emergency care (AEC) area was overseen by an emergency department consultant. This area operated between 8:00am and 10:00pm seven days per week. There were

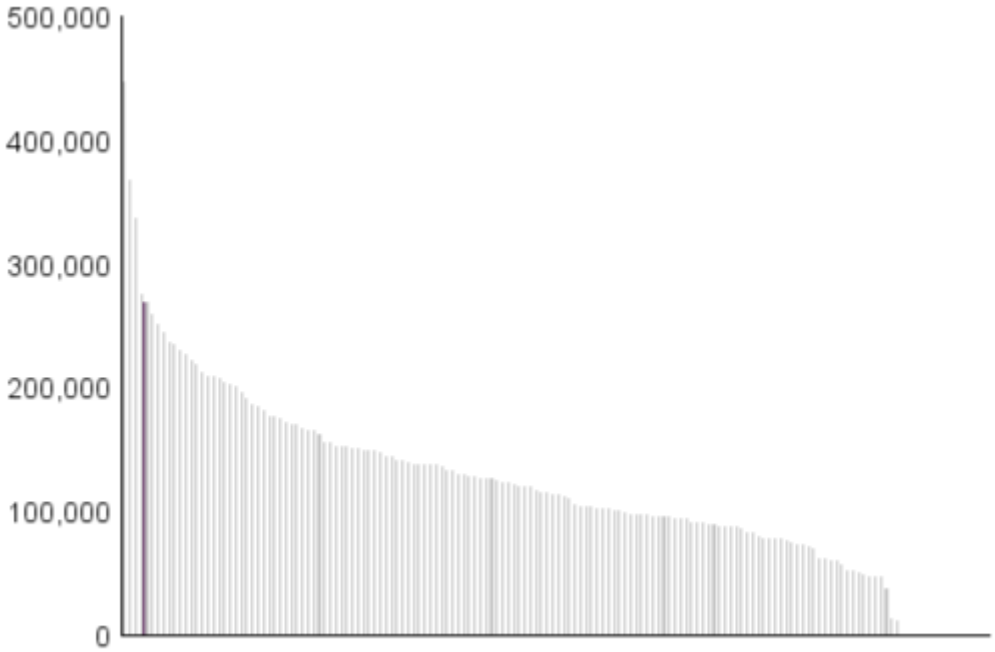
several pathways for patients who were directed to the AEC. These included those with deep vein thrombosis, abscesses, cellulitis and renal colic.

Expected patients were directed to the adult assessment lounge to see specialty doctors for assessment or admission. Patients in this area were supervised by emergency department staff in the AEC until the specialty doctor attended.

In addition, there were nine ring-fenced beds for ED patients in the adult assessment unit (AAU), which had capacity of up to 29 patients, it was managed within the medical division. These beds were for patients who were not well enough to go home but expected to be able to do so within 24 hours.

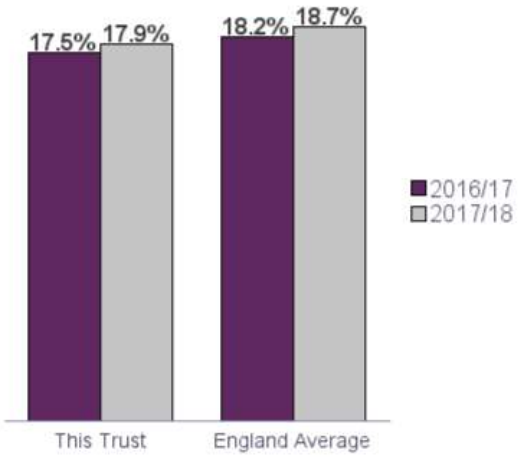
The Royal Free Hospital site provides a 24-hour, seven days a week service. A total of 113,265 patients attended the emergency department between November 2017 to October 2018, of which 90,765 were adults and 22,500 were children.

Total number of urgent and emergency care attendances at Royal Free London NHS Foundation Trust compared to all acute trusts in England, July 2017 to June 2018



From July 2017 to June 2018 there were 267,920 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

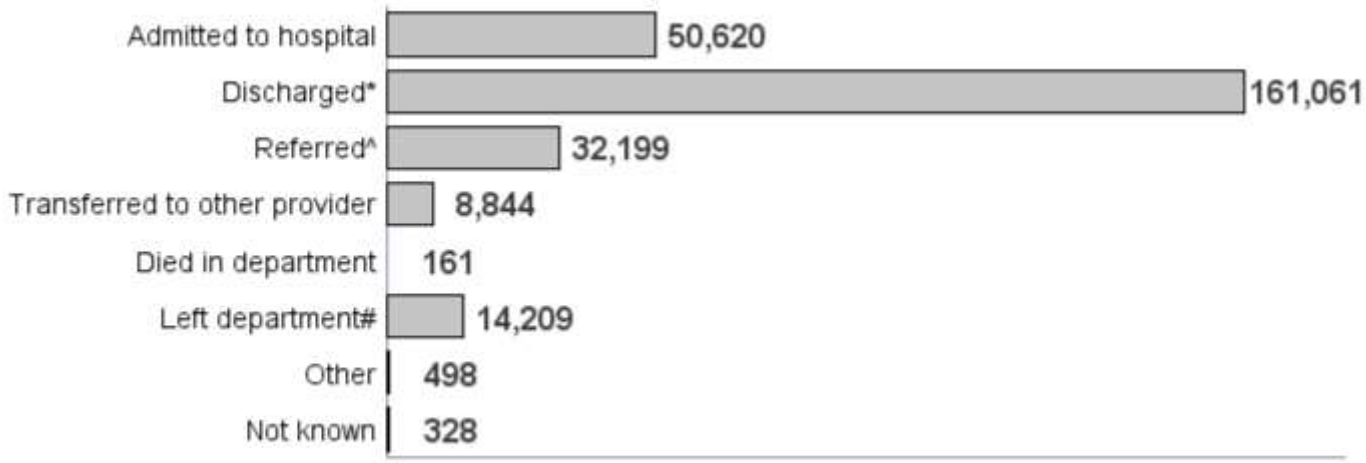
(Source: Hospital Episode Statistics)



The percentage of A&E attendances at this trust that resulted in an admission remained similar in the most recent year compared to previous year. In both years, the proportions were lower than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from July 2017 to June 2018



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

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Although the service provided mandatory training in key skills to all staff, not all staff had

completed it.
The trust set a target of 85% for completion of mandatory training.
A breakdown of compliance for mandatory training courses from April 2018 to August 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	178	181	98.3%	85%	Yes
Resuscitation L1	175	181	96.7%	85%	Yes
Infection Control L1	169	181	93.4%	85%	Yes
Basic Radiation Safety	159	181	87.8%	85%	Yes
Health & Safety Awareness	157	181	86.7%	85%	Yes
Emergency Planning	156	181	86.2%	85%	Yes
Fraud & Security	155	181	85.6%	85%	Yes
WRAP	144	170	84.7%	85%	No
Waste Management	149	181	82.3%	85%	No
Equality, Diversity & Human Rights	144	181	79.6%	85%	No
Moving and Handling	141	181	77.9%	85%	No
Information Governance	137	181	75.7%	85%	No
Conflict Resolution	123	181	68.0%	85%	No
Fire Safety	122	181	67.4%	85%	No
Infection Control L2	120	181	66.3%	85%	No
Resuscitation L2	118	181	65.2%	85%	No
Blood Transfusion	110	181	60.8%	85%	No
RTT L1	63	181	34.8%	85%	No

At trust level in urgent and emergency care the 85% target was met for seven of the 18 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 at trust level for medical staff in urgent and emergency care is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Resuscitation L1	116	166	69.9%	85%	No
BPAT	114	166	68.7%	85%	No
Infection Control L1	103	166	62.0%	85%	No
Health & Safety Awareness	102	166	61.4%	85%	No
WRAP	28	46	60.9%	85%	No
Fire Safety	100	166	60.2%	85%	No
Basic Radiation Safety	98	166	59.0%	85%	No
Fraud & Security	94	166	56.6%	85%	No
Equality, Diversity & Human Rights	93	166	56.0%	85%	No
Emergency Planning	92	166	55.4%	85%	No
Moving and Handling	86	166	51.8%	85%	No
Waste Mgt	84	166	50.6%	85%	No
Blood Transfusion	78	166	47.0%	85%	No

Resuscitation L2	78	166	47.0%	85%	No
Information Governance	75	166	45.2%	85%	No
Conflict Resolution	74	166	44.6%	85%	No
Infection Control L2	69	166	41.6%	85%	No
RTT L1	68	166	41.0%	85%	No

At trust level in urgent and emergency care the 85% target was not met for any of the 18 mandatory training modules for which medical staff were eligible.
A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the urgent and emergency care department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	80	83	96.4%	85%	Yes
Resuscitation L1	78	83	94.0%	85%	Yes
Infection Control L1	74	83	89.2%	85%	Yes
Emergency Planning	71	83	85.5%	85%	Yes
Basic Radiation Safety	70	83	84.3%	85%	No
Fraud & Security	68	83	81.9%	85%	No
Health & Safety Awareness	67	83	80.7%	85%	No
Waste Management	67	83	80.7%	85%	No
WRAP	64	83	77.1%	85%	No
Information Governance	60	83	72.3%	85%	No
Equality, Diversity & Human Rights	59	83	71.1%	85%	No
Moving and Handling	58	83	69.9%	85%	No
Conflict Resolution	57	83	68.7%	85%	No
Fire Safety	49	83	59.0%	85%	No
Infection Control L2	47	83	56.6%	85%	No
RTT L1	16	30	53.3%	85%	No
Blood Transfusion	44	83	53.0%	85%	No
Resuscitation L2	41	83	49.4%	85%	No

At Royal Free Hospital urgent and emergency care department the 85% target was met for four of the 18 mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following inspection, the trust submitted data which showed that 95% of nursing staff had intermediate life support training; 100% of the paediatric emergency departments staff had paediatric intermediate life support and 44% of nursing staff had advanced life support training.

Mandatory training data submitted for nursing staff that showed compliance rates at November 2018 were similar to those at August 2018.

Name of course	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	87	94.9%	85%	Yes
Resuscitation L1	87	96.2%	85%	Yes

Infection Control L1	87	87.2%	85%	Yes
Emergency Planning	87	85.9%	85%	Yes
Basic Radiation Safety	87	82.1%	85%	No
Fraud & Security	87	79.5%	85%	No
Health & Safety Awareness	87	75.6%	85%	No
Waste Management	87	80.8%	85%	No
WRAP	87	88.5%	85%	Yes
Information Governance	87	71.8%	85%	No
Equality, Diversity & Human Rights	87	70.5%	85%	No
Moving and Handling	87	70.0%	85%	No
Conflict Resolution	87	80.8%	85%	No
Fire Safety	87	57.7%	85%	No
Infection Control L2	87	60.3%	85%	No
RTT L1	87	57.7%	85%	No
Blood Transfusion	87	53.9%	85%	No
Resuscitation L2	87	59.0%	85%	No

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the urgent and emergency care department at Royal Free Hospital is shown below:

Name of course	**Staff trained**	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Fire Safety	24	34	70.6%	85%	No
Infection Control L1	22	34	64.7%	85%	No
Resuscitation L1	22	34	64.7%	85%	No
BPAT	22	34	64.7%	85%	No
WRAP	13	21	61.9%	85%	No
Basic Radiation Safety	20	34	58.8%	85%	No
Emergency Planning	19	34	55.9%	85%	No
Fraud & Security	19	34	55.9%	85%	No
Resuscitation L2	19	34	55.9%	85%	No
Health & Safety Awareness	18	34	52.9%	85%	No
Waste Mgt	18	34	52.9%	85%	No
Information Governance	17	34	50.0%	85%	No
Conflict Resolution	16	34	47.1%	85%	No
Blood Transfusion	15	34	44.1%	85%	No
Equality, Diversity & Human Rights	15	34	44.1%	85%	No
Moving and Handling	14	34	41.2%	85%	No
RTT L1	14	34	41.2%	85%	No
Infection Control L2	13	34	38.2%	85%	No

At Royal Free Hospital urgent and emergency care department the 85% target was not met for any of the 18 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following inspection, the trust submitted training data for medical staff that showed compliance rates at November 2018 were similar to those at August 2018.

Name of course	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	37	86.5%	85%	Yes
Resuscitation L1	37	73.0%	85%	No
Infection Control L1	37	67.6%	85%	No
Emergency Planning	37	75.7%	85%	No
Basic Radiation Safety	37	83.8%	85%	No
Fraud & Security	37	75.7%	85%	No
Health & Safety Awareness	37	70.3%	85%	No
Waste Management	37	64.9%	85%	No
WRAP	37	62.5%	85%	No
Information Governance	37	73.0%	85%	No
Equality, Diversity & Human Rights	37	70.3%	85%	No
Moving and Handling	37	70.0%	85%	No
Conflict Resolution	37	62.2%	85%	No
Fire Safety	37	83.8%	85%	No
Infection Control L2	37	56.8%	85%	No
RTT L1	37	56.8%	85%	No
Blood Transfusion	37	59.5%	85%	No
Resuscitation L2	37	56.6%	85%	No

Members of nursing staff we spoke with told us they got reminders from the education centre to complete their mandatory. We were told there was protected time to complete mandatory training, which staff confirmed. However, there were mixed views on whether this was achievable. Some nursing staff told us it was seldom possible since the floor was busy and there was not always the full complement of staff on shift.

Nursing staff told us there was a robust induction programme and they were supernumerary for the first month when they joined the department. Their competencies were signed off by a nurse practice educator.

Doctors told us they felt well supported with their professional development. They had a named mentor who helped them build their training portfolio and supported revalidation. There was weekly junior doctor teaching which they were always able to attend. They told us there was a good training programme which included delivery from other specialties. There was an induction programme designed for locum doctors which explained their responsibilities, the different areas in the department; documentation and pathways.

We were told that mental health training was provided to nursing staff by members of the mental health liaison team.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed their safeguarding training.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018

for qualified nursing staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	179	181	98.9%	85%	Yes
Safeguarding Children L2	179	181	98.9%	85%	Yes
Safeguarding Adults L1	155	181	85.6%	85%	Yes
Safeguarding Adults L2	150	181	82.9%	85%	No
Safeguarding Children L3	123	181	68.0%	85%	No

Trust wide, the urgent and emergency care department 85% target was met for three of the five safeguarding training modules for which nursing staff were eligible.

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018 for medical/dental staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L3	31	49	63.3%	85%	No
Safeguarding Children L1	103	166	62.0%	85%	No
Safeguarding Children L2	98	166	59.0%	85%	No
Safeguarding Adults L1	94	166	56.6%	85%	No
Safeguarding Adults L2	90	166	54.2%	85%	No

Trust wide, the urgent and emergency care department 85% target was not met for any of the five safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018 for qualified nursing staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	81	83	97.6%	85%	Yes
Safeguarding Children L2	81	83	97.6%	85%	Yes
Safeguarding Adults L1	63	83	75.9%	85%	No
Safeguarding Children L3	63	83	75.9%	85%	No
Safeguarding Adults L2	58	83	69.9%	85%	No

At Royal Free urgent and emergency care department the 85% target was met for two of the five safeguarding training modules for which nursing staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Following inspection, the trust submitted training data for nursing staff that showed that compliance rates at November 2018 were similar to those in August 2018.

Name of course	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	78	97.4%	85%	Yes
Safeguarding Children L2	78	97.4%	85%	Yes
Safeguarding Adults L1	78	78.2%	85%	No
Safeguarding Adults L2	78	74.4%	85%	No
Safeguarding Children L3	78	61.5%	85%	No

A breakdown of compliance for the safeguarding training course from April 2018 to August 2018 for medical/dental staff in the urgent and emergency care department is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	18	34	52.9%	85%	No
Safeguarding Children L3	11	21	52.4%	85%	No
Safeguarding Children L2	17	34	50.0%	85%	No
Safeguarding Adults L1	14	34	41.2%	85%	No
Safeguarding Adults L2	14	34	41.2%	85%	No

At Royal Free urgent and emergency care department the 85% target was not met for any of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following inspection, the trust submitted training data for medical staff that showed compliance rates at November 2018 were improved but remained below the trust standard for all modules.

Name of course	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	37	75.7%	85%	No
Safeguarding Children L2	37	73.0%	85%	No
Safeguarding Adults L1	37	70.3%	85%	No
Safeguarding Adults L2	37	67.6%	85%	No
Safeguarding Children L3	37	62.5%	85%	No

Emergency department staff made 116 safeguarding children and adult alerts to the trust safeguarding team between June and November 2018.

Staff told us they were confident in their knowledge of the trust safeguarding procedures and showed us them on the trust intranet. They told us they would not hesitate to escalate any concerns about patient safety and demonstrated how to do this. Staff we spoke with were aware of the signs of female genital mutilation and knew how to raise an alert. They cited recent safeguarding referrals made which included an elderly person who came in with clear signs of

neglect and a person with learning disabilities who did not have a carer with them, despite their apparent vulnerability.

Cleanliness, infection control and hygiene

The department was visibly clean, tidy and free of any odours and we saw standards of cleanliness were maintained.

There were established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health's code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of the spillage of body fluids. All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

Patients and relatives told us they found the department to be clean. There were housekeeping staff for cleaning all areas of the emergency department and we found all areas were maintained to a good standard of cleanliness. There were 'I am clean' stickers marked with the date the item was cleaned. Most areas we visited were tidy, clean and uncluttered. All cubicles had sliding doors with disposable curtains to maintain privacy.

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

Sharps bins were available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations, 5 (1) (d)). The regulation requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area.

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

Staff complied with local infection control policies. We observed clinical, nursing and support staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection. We were told that patients with a known or suspected infection were nursed in one of six isolation rooms.

However, hand hygiene data submitted by the trust following inspection showed that performance was lowest in handwashing before and after patient contact. For example, one recent audit showed that there was 12.5% compliance with hand washing before patient contact and 75% compliance after patient contact. Compliance with correct hand washing technique varied between 37.5% and 80%. This data was not differentiated for different groups of staff. Whiteboards in the different parts of the emergency department showed that the current compliance with hand hygiene was 96%.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The majors area, known as the adult treatment area (ATA) opened in June 2018, with increased capacity. It included 16 cubicles, one isolation room, one room for patients with gynaecological

conditions and two close observation rooms for patients awaiting a mental health assessment. Each cubicle had handwashing facilities. There were six cubicles in the resuscitation area one of which was a dedicated paediatric bay, located nearest to the door into the paediatric emergency department for rapid access.

The ATA could ‘step down’ patients still in receipt of active treatment and well enough to be moved to an adjacent area; this had eight chairs in individual cubicles and was known as ‘care in a chair’. There was a separate paediatric ED (PED) and waiting area that treated patients up to the age of 18. This had five cubicle spaces, a four-bedded close observation bay, a triage room as well as a waiting area and 24-hour reception cover.

Spare consumables and other equipment were appropriately stored and labelled. Consumables including fluids were in date. We checked the contents of four adult and one paediatric resuscitation trolley and saw that all equipment was present, including appropriately sized equipment for smaller or paediatric patients on most trollies. We also noted there were no gaps in daily checks. However, there were gaps in the daily checks of the resuscitation trolley in the rapid assessment and triage (RAT) area, including a gap of three consecutive days where no checks were evidenced. There was also a missing piece of equipment (suction); we identified this as an issue on the inspection day to the matron who immediately managed the situation and placed a notice to this effect on the trolley in question.

Patients who required a mental health assessment went to one of two close observation rooms located within the department. These were new and opened at the same time as the rest of the department (June 2018) and were well maintained. There were no ligature points in the assessment rooms; they had two doors which opened outwards and were fitted with toughened glass privacy panels for staff to see into the rooms. Any blind spots within the room were mitigated by CCTV in each room and the positioning of nursing staff who could view the CCTV on a monitor positioned outside the observation rooms. These characteristics reduced the risk of harm to patients and staff. They met the standard for mental health assessment rooms in emergency departments (Quality standards for liaison psychiatry services, Psychiatric Liaison Accreditation Network (PLAN), 2017).

We reviewed a spreadsheet of all the equipment in the department, along with the next service schedule date. Service reviews of high-risk items of equipment in the department which included defibrillators and resuscitation equipment were up-to-date.

Assessing and responding to patient risk

Staff in the urgent and emergency care department completed and updated risk assessments for each patient. However, staff in the Adult Assessment Unit were unclear whose responsibility this was.

At the last CQC inspection we found staff did not consistently use their chart based early warning score system to identify deteriorating patients. The trust introduced an early warning tool three weeks prior to this inspection which was a system of national early warning scores (NEWS for adults and PEWS for children) to alert staff to the deteriorating patient. The tool included a clear escalation plan with prompts incorporated into the score and observation chart.

Although there was no audit available at the time of inspection to assess the completeness of recording; we reviewed eight sets of adult patient notes in the adult treatment area (ATA) and four sets of paediatric notes in the paediatric emergency department and saw vital sign scores were regularly recorded and correctly calculated on all.

The trust submitted data following inspection of recent audits of ATA patient records between June and November 2018. These showed that completeness of documentation varied between 83% and 95%. The main areas of incompleteness included lack of recording of patient valuables and social history.

There were nine beds in the adult assessment unit (AAU) ring fenced for emergency department patients. The AAU was overseen by the medical division and patients were cared for by medical nursing staff. We reviewed four sets of emergency department patient records and found there was inconsistent documentation. For example, there was no assessment of pressure areas on three out of four records and no venous thromboembolism (VTE) assessment on two. Some members of staff told us that observations were not routinely completed between 9:00pm and 6:00am (approximate timings) in the unit and there was confusion about whose responsibility this was – whether it was healthcare assistant or the general medical nursing staff.

A number of doctors expressed concern about the care of patients with neck and spinal injuries in the AAU. They told us that patients were not routinely woken-up for head injury neurological observations. It was their view that the general medical nurses who staffed the AAU did not have emergency care specific skills related to the safe management of spinal or neck injuries.

We spoke with a recently appointed member of staff who acknowledged that nursing documentation required improvement. In response to this, they were in the early stages of planning a training session on 'back to basics of nursing', to include documentation and observations.

We saw examples in patient records of the sepsis pathway being followed appropriately and staff followed the trust 'sepsis 6' protocol. Sepsis screening was in place as part of the NEWS and PEWS records and we were told that actions were escalated as appropriate and in line with guidance on the chart. The PEWS observation chart included a section for staff to record concerns about the child's health.

Patients who self-presented to the department booked in with reception at which point the four-hour target time started. This was line with the Department of Health's standard for emergency departments that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. They were then seen by a nurse who did patient streaming and was always a band 6 nurse or above. They took basic details including the presenting complaint and assigned the patient to the most clinically appropriate area. Patients were triaged in order to determine their priority for treatment, and to inform them of the waiting time. We observed how the patients were kept informed of next steps.

We observed and spoke with streaming staff during the inspection. They told us they were trained on how to stream and triage prior to managing the streaming front desk. Where there were significant concerns about a patient, they accompanied them directly to triage or with more serious concerns, straight to the majors area (adult treatment area). Senior nursing staff could order x-rays as required. During inspection, we saw patients were streamed in accordance with the NHS standard of 15 minutes from arrival to initial assessment and pathways were relevant and in line with current NICE guidance.

Since the time of the last CQC inspection, the trust introduced a rapid assessment and treatment area which was staffed with senior nurses and clinicians between 9am and midnight. The trust submitted data which showed that 80% of type 1 patients (the most seriously ill) were assessed by a nurse within 15 minutes of arrival and 70% of patients are seen by a clinician within 60 minutes.

Staff understood where a patient required physical restraint and sedation by injectable medicine (rapid tranquilisation), there should be hourly physical observations carried out. They also knew

that in some circumstances physical observations of patients are recommended to be initially undertaken every 15 minutes (Violence and aggression: short-term management in mental health, health and community settings, National Institute for Health and Care Excellence, 2015). We were told that instances of the use rapid tranquilisation were not recorded on the electronic incident reporting system.

The psychiatric liaison team operated a 24-hour service. This meant that there were psychiatric liaison staff available to assess patients at all times. This followed best practice guidance (Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2, NHS England). All emergency department clinical staff could make referrals to the psychiatric liaison team who had a response time of one hour from referral. Emergency department staff told us this was achieved 96% of the time.

The trust scored worse than other trusts for one of the five Emergency Department Survey questions relevant to safety. The trust scored “about the same” as other trusts for the remaining four questions.

Question	Score	RAG
Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	7.3	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	5.4	About the same as other trusts
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	5.6	About the same as other trusts
Q33. In your opinion, how clean was the emergency department?	7.9	Worse than other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.3	About the same as other trusts

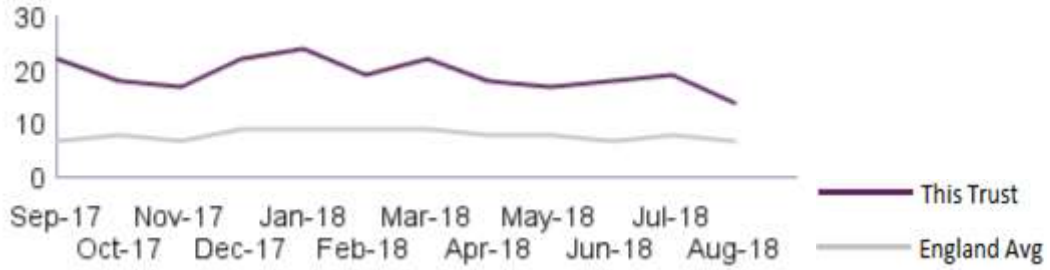
(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

Since this survey, the emergency department had been completely refurbished and during inspection, patients and relatives told us they found the department to be clean. There were housekeeping staff for cleaning all areas of the emergency department and we found all areas were maintained to a good standard of cleanliness.

The median time from arrival to initial assessment was consistently better than the overall England median over the 12-month period from September 2017 to August 2018.

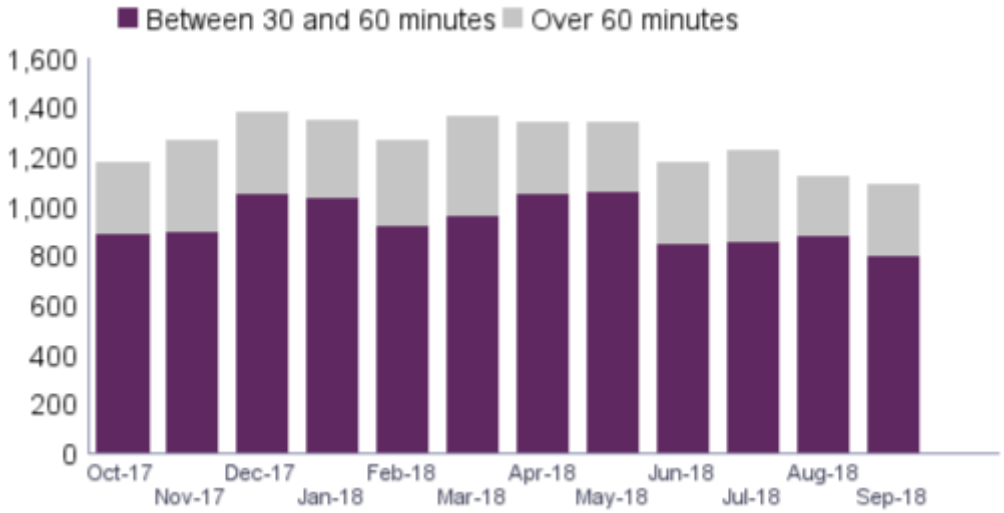
The trust submitted data following inspection which showed that in May 2018 90% of patients were streamed within 15 minutes. In the latest period, August 2018 the median time to initial assessment was seven minutes compared to the England average of 14 minutes. The trust told us the work done on streaming was recently presented to the emergency care intensive support team (ECIST). This is a clinically led national NHS team that has been designed by clinicians to help health and care systems deliver high quality emergency care. The trust was described as an exemplar site for improvement.

Ambulance – Time to initial assessment from September 2017 to August 2018 at Royal Free London NHS Foundation Trust

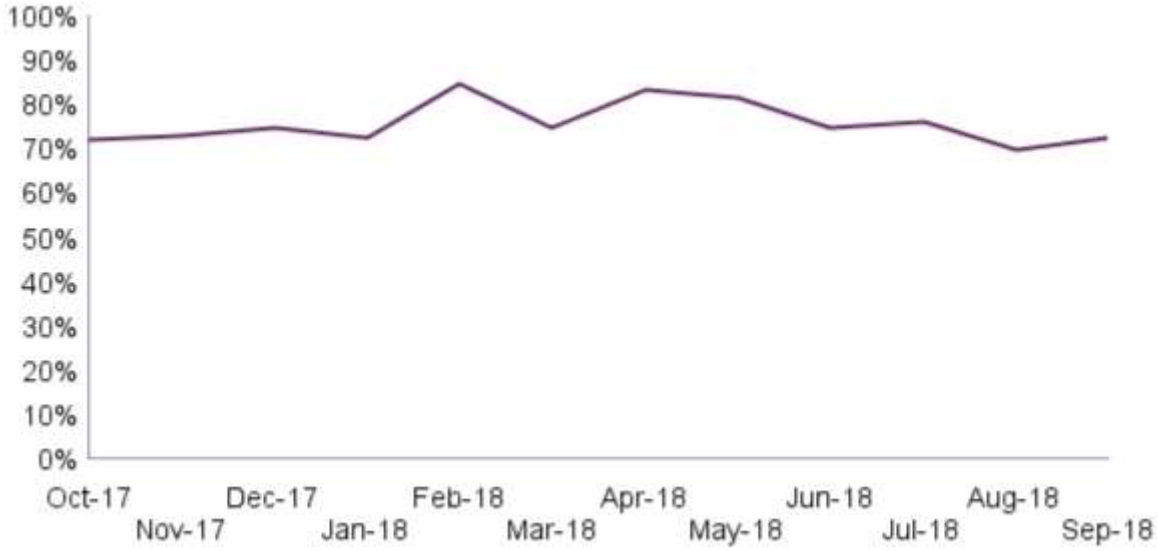


(Source: NHS Digital - A&E quality indicators)

From September 2018 to September 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Free. In the latest period, September 2018, 73% of ambulance journeys had turnaround times over 30 minutes.



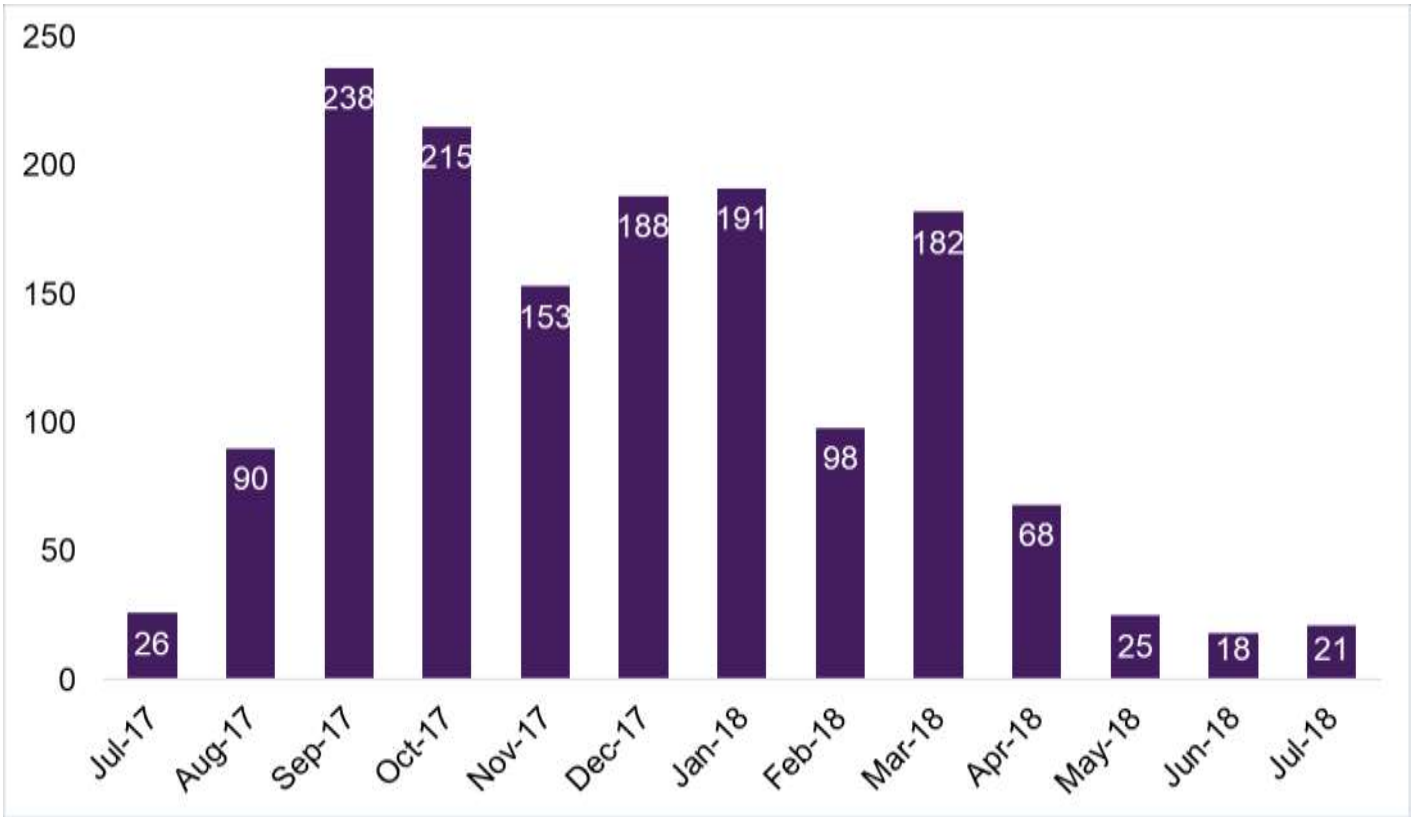
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Royal Free



(Source: National Ambulance Information Group)

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

From July 2017 to July 2018 the trust reported 1,513 “black breaches”, with a downward trend over the period.



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust has reported the following qualified nursing staff numbers in urgent and emergency care from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	122.7	100.5	81.9%	125.2	88.8	70.9%
Chase Farm Hospital	19.0	11.8	62.1%	18.3	12.4	67.5%
Royal Free Hospital	110.9	84.0	75.7%	120.7	81.0	67.1%
Total	**252.6**	**196.3**	**77.7%**	**264.1**	**182.1**	**69.0%**

From April 2017 to March 2018, the trust reported a staffing level of 77.7% for qualified nursing staff in urgent and emergency care. This had decreased to 69.0% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From September 2017 to August 2018, the trust reported a vacancy rate of 23.9% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 12%.

The breakdown by site was as follows:

- Barnet Hospital: 20.3%
- Chase Farm Hospital: 37.3%
- Royal Free Hospital: 25.6%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 27.1% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 13%.

The breakdown by site was as follows:

- Barnet Hospital: 20.6%
- Chase Farm Hospital: 33.8%
- Royal Free Hospital: 33.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 3.3% for qualified nursing staff in urgent and emergency care. This was lower than the trust target of 3.5%.

The breakdown by site was as follows:

- Barnet Hospital: 4.1%
- Chase Farm Hospital: 6.1%
- Royal Free Hospital: 1.8%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 20% of all staff shifts in urgent and emergency care were filled by bank staff and 6% of shifts were filled by agency staff. In addition, 1% of shifts were over-filled by bank and agency staff to cover staff absence.

The breakdown by site is shown in the table below.

Site	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Barnet	282,484	61,876	22%	12,281	4%	Over-filled by 19,139	Over-filled by 7%
Chase Farm	41,363	4,979	12%	11,316	27%	2,576	6%
Royal Free	254,980	51,447	22%	8,301	4%	11,041	4%

Total	**578,827**	**118,301**	**20%**	**31,898**	**6%**	**Over-filled by 5,522**	**Over-filled by 1%**

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

Nurses told us they understood there were vacancies in establishment, but shifts were usually filled. They spoke positively about their induction during which they worked alongside experienced staff as supernumerary to the rota for two weeks. They told us that whilst there were times when some shifts were unfilled, they did not feel patient safety was compromised. We were told there was an active recruitment campaign underway and, in the meantime, shifts were covered by regular bank staff or agency staff who were familiar with the department.

The emergency department nurse staffing ratios and skill-mix were set in accordance with Royal College of Nursing guidelines.

Nursing allocations were planned at the beginning of each shift; staff were allocated according to activity levels in the different areas and flexed during the day as needed. We observed a mid-morning situation report (sitrep) given by a band 7 nurse to staff on duty. They gave an overview of the whole emergency department, including current pressures and an update on patients and their progress through the department. Staff could be reassigned to other areas, according to need.

We looked at nursing rosters and noted there was a good skill mix included in shifts. This included a range of senior and junior nurses. Nurses self-rostered which allowed them to design their own work schedule. Many told us this flexible approach which enhanced their work/life balance. Managers told us they recognised the value of this system. All staff understood they must commit to a certain amount of weekend and long days per rota. Once that was in place, then most requests could be approved.

The trust submitted data following inspection which confirmed that 4% of shifts did not have a paediatrically trained nurse on shift between June and November 2018 due to short notice absence. However, the trust told us that all staff on duty during these shifts had completed paediatric life support and had extensive experience working in the main emergency department, which included experience of working with paediatric patients.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust has reported the following medical staff numbers in urgent and emergency care from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	**Actual WTE staff**	**Fill rate**	**Planned WTE staff**	**Actual WTE staff**	**Fill rate**
Barnet Hospital	118.5	124.4	Over-established	140.9	132.4	93.9%

			by 5.0%			
Chase Farm Hospital	5.6	2.7	48.2%	7.8	3.0	38.7%
Royal Free Hospital	45.7	34.0	74.4%	46.0	34.3	74.5%
Total	**169.8**	**161.1**	**94.9%**	**194.7**	**169.7**	**87.2%**

From April 2017 to March 2018, the trust reported a staffing level of 94.9% for medical staff in urgent and emergency care. This had decreased to 87.2% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
From September 2017 to August 2018, the trust reported a vacancy rate of 10.8% for medical staff in urgent and emergency care. This was lower than the trust target of 12%.

The breakdown by site was as follows:

- Barnet Hospital: 2.0%
- Chase Farm Hospital: 63.4%
- Royal Free Hospital: 27.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
From September 2017 to August 2018, the trust reported a turnover rate of 7.8% for medical staff in urgent and emergency care. This was lower than the trust target of 13%.

The breakdown by site was as follows:
- Barnet Hospital: 6.7%
- Chase Farm Hospital: 41.1%
- Royal Free Hospital: 6.8%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 0.7% for medical staff in urgent and emergency care. This was lower than the trust target of 3.5%.

The breakdown by site was as follows:

- Barnet Hospital: 0.9%
- Chase Farm Hospital: 0.4%
- Royal Free Hospital: 0.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 10% of medical shifts in urgent and emergency care were filled by bank staff and 5% of shifts were filled by locum staff.

The breakdown by site is shown in the table below:

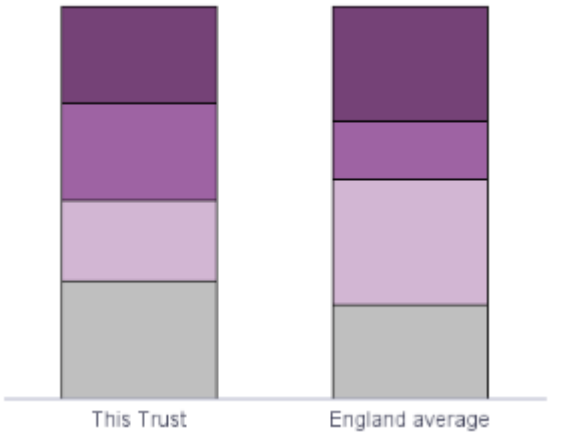
Site	Total hours available	Bank Usage		Locum Usage		NOT filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Barnet	250,029	15,603	6%	3,030	1.2%	Over-filled by 1,301	Over-filled by 1%
Chase Farm	12,996	5,107	39%	0	0%	3,127	24%
Royal Free	89,577	13,452	15%	13,457	15%	Over-filled by 1,181	Over-filled by 1%
Total	**352,602**	**34,162**	**10%**	**16,486**	**5%**	**646**	**0%**

The trust told us that the negative values are for areas where total hours plus agency and bank hours have exceeded the establishment (effectively unfunded hours).

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In July 2018, the proportion of consultant staff and the proportion of registrar group reported to be working at the trust were both lower than the England average. The proportion of junior (foundation year 1-2) staff and middle career were both higher.

Staffing skill mix for the 77 whole time equivalent staff working in urgent and emergency care at Royal Free London NHS Foundation Trust.



	This Trust	England average
Consultant	25%	29%
Middle career^	25%	15%
Registrar group~	21%	32%
Junior*	30%	24%

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

(Source: NHS Digital Workforce Statistics)

The Royal College of Emergency Medicine (RCEM) recommendation is that there is consultant presence in the emergency department 16 hours a day seven days per week as a minimum in all emergency departments. There were two consultants on the shop floor between 8.00 and 11:00 Monday to Friday and every second weekend. There was nine hours consultant cover on

alternate weekends and then on call. Additional five-hour locum shifts were offered to consultant staff to increase coverage where possible on these weekends.

There was 24/7 paediatric consultant cover in the paediatric emergency department (PED) with paediatric consultants rostered to be in PED from 9:00 to 5:00pm. Out of hours PED was covered by the emergency department consultant. There was a recruitment drive in progress to recruit a paediatric emergency medicine consultant to work 2.5 days in PED, to include one evening a week. Rosters from January 2019 for newly recruited middle grade doctors included a four-month secondment to the PED which was designed to strengthen staffing levels there, as well as enhance their learning and experience.

Records

Staff in the emergency department kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, we found there was inconsistent record keeping in the Adult Assessment Unit.

Following the last CQC inspection in 2016, we told the trust it should ensure medical and nursing records were fully completed without gaps or omissions. On this inspection, we reviewed four patient records in the emergency department (adult treatment area) and found most information, including clinical data, was written and managed in a way that kept patients safe. Allergies, pain scores and early warning scores were completed and correctly recorded in all four patient notes. Administered medicines were recorded on the paper chart. We reviewed six charts, and all evidenced the medicine and dose given, as well as the name and registration number of the nurse who administered it.

We reviewed four paediatric patient records, and all were comprehensive and well documented. The notes were legible, complete, signed, timed and dated. Each record included allergies and the child's weight. We saw that a final set of observations was repeated before the child was admitted to a ward.

However, we reviewed four patient notes in the adult assessment unit (AAU) and found there was inconsistent recording on all four records. There was no evidence of vital signs recorded at regular intervals; no evidence of consent to care and no evidence of discussion with family on any record. There was no evidence of assessment of pressure areas on three out of four records and no evidence of nutritional assessment on two out of four records. There was review of pain management evident on all four records as well as documentation of diagnosis and management plan. We spoke with staff about this inconsistent recording and were told that observations were not routinely completed between 21:00 and 06:00 (approximate timings) in the unit. They also told us and there was lack of clarity about whose responsibility this was – whether it was healthcare assistant or the general medical nursing staff.

Records in the emergency department were largely paper based. Some staff told us this created occasional difficulties when patients were transferred to the ward from the emergency department in terms of quality of handover information. Ward staff relied on what was written on the accompanying paper record since the IT system they used was not consistent with that used in the emergency department and therefore inaccessible to them. There were plans to phase in an electronic patient record accessible to all by the end of 2019.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971 (and subsequent amendments). These medicines are known as controlled medicines or controlled drugs and their storage and dispensing are regulated by legislation. Controlled drugs should be kept in a separate locked cupboard with those keys kept separately from the main cupboard keys; counted twice daily and when dispensed, signed by two members of staff in a separate controlled drugs register. We checked the controlled drugs cabinet and confirmed that this procedure was followed in accordance with safety guidelines.

Patient group directions (PGDs) were in place for triage and streaming and nurses could prescribe simple analgesia. A PGD is a prescription signed by a doctor and agreed by a pharmacist, which acts as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients.

We reviewed four prescription cards for paediatric patients which were also completed in accordance with procedure. This included any allergies and the child's weight as well as the name, grade and NMC registration number of the nurse.

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

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

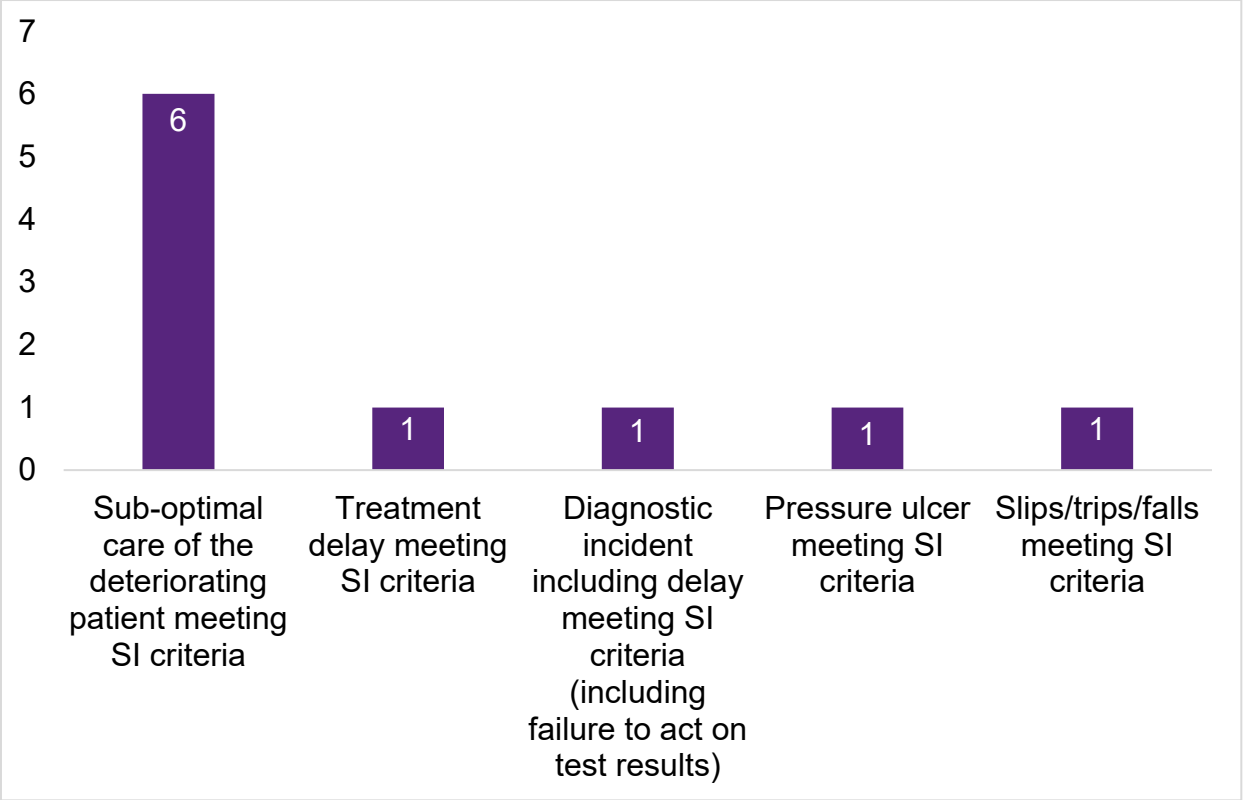
From September 2017 to August 2018, there were no reported incidents classified as never events for urgent and emergency care at the Royal Free hospital.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from August 2017 to September 2018.

These were:

- Sub-optimal care of the deteriorating patient meeting SI criteria with six (60% of total incidents)
- Treatment delay meeting SI criteria with one (10% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (10% of total incidents)
- Pressure ulcer meeting SI criteria with one (10% of total incidents)
- Slips, trips and falls with one (10% of total incidents)



(Source: Strategic Executive Information System (STEIS))

There were three serious incidents (SIs) in urgent and emergency care at the Royal Free hospital which met the reporting criteria set by NHS England from August 2017 to September 2018. Two of these were closed and one was on-going which related to sub-optimal care of the deteriorating patient.

We saw that 72-hour reports and root cause analyses of serious incidents were carried out and action plans drawn up. We found staff were aware of the current SI and learning from them, including those which were trust wide. For example, staff told us doctors must sign off all patient ECGs in direct response to findings from one SI investigation. They told us there should not be duplicate CAS cards created as this can give rise to original patient information not being transferred onto the duplicate one. Where there was an issue with correct identification of gas and air outlets, staff told us they were issued with keys to access the valves, which were labelled.

SI details and learning were e-mailed out to all staff and included in a trust wide quality and safety bulletin as well as discussed at daily safety meetings. Each member of staff we spoke with told us they were encouraged to report and said there was no sense of blame attached, with each incident seen as a learning experience. We saw copies of a weekly email to all trust staff sent by the deputy director of patient safety and risk which included information on aggression and violence towards staff; incidents and links to policies. It also included a standing invitation to staff to attend the serious incident review panel as an observer. There was also a monthly patient safety newsletter which gave guidance on current topics; for example, on medicines management, safeguarding and never events.

The trust submitted data following inspection which showed were 626 incidents recorded on the electronic incident reporting system between December 2017 and November 2018. Of these 0 were severe harm; two (0.003%) were moderate harm; 11 (70%) were low harm and 554 (88%) were no harm.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from September 2017 to September 2018 within urgent and emergency care.
(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its. The service had systems in place to ensure policies, protocols and clinical pathways were reviewed regularly and reflected national guidance, best practice and legislation.

The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment provided. Senior staff told us the paediatric unit was meeting Royal College of Paediatrics and Child Health standards. Guidance was regularly discussed at team meetings, and regular audits were completed and learning opportunities shared with staff.

A range of clinical care pathways and proforma were developed in accordance with national guidelines. These included treatment of stroke, sepsis, asthma, fractured neck of femur, acute coronary syndrome, diabetic ketoacidosis, suspected pulmonary embolism and patients with mental health problems. We found staff understood and used them effectively to manage patients' care.

We reviewed several clinical policies and guidelines during the inspection within the emergency department (ED) and on the trust intranet. Policies were in date, regularly updated and based on NICE and best practice guidelines. These were accessible to staff on the trust intranet. However, we saw there were out of date printed policies on the noticeboard in the paediatric emergency department. We drew this to the attention of staff who immediately removed them. They told us they always accessed policies on the intranet since this ensured they were using the most current ones.

The department had an active audit programme. These included national audits requested by the RCEM. Others were based on NICE guidance such as pressure ulcer reduction and local ones which looked at the flow for patients who presented with subarachnoid haemorrhage.

Emergency department staff took part in a local Commissioning for Quality & Innovation (CQUIN) project to reduce the number of frequent attenders who would otherwise benefit from mental health and psychosocial interventions. The trust worked closely with mental health providers and other agencies (including police, ambulance, substance misuse, social care and the voluntary

sector) to ensure that people who presented with primary or secondary mental health requirements had their needs met by an improved integrated service. All registrars were required to undertake a QUIP as part of their training.

Clinical Practice Groups (CPGs) were multidisciplinary groups with clinical oversight and established to reduce variation and improve care delivery across the trust. Multi-professional teams of clinicians supported by operational teams used evidence-based principles and current best practice to redesign care pathways. For example, one CPG looked at the care of children aged between two and 15 years of age that presented with a wheeze. The expectation was that there would be a reduction in admissions onto the ward and readmissions within seven days of discharge. We were told that patients and carers were part of this redesign.

Patients with potential mental health problems were identified by the emergency department triage nurse who referred directly to the psychiatric liaison team. This followed best practice (Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2, NHS England). Patients with both physical health needs and possible mental health needs were referred to the psychiatric liaison team shortly after the emergency department staff assessed them. They had a mental health assessment alongside their physical health assessment or treatment. This reduced delays for patients and improved patient experience and safety. It also followed best practice guidance (Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2, NHS England; Mental Health in Emergency Departments, The Royal College of Emergency Medicine, 2017).

Nutrition and hydration

The nutrition and hydration needs of patients was considered during their time in the service, taking their cultural, dietary and religious need into consideration.

The emergency department had a kitchen area with sandwiches and microwaveable food. Nurses took care of patient's requirements, including hot and cold drinks. We observed healthcare assistants and nursing staff offering hot or cold drinks to patients and saw members of staff assist those patients who were unable to feed themselves.

In the CQC Emergency Department Survey, the trust scored 6.1 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

Pain relief

Patients' pain was assessed and managed appropriately by staff on arrival at the department, including those with difficulties communicating.

In the CQC Emergency Department Survey, the trust scored 5.6 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts.

The trust scored 7.2 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

Question – Effective	Score	RAG
Q31. How many minutes after you requested pain relief	5.6	About the same as

medication did it take before you got it?		other trusts
Q32. Do you think the hospital staff did everything they could to help control your pain?	7.2	About the same as other trusts
Q35. Were you able to get suitable food or drinks when you were in the emergency department?	6.1	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

We spoke with patients in waiting areas as well as in the cubicles who told us staff offered pain relief at regular intervals. We did not observe any patients left in pain and saw they were repeatedly asked whether they required any 'top up' pain relief.

Pain scores were incorporated into the paediatric early warning score (PEWS) observation chart. We heard staff encouraged patients to self-report and reminded them that they should not remain in pain for any length of time.

Patient outcomes

Managers monitored the effectiveness of care and treatment but did not always use the findings to improve them.

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, the Royal Free Hospital's emergency department was in the upper UK quartile for one standard:

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 87.1%; UK: 77%.

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

- Standard 1a (fundamental): O_2 should be given on arrival to maintain saturation at 94-98%. This department: 12.8%; UK: 19%.
- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 10.3%; UK: 26%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 7.7%; UK: 25%.

The department's results for the remaining three standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Consultant sign-off audit, the Royal Free Hospital's emergency department failed to meet any of the national standards.

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

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 4.0%; UK: 11%.
- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 0%; UK: 8%.

- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 3.3%; UK: 12%.

The department's result for the remaining standard was within the middle 50% of results.
We were told during inspection that no re-audit was planned of either of these two RCEM audits, so it was not possible to comment on whether any improvements were evident.
Following inspection, the trust informed CQC that a spot check done between November and December 2018 showed there was improved consultant sign-off. For example, there was 50% consultant sign off for fever in children under one year old and 25% for atraumatic chest pain in patients aged 30 years and over.

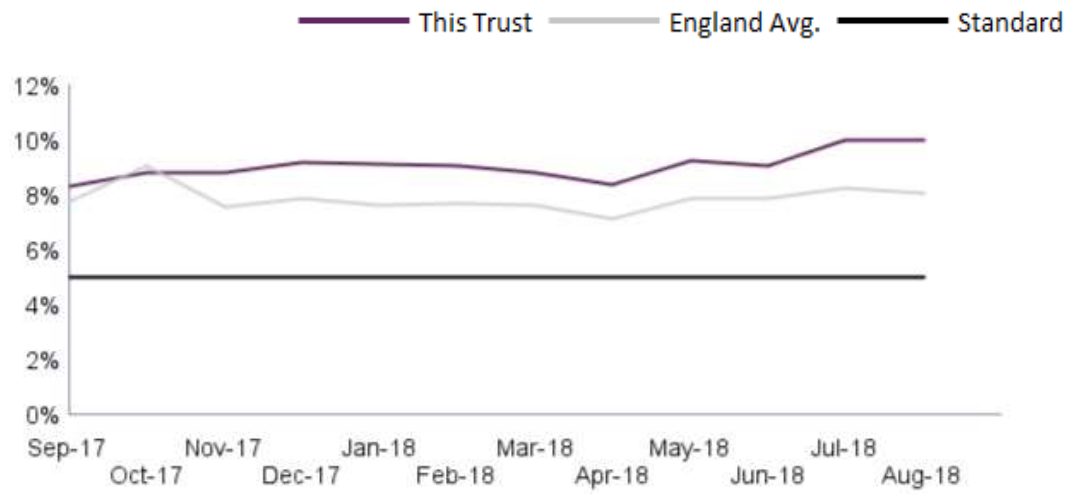
(Source: Royal College of Emergency Medicine)

In the 2016/17 Severe sepsis and septic shock audit, the Royal Free Hospital's emergency department was in the upper UK quartile for four standards:

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 66.3%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 62.5%; UK: 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 66.3%; UK: 44.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 75.3%; UK: 18.4%.

The department's results for the remaining four standards were all within the middle 50% of results.
(Source: Royal College of Emergency Medicine)

From September 2017 to August 2018, the trust's unplanned re-attendance rate to the emergency department within seven days was worse than the national standard of 5% and worse than the England average with the exception of October 2017 where performance was similar to the England average. In the latest period, August 2018, trust performance was 10.0% compared to an England average of 8.1%.
Unplanned re-attendance rate within seven days - Royal Free London NHS Foundation Trust



(Source: NHS Digital - A&E quality)

Competent staff

The service made sure staff were competent for their roles. Patients were cared for by staff with the right qualifications, skills and knowledge to provide safe care. However, managers did not appraise all staff.

From April to September 2018, 73.7% of staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 85%. Nursing staff had a 78.8% completion rate and medical/dental staff had a 75.3% completion rate.

Trust wide

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Estates and Ancillary	1	1	85%	100%	Yes
Nursing Registered	146	115	85%	78.8%	No
Medical and Dental	73	55	85%	75.3%	No
Healthcare Assistants	40	23	85%	57.5%	No
Administrative and Clerical	10	5	85%	50.0%	No
Total	**270**	**199**	**85%**	**73.7%**	No

Nursing staff at Royal Free Hospital had a completion rate of 69.2% and medical/dental staff had a completion rate of 33.3%, compared to the 85% trust target.

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Estates and Ancillary	1	1	85%	100%	Yes
Nursing Registered	65	45	85%	69.2%	No
Healthcare Assistants	17	6	85%	35.3%	No
Medical and Dental	9	3	85%	33.3%	No
Total	**92**	**55**	**85%**	**59.8%**	**No**

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

During inspection, we saw data for December 2018 which showed there was improved compliance with appraisals which was 74% for nursing staff and 77% for medical staff, both of which remained below the trust 85% trust standard.

Newly qualified nursing staff spoke positively of the support they received to enhance their clinical skills. They described the range of training they completed or were about to complete.

These included intravenous cannulation, venepuncture and plastering.

We spoke with nurse clinical practice educators whose role it was to support newly qualified nurses and ensure they accessed training relevant to their development. There was an extended preceptorship programme (a structured transition period for newly qualified nurses when they start employment) for all newly qualified nurses which was delivered over eight days. We were told there was protected time for training. However, some staff we spoke with told us it was not always possible to be released for training due to pressures on the shop floor.

There were study days held each month which focussed on themes, discussed case studies and often included simulated training.

Junior doctors told us there was a high degree of importance placed in their learning and they were always able to attend their teaching. On teaching days, senior doctors took responsibility for their patients which enable them to attend. Doctors told us there was good opportunity to learn on the shop floor from other doctors and nursing staff. An induction programme was run every four months for junior and middle grade doctors. This included governance, learning from serious incidents and Royal College of Emergency Medicine guidelines. There were guest speakers from the paediatric and mental health teams. There was a test at the end of the three days to check doctor's learning.

Multidisciplinary working

Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff of different kinds worked together as a team to benefit patients. Staff told us there was a sense of multidisciplinary (MDT) working; they described the interface between nursing and medical staff as cohesive and effective. They said the department worked as a collective between nursing, medical and non-clinical staff to achieve a well-run department with the patient's best interest at the forefront of everything.

Many staff said that MDT working with other specialties had improved since the time of the last CQC inspection. There was engagement with certain specialties and discussions around how to get them down to the emergency department to assess their patients in good time. However, some members of staff expressed concern about the inconsistency of specialty engagement.

We observed a situation where an elderly patient waited some time for their planned specialty appointment in the adult assessment lounge (AAL). The AAL adjoins the ambulatory emergency care (AEC) area and the emergency department staff in charge of the AEC has responsibility for patients until the specialty doctor arrives.

AEC staff raised concerns by telephone to the speciality doctor about care of the patient, who was already in the department for two hours and likely to require medical input related to their specific illness. There was lack of clarity about when the specialty doctor would attend the department to see this patient and the situation was not resolved by the time inspectors left the department.

Members of the leadership team told us the ED embraced multidisciplinary team working, which benefited staff and patients alike. Clinical practice group (CPG) membership included multidisciplinary trust wide staff. The CPG comprised of work streams which considered ways to

harmonise patient pathways to and reduce clinical variation so that patients were getting a consistent standard of care in each of the hospital sites.

Seven-day services

There was a seven-day service for radiology including-ray and computerised tomography (CT) scans. Magnetic Resonance Imaging scans were available from 9:00am to 5:00pm Monday to Friday and 9:00 to 1:00pm at weekends. There was a 24/7 pathology service.

Pharmacy was available from 9:00am to 6:30pm Monday to Friday, with limited outpatient service at the weekends.

There was weekend occupational therapy cover in the emergency department and there was support provided by a consultant on call specialist in care of the elderly.

The psychiatric liaison service was available 24/7.

There were interpreting and translation services in place where patients had instant access over the phone to a qualified interpreter 24 hours a day, seven days a week. Face-to-face interpreters could be arranged when required. This service provided qualified interpreters in 256 languages and dialects as requested by patients. British sign language and deaf blind signing were also available.

Health promotion

Patients were supported and encouraged by staff to take ownership of their recovery which helped to improve patient outcomes.

There were leaflets around the department which explained about drugs and alcohol services as well as mental health and domestic violence. Patient leaflets were available which gave information on the signs and symptoms of sepsis.

There was an alcohol care team which staff told us was responsive to requests for support. This team offered a range of interventions which included referral to community alcohol services if required.

Staff were aware of the trust domestic abuse programme in place called ‘You are not alone’ which was in line with Home Office report ‘Ending Violence Towards Women and Girls 2016’. Domestic abuse awareness training for staff was part of safeguarding training.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The trust reported that from April 2018 to August 2018 Mental Capacity Act (MCA) and DoLs training was completed by 50% of staff in urgent and emergency care compared to the trust target of 85%.

The breakdown by site was as follows:

- Royal Free Hospital emergency department: 52%
- Barnet Hospital emergency department: 54%
- Chase Farm UCC: 39%

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

Following inspection, the trust submitted Mental Capacity training data for nursing and medical staff at the Royal Free hospital. This showed that compliance rates at November 2018 were 80% for nursing staff and 70% for medical staff which was below the trust standard of 85%. However, ED staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). Staff we spoke with understood their responsibilities in relation to patients who lacked the mental capacity to make decisions about their care and treatment and the key principles of the MCA. They understood their duty to act in the patient's best interests.

A best interest decision was taken in an emergency, for example where emergency intubation was required. A best interest decision is where a patient is assessed to lack capacity; any action taken, or any decision made for, or on behalf of that patient, must be made in his or her best interests by a doctor or nurse.

The nature of emergency medicine was such that there were few occasions when written consent was required and consent was implied. Staff were therefore focused on patients giving them verbal or implied consent. We observed verbal consent taking and appropriate recording, including consent for inspectors and specialist advisors to observe aspects of care. We saw consent documented in patient records and, in the case of a child; we saw the parent or guardian signed their consent.

Patients with mental health issues assessed as requiring admission to a mental health unit waited in one of two close observation rooms in the department until a bed became available in a specialist unit. They were assigned a registered mental health nurse to supervise them as well as a security guard if this was deemed necessary. We were told there were occasions when it took up to 36 hours for a bed to become available; during which time patients were risk assessed by the mental health liaison team to determine their mental capacity in relation to an expressed wish to leave or refuse further assessment. Provided the patient could demonstrate mental capacity to make that decision and was not a risk to themselves then they could immediately leave.

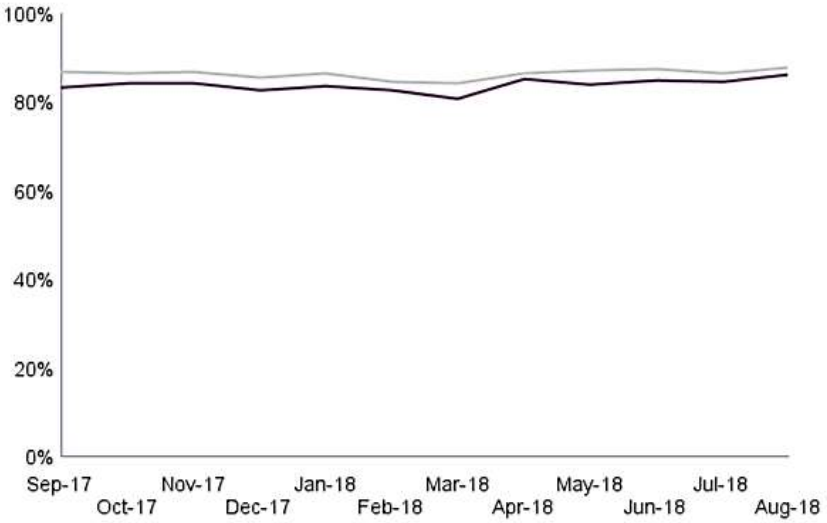
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

From September 2017 to August 2018, the trust's urgent and emergency care friends and family test (FFT) performance (% recommended) was slightly worse than the England average. In the latest period, August 2018 performance was 86.3% compared to the England average of 87.7%. NHS England recommends that FFT results should not be used to compare trusts.

A&E Friends and Family Test performance - Royal Free London NHS Foundation Trust



(Source: NHS England Friends and Family Test)

We spoke with fourteen patients and relatives, most of whom praised the staff for their kindness. Patients told us they were treated with dignity and respect at all times. Those in the general waiting area told us “the nurses are all very professional, keep me informed" and “they all work so hard and keep smiling through it.”

Staff closed the curtains within the cubicles to provide privacy when assessing and treating patients, and ensured patients’ dignity was maintained when curtains were opened. Patients were always covered up when in public areas. We observed how staff took care during handover to anonymise patients and refer to them by their cubicle number. They spoke in low voices when discussing patient related information.

We heard staff introduce themselves when they entered patient cubicles and asked the patient what their preferred name was. We observed several instances of staff being caring towards patients. For example, we saw a nurse accompanying a family member to where their relative was within the department. We also saw many staff take turns to spend time with an unsettled elderly frail patient in their cubicle.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. For example, ED staff told us that the lights could be dimmed in the bay area to manage patient’s hypersensitivity to light.

The department received positive feedback about the compassionate care provided in the form of cards and letters, many of which were displayed in the staff room.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Emotional support was provided to patients and relatives. There was a relative’s room in ED where family members could go to when their relative was gravely ill or had died. This enabled them to have confidential discussions with the medical and nursing team away from the general busyness of the department. The room had comfortable seating, was well maintained and had tea and coffee making facilities. Staff we spoke with showed understanding and a non-judgmental attitude when talking about patients with mental health needs, learning disabilities, autism or dementia.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

The trust scored worse than other trusts for three of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 21 questions.

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	4.4	About the same as other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.1	About the same as other trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.2	About the same as other trusts
Q14. Did the doctors and nurses listen to what you had to say?	8.8	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.8	About the same as other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	8.4	Worse than other trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	7.5	About the same as other trusts
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?	8.3	About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	7.4	About the same as other trusts
Q22. Sometimes in a hospital, a member of staff will say one thing, and another will say something quite different. Did this happen to you in the emergency department?	8.8	About the same as other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.5	About the same as other trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	8.8	About the same as other trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.1	About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	5.5	About the same as other trusts
Q26. Did a member of staff explain why you needed these test(s) in a way you could	8.4	About the same as other trusts

Question	Trust 2016	2016 RAG
understand?		
Q27. Before you left the emergency department, did you get the results of your tests?	8.5	About the same as other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	8.8	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.4	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	4.6	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	4.5	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	2.9	Worse than other trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	4.3	Worse than other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	6.5	About the same as other trusts
Q45. Overall	7.7	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Most patients and their relatives we spoke with told us they received regular communications and were kept informed about their care, treatment and condition during their time in the department. Patients in the waiting area told us although there was no electronic indicator to indicate waiting times, the receptionist or nurse kept them updated on their expected waiting time. Staff made sure patients and relatives understood the assessments being done and the likely diagnosis and treatment plan. We observed patients and relatives were given opportunities to ask questions following any explanations about their treatment plan.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The trust planned and provided services in a way that met the needs of local people. Patients were streamed to a number of areas for their safe treatment when they arrived at the hospital. The emergency department treated people with serious and life-threatening emergencies and the paediatric emergency department treated children up to the age of 18. Adults and children with less urgent illnesses and minor injuries were treated in the urgent care centre or streamed to the

adult emergency care area. The paediatric emergency department was a dedicated facility with a separate entrance and waiting area.

The Royal Free emergency department was completely remodelled, and all functions moved into the new area in June 2018. The rapid assessment and treatment area (RAT) had six bays to receive patients brought in by ambulance. The RAT area enabled senior decision making to take place since there was consultant or senior doctor assessment within the first hour, as well as early referral to specialties.

The majors area (ATA - adult treatment area) had 16 cubicles and one isolation cubicle, as well as two close observation rooms for patients who presented with mental health problems. The remodelled department included an x-ray facility which enabled patients to access urgent diagnostic imaging more rapidly. Staff spoke positively about the redesigned department, including the x-ray facility which they said enhanced patient care and safety.

Patients who did not require hospital admission but were not fully fit for discharge were nursed on the adult assessment unit (AAU). This was a unit with 29 beds, nine of which were ring-fenced for emergency department patients. This number could be flexed when there were bed pressures and was included in winter pressure planning.

The AAU was overseen by medicine division and nursing staff were general medicine nurses. A registrar from the emergency department was assigned to the unit each day to attend to emergency department patients. Medical staff responsibility for the rest of the patients was dependent upon which specialty the patient was under. Some staff expressed concern that whilst medical patient responsibility was usually clarified at handover, this occasionally changed without it being notified to the unit staff. This meant that in the case of a deteriorating patient, nursing staff may not always know who to contact.

The department had several patients who were frequent attenders, many of whom had a management plan which emergency department staff accessed. There was a working party which met every two months to discuss and plan for this patient group. This was a multidisciplinary meeting and included members of staff from different specialties as well as representatives from the ambulance service, local authority and clinical commissioning group.

Meeting people's individual needs

Although the needs and preferences of patients were considered when delivering and coordinating services including those with complex needs and vulnerable circumstances, services did not always meet the needs of people with a learning disability.

Staff did not use or access specific communication aids for patients with a learning disability and were unfamiliar with hospital passports. A hospital passport provides immediate and important information specific to the patient for doctors, nurses and administrative staff in an easy to read form. It includes communication methods, likes and dislikes and help to make the hospital journey easier for those patients with a learning difficulty.

Staff told us there were trust leads for learning disabilities and dementia. They also told us the trust learning disability lead visited the department on a weekly basis and offered support and advice as and when required. We were also told there were members of staff in the department with a special interest in patients with learning disabilities and dementia, but they did not have training specific to the role of a learning difficulty or dementia champion.

There were flags on the patient record to indicate certain risks. For example, if the person was known to fall; had dementia; had a frailty score; was on the sepsis pathway or was at risk of absconding. There was a flag for patients with a learning disability on the electronic patient record

system. Patients identified as vulnerable or with a special need were fast-tracked by reception staff to the nurse streamer, so they did not have to be in the department any longer than was necessary.

The cubicles were dementia friendly in design. One wall had a scene such as a seascape or woodland, which members of staff chose during the design phase. There was a clock in each cubicle and an electronic skyscape in the ceiling above the bed. One member of staff told us when fully operational; this will replicate the sky according to the time of day. Lights in the department were dimmed at night to encourage sleep. Some cubicles in the resuscitation area had writing on the ceiling which informed the patient of where they were.

Staff members told us they could access a British Sign Language signer for those with a hearing impairment as well as a translation service if required by patients for whom English was their second language.

Patients who required a longer period of recovery time but were not sick enough to be admitted were transferred to the adult assessment unit (AAU), which had capacity for up to 29 patients, nine beds of which were ring-fenced for ED patients. These were patients who were not immediately well enough to go home but expected to be able to do so within 24 hours.

The psychiatric liaison service provided assessments of patients aged 17 or over presenting to the ED with mental health needs and/or drugs and alcohol needs. Members of nursing and medical staff told us this team was both responsive and supportive and said 96% of patients referred to the team were seen within the standard of one hour.

People who arrived at the emergency department and displayed suspected mental health problems were initially assessed by emergency department staff. This assessment included a brief mental health assessment to determine the possible level of risk to the patient. Based on this, staff made a referral to the psychiatric liaison team. This practice followed best practice guidance (Mental Health in Emergency Departments, The Royal College of Emergency Medicine, 2017).

When patients were assessed as at high risk of self-harm or absconding, staff could request a mental health nurse (RMN) from a bank or agency to observe the patient. Security staff observed the patient until the RMN arrived. There were clear procedures in place for 1:1 observations.

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

Question – Responsive	Score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	6.9	About the same as other trusts
Q11. Overall, how long did your visit to the emergency department last?	6.2	About the same as other trusts
Q20. Were you given enough privacy when being examined or treated?	8.9	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))

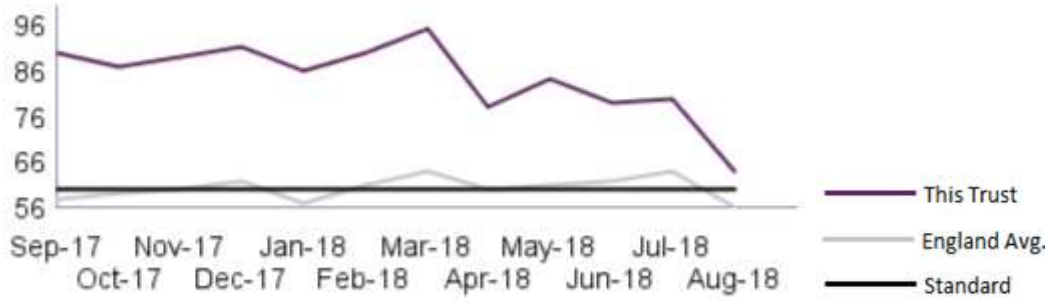
Access and flow

People could always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with good practice.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard over the 12-month period from September 2017 to August 2018.

From September 2017 to August 2018 performance against this standard was worse than the England average although showed an improving trend. In the latest period, August 2018, the median time to treatment was 64 minutes compared to the England average of 56 minutes.

Median time from arrival to treatment from September 2017 to August 2018 at Royal Free London NHS Foundation Trust



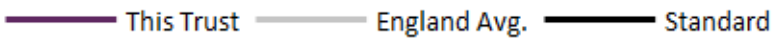
(Source: NHS Digital - A&E quality indicators)

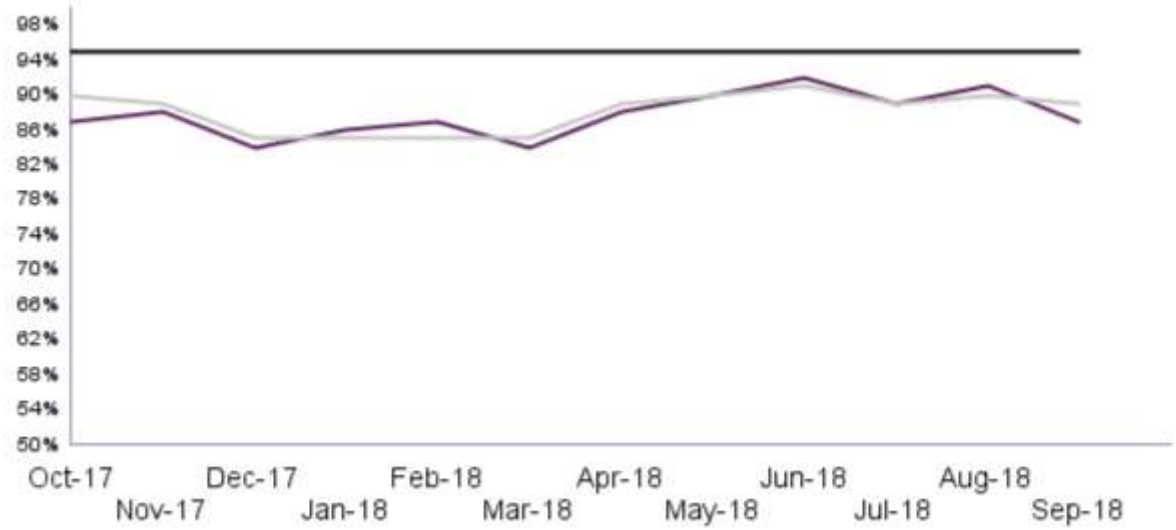
The trust submitted data following inspection which showed that average performance of this standard was 58% between November 2017 and October 2018. The highest performing month was August 2018 where 49.7% of patients waited more than one hour from time of arrival to receiving treatment.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From October 2017 to September 2018 the trust failed to meet the standard and performed about the same as the England average. Over the same period, performance against this metric showed a similar pattern to the England average.

Four-hour target performance - Royal Free London NHS Foundation Trust



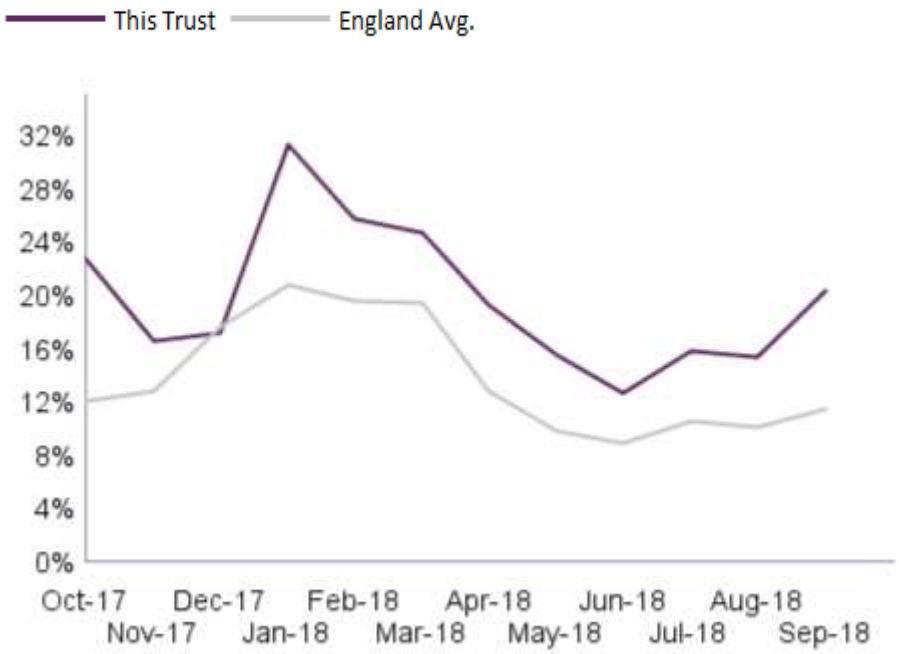


(Source: NHS England - A&E Waiting times)

The trust submitted data following inspection which showed that average performance of this standard was 85% between November 2017 and October 2018. The lowest performing month was December 2017 (79%) and the highest was October 2018 (89.7%).

From October 2017 to September 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average, with the exception of December 2017 where performance was similar.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Royal Free London NHS Foundation Trust



A breakdown by month of patients waiting more than four hours to admission is below:

Month	Number of patients waiting more than four hours to admission
October 2017	935
November 2017	742
December 2017	742

January 2018	1,190
February 2018	962
March 2018	1,060
April 2018	786
May 2018	690
June 2018	567
July 2018	718
August 2018	663
September 2018	840

(Source: NHS England - A&E SitReps)

Over the 12 months from October 2017 to September 2018, no patients waited more than 12 hours from the decision to admit until being admitted.

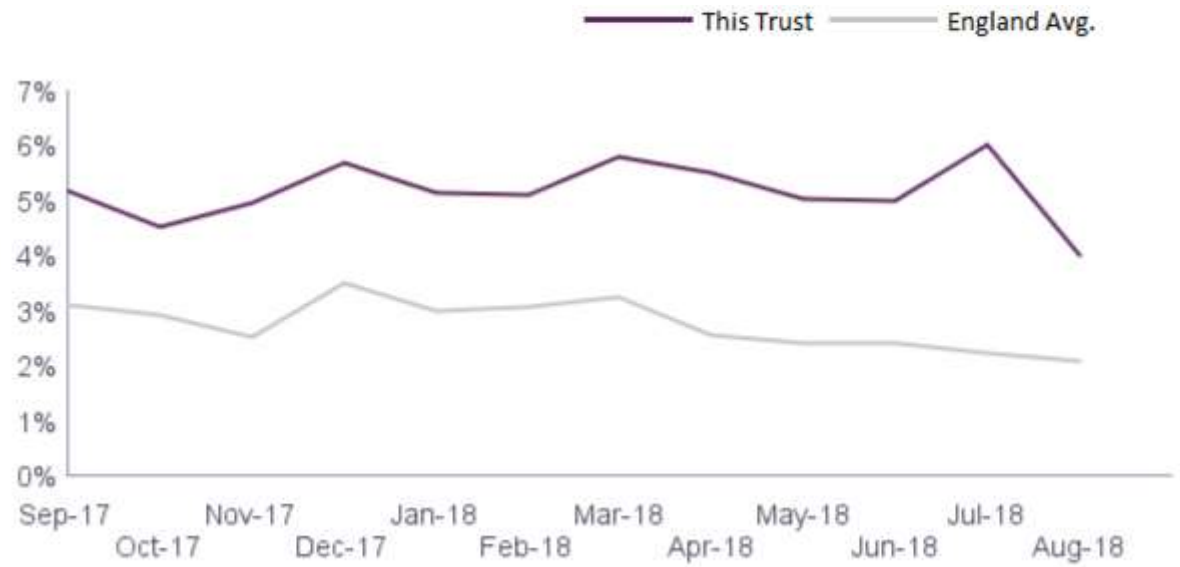
(Source: NHS England - A&E Waiting times)

From September 2017 to August 2018 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average with performance ranging from 4% to 6%.

Over the same period, performance against this metric showed a stable trend until July 2018 where performance worsened, with 6% of patients leaving the trust's urgent and emergency care services before being seen for treatment, compared to the England average which was 2.2%.

Performance showed an improvement in the latest period, August 2018 where the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 4.0%, compared to the England average which was 2.1%.

Percentage of patient that left the trust's urgent and emergency care services without being seen - Royal Free London NHS Foundation Trust

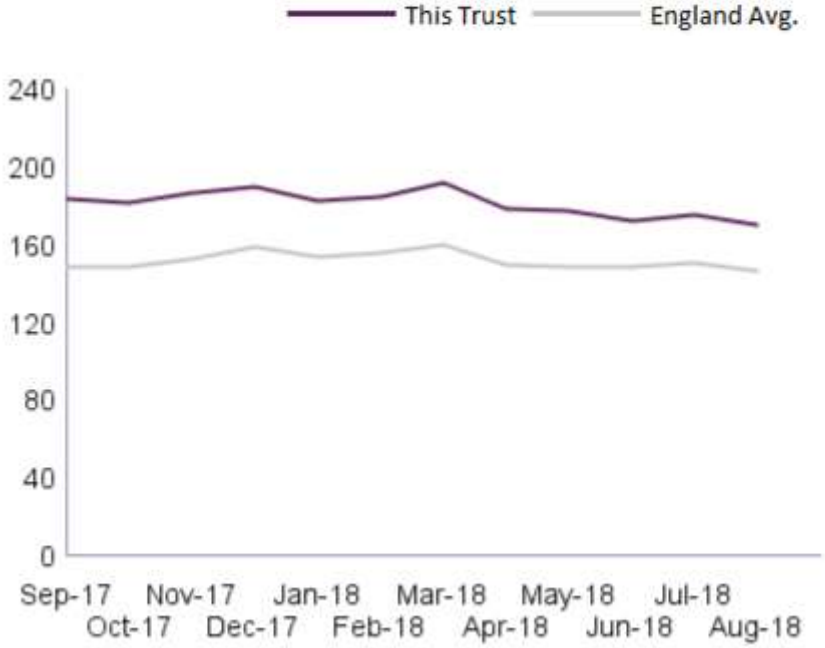


(Source: NHS Digital - A&E quality indicators)

From October 2017 to September 2018 the trust's monthly median total time in A&E for all patients was higher than the England average. In the latest period, August 2018 the trust's monthly median total time in A&E for all patients was 170 minutes compared to the England average of 146 minutes.

From October 2017 to September 2018, performance against this metric ranged between 172-192 minutes, compared to the England average of 146-160 minutes.

Median total time in A&E per patient - Royal Free London NHS Foundation Trust



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

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From September 2017 and August 2018 there were 156 complaints about urgent and emergency care services. The trust took an average of 34 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed and closed with 35 days.

The three most common subjects of complaints are shown in the table below:

Subject	Number of Complaint
All aspects of clinical treatment	84 (53.9%)
Attitude of staff	32 (20.5%)
Communication/information to patients (written and oral)	14 (9.0%)

Site	Number of Complaints
Barnet Hospital	73 (46.8%)
Royal Free Hospital	67 (43.0%)
Chase Farm Hospital	16 (10.3%)

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

We saw posters and leaflets advertising the Patient Advice and Liaison Service (PALS) throughout the wards. Many patients and relatives told us they were aware of how to make a complaint and said they would initially speak with staff for a more immediate resolution.

Staff we spoke with stated they were aware of how to direct patients or visitors to the PALS team and stated that PALS would regularly provide advice and support when requested.

We looked at copies of two complaints during inspection. The department allocated a senior consultant to manage the complaints. We saw the complaint was acknowledged and the response time was in line with trust policy. The department apologised and offered to meet with the complainants which one accepted. There was evidence that learning points had been identified and lessons learned were shared with to prevent future occurrences.

From September 2017 to August 2018 there were 101 compliments in urgent and emergency care.

- Barnet Hospital: 59
- Royal Free Hospital: 39
- Chase Farm: Nine

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

Is the service well-led?

Leadership

Managers had the right skills and abilities to run a service providing high-quality sustainable care.

The emergency department sat within the medicine and urgent care division. It was led by a clinical director, two matrons and an operational manager. They reported to the board through the medical director. We saw that the senior leadership across the department was cohesive with a high level of interaction and good communication across all staff groups. Staff members told us they were familiar with all the team, who were very visible and were usually around the department.

The emergency department senior leadership team were aware of the challenges and barriers to improving the safety and quality of care for patients, including those with known or suspected mental health symptoms.

Nursing staff told us how the two matrons were supportive and approachable. They told us they were good role models and spent a substantial amount of time on the shop floor, ready to guide and support when required.

Junior doctors said they never felt uncomfortable about contacting the on-call consultant or raise concerns or uncertainties with them. They said they were strongly encouraged to do so, and they were told that every experience was a learning experience. They said they were comfortable to discuss matters with the clinical lead whom they found to be very visible, calm and encouraging.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Most staff understood and shared the trust vision of being positively welcoming; actively respectful; clearly communicating and visibly reassuring. They told us they were proud of the way in which the emergency department upheld this vision and expressed great pride in working at the Royal Free hospital.

The leadership team shared with us their vision of the department, which was to provide seamless flow; integrated care from the front door; fast and effective communication and a focus on ambulatory care.

The clinical director came into post in September 2018 and was in the process of formulating a three-year plan. This included active recruitment; work streams to consolidate practice and procedures in different parts of the department to improve flow as well as improvement to IT systems to enable better information sharing across the hospital.

Most staff we spoke with were aware of the improvement plans and were familiar with many aspects of it. They told us they believed it was realistic and achievable and their hope was that it would result in continuing improvements to the department.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Members of the leadership team told us they were proud to work in the department. They cited the commitment and skills of the staff group as a major contributory factor in this. They said the restructure of the department was disruptive for a period of time. Staff resilience meant that they adapted to and embraced this change, which led to enhanced patient safety and service delivery.

Many staff described the culture of the emergency department as progressive, with consideration given to patient care, comfort and safety at all times. They were excited about the new department and whilst they acknowledged that certain aspects of flow were yet to be embedded, they were optimistic for the future and confident that the department would continue to go from strength to strength. Members of staff also told us there was support and encouragement from their leadership team to develop their careers; this included representing the department in multidisciplinary meetings with other specialities, as well as taking on senior nursing roles in the urgent care centre. Band 7 nurses told us they were actively encouraged to undertake management roles.

Staff told us there was no sense of blame attached to any mistake made. The culture was one of openness where staff understood it was safe to discuss issues without fear of blame or punishment. The emphasis was on learning from each incident and each other.

Governance

The trust used a systematic approach to continuous improvement of the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The clinical director told us that consultants were allocated governance roles. These included complaints lead; coroner coordinator; morbidity and mortality lead; recorded incident investigator; serious incidents investigator; audit lead and learning from deaths lead. This meant the overall governance structure was robust since there was oversight of and assurance from each area.

The clinical lead and operations manager met each week to review all electronically recorded incidents, current serious incidents and outstanding actions as well as the risk register. There was a multidisciplinary meeting with specialities each month to review incidents and themes as well as complaints.

All deaths in the department were discussed at the M&M meetings three times per year. There was an open invitation to all medical and nursing staff to attend, though we were told that mainly medical staff attended. We looked at a selection of minutes between January 2018 and September 2018 and saw that following the presentation of each death there was a discussion which identified learning and action points. These action points were assigned to named individuals to disseminate. For example, one learning point related to a spinal fracture was that whilst spinal proformas were in place, they were not well embedded. The proforma gave instructions on how the patients should be managed whilst waiting on guidance from a local hospital which was a trauma centre. During inspection, staff told us they were aware of the spinal injury proforma and we saw this was on the departmental risk register.

Management of risk, problems and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The Risk Register was reviewed and updated at every governance meeting. There were 14 risks currently on the departmental risk register, the highest of which were delays in allocation of mental health beds by mental health providers; speciality delays in review of patients; Wi-Fi connectivity in the emergency department and use of inappropriate physical space for mental health patients.

Members of the departmental leadership team told us about risk reduction measures in relation to those identified. For example, one risk identified related to delays in speciality doctors attending the emergency department to review patients within trust specified timeframe. We saw that an inter-professional standards document was signed off by the medical director in November 2018 and distributed amongst all specialty teams. This document states that the specialty doctor should attend the emergency department within 30 minutes to assess the patient and a management plan should be in place within one hour of referral. This is currently being monitored in the adult assessment lounge area as well as via breach data. Since this document was so recently introduced, there was no available data to assess the impact.

It is generally acknowledged that there is a countrywide shortage of mental health bed provision. Delays in allocation of mental health beds were discussed at monthly meetings with the local mental health trust. Members of the leadership team told us whilst there was little they could do to about the shortages of beds; they ensured that there was a good working relationship with the local mental health trust so that they could seek their support as required for the safe management of patients.

The internet connectivity in the emergency department was described as unreliable frequently went down, including during essential phone calls. Staff at all levels expressed frustration about this. Members of the leadership team told us they had numerous meetings with the IT department and were optimistic about a resolution early in to 2019.

We found that clinical and nursing staff we spoke with were aware of the top departmental risks as listed by the leadership team and told us the risk most relevant to them was the safe care and management of patients with a combined mental health problem. They told us that the frequently lengthy stays of this patient group placed additional pressures on the nursing team, particularly in relation to ensuring their well-being, as well as that of other patients in the department.

We discussed planning for winter pressures with the leadership team. They told us the beds in the adult assessment lounge could be flexed to accommodate more than the nine beds ring-fenced for the emergency department. They also said there would be a greater emphasis on redirection of patients at the front door which was currently a work in progress.

They also said it was important to retain the presence of the admission avoidance team and frailty team in the ED; as well as develop the work done in the 'pit-stop' area on admission avoidance work piloted by members of the allied health professionals. However, we understood that finance was not yet secured for this at the time of the inspection.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The department monitored accident and emergency performance against the four-hour target on a daily basis. This information was shared during bed management meetings each day. The emergency department was part of the divisional quality meeting which fed into the trust's quality board. Key quality indicators such as four-hour waits were discussed here and any concerns in the department were escalated to the trust.

Engagement

The trust ensured that patients, and their relatives and carers, the public, staff and external partners were actively engaged and involved in identifying and driving improvements in services.

The department ran focus groups to seek staff feedback on the programme of changes to the department. Many staff requested a regular forum in which they could meet with members of the leadership team to discuss plans and makes contributions to any developments. In response to this, a weekly breakfast meeting was set up where all staff, clinical and non-clinical were invited to drop in. This was led by the ED triumvirate leadership team and was an opportunity to hear updates, proposals for change and any suggested improvements. It was also an opportunity to share learning learn from incidents and address any urgent issues raised by staff. When required, staff from outside of the department attended to clarify any queries specific to their role. Most staff told us they valued these breakfast meetings; they said it felt a safe space to put forward ideas and to query suggested changes. It was also a chance to meet with colleagues in an informal way away from the shop floor.

A consultant from the emergency department was recently appointed as patient advocate to attend patient feedback groups and gather feedback relevant to the emergency department.

Patients were invited to make suggestions to inform the design of department. This was particularly evidenced in the dementia-friendly cubicles in the emergency department. Members of staff in the paediatric emergency department told us how patients and parents were consulted on the design of the environment.

Learning, continuous improvement and innovation

There were robust systems and processes for learning, continuous improvement an innovation.

Members of the leadership team told us how the environment in the new department improved patient experience and was a safer and more efficient working environment. There were plans in progress to develop a multi-disciplinary urgent treatment centre. We were told there was joint

learning between primary and secondary care staff with regards to streaming within the hospital and redirection of patients to other points of care in the community.

The structured approach to improvement work in the department was carried out using the quality, innovation, productivity and prevention programme (QUIPP). The department recently won first prize in a local competition for their streaming work which was presented by the institute for healthcare improvement.

Medical care (including older people's care)

Facts and data about this service

The medical care service at the trust provides care and treatment for a number of specialties. There are 281 medical inpatient beds located across 12 wards on the Royal Free Hospital Hampstead site.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 66,461 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 24,946 (37.5%), 2,647 (4.0%) were elective, and the remaining 38,868 (58.5%) were day case. Admissions for the top three medical specialties were:

- General medicine - 16,323 admissions
- Gastroenterology - 13,648 admissions
- Dermatology - 5,987 admissions

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff although they did not make sure everyone completed it.

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 at trust level for qualified nursing staff in medicine is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	509	535	95.1%	85%	Yes
Infection Control L1	505	535	94.4%	85%	Yes
Resuscitation L1	505	535	94.4%	85%	Yes
Basic Radiation Safety	486	535	90.8%	85%	Yes
Fraud & Security	481	535	89.9%	85%	Yes
Emergency Planning	478	535	89.3%	85%	Yes
Health & Safety Awareness	471	535	88.0%	85%	Yes
Waste Management	470	535	87.9%	85%	Yes
Moving and Handling	443	535	82.8%	85%	No

Information Governance	421	535	78.7%	85%	No
IRR17	31	40	77.5%	85%	No
WRAP	10	13	76.9%	85%	No
Infection Control L2	406	535	75.9%	85%	No
Conflict Resolution	403	535	75.3%	85%	No
Equality, Diversity & Human Rights	401	535	75.0%	85%	No
Fire Safety	393	535	73.5%	85%	No
Blood Transfusion	374	530	70.6%	85%	No
RTT L1	118	169	69.8%	85%	No
Resuscitation L2	346	535	64.7%	85%	No

In medicine the 85% target was met for eight of the 19 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 at trust level for medical staff in medicine is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
IRR17	14	21	66.7%	85%	No
Resuscitation L1	186	312	59.6%	85%	No
BPAT	172	312	55.1%	85%	No
Infection Control L1	169	312	54.2%	85%	No
Health & Safety Awareness	168	312	53.8%	85%	No
Fire Safety	167	312	53.5%	85%	No
Basic Radiation Safety	164	312	52.6%	85%	No
Emergency Planning	157	312	50.3%	85%	No
Fraud & Security	155	312	49.7%	85%	No
Equality, Diversity & Human Rights	147	312	47.1%	85%	No
Waste Management	145	312	46.5%	85%	No
Information Governance	137	312	43.9%	85%	No
Moving and Handling	129	312	41.3%	85%	No
RTT L1	125	312	40.1%	85%	No
Blood Transfusion	118	297	39.7%	85%	No
Conflict Resolution	118	311	37.9%	85%	No
Resuscitation L2	114	312	36.5%	85%	No
Infection Control L2	112	312	35.9%	85%	No

In medicine the 85% target was not met for any of the 18 mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the medicine department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)

BPAT	271	286	94.8%	85%	Yes
Resuscitation L1	270	286	94.4%	85%	Yes
Infection Control L1	268	286	93.7%	85%	Yes
Emergency Planning	262	286	91.6%	85%	Yes
Basic Radiation Safety	259	286	90.6%	85%	Yes
Waste Management	257	286	89.9%	85%	Yes
Fraud & Security	253	286	88.5%	85%	Yes
Health & Safety Awareness	250	286	87.4%	85%	Yes
Moving and Handling	239	286	83.6%	85%	No
Equality, Diversity & Human Rights	225	286	78.7%	85%	No
Conflict Resolution	221	286	77.3%	85%	No
Information Governance	217	286	75.9%	85%	No
Fire Safety	209	286	73.1%	85%	No
IRR17	24	33	72.7%	85%	No
Infection Control L2	205	286	71.7%	85%	No
Blood Transfusion	186	281	66.2%	85%	No
RTT L1	51	78	65.4%	85%	No
Resuscitation L2	180	286	62.9%	85%	No

At Royal Free Hospital medicine department, the 85% target was met for eight of the 18 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the medicine department at Royal Free Hospital is shown below:

Name of course	**Staff trained**	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Fire Safety	118	188	62.8%	85%	No
Resuscitation L1	108	188	57.4%	85%	No
Health & Safety Awareness	97	188	51.6%	85%	No
Infection Control L1	96	188	51.1%	85%	No
BPAT	96	188	51.1%	85%	No
IRR17	6	12	50.0%	85%	No
Basic Radiation Safety	92	188	48.9%	85%	No
Equality, Diversity & Human Rights	89	188	47.3%	85%	No
Fraud & Security	88	188	46.8%	85%	No
Emergency Planning	87	188	46.3%	85%	No
Waste Management	84	188	44.7%	85%	No
Information Governance	79	188	42.0%	85%	No
Conflict Resolution	77	187	41.2%	85%	No
Moving and Handling	74	188	39.4%	85%	No
Blood Transfusion	66	173	38.2%	85%	No
RTT L1	71	188	37.8%	85%	No
Infection Control L2	58	188	30.9%	85%	No
Resuscitation L2	54	188	28.7%	85%	No

At Royal Free Hospital medicine department, the 85% target was not met for any of the 18

mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

In endoscopy, 32% of staff were fully compliant with mandatory training requirements and amongst in allied health professionals therapies teams, 90% of staff were compliant. Amongst private patients unit (PPU) staff, 85% had up to date training, which reflected 13 modules in which the trust 85% target was met or exceeded.

Staff we spoke with said they did not consider the mandatory training completion rates to be accurate because of problems with the administration system. For example, staff said they were allocated courses on the system that they were not required to complete and managers could not easily remove these. This affected their overall completion rate and meant they could not access other training that required 100% completion. Ward managers and clinical practice educators (CPEs) confirmed this and said that because the system only updated periodically it caused lengthy delays and administrative 'conflicts' that prevented staff accessing other training.

We spoke with CPEs about the provision of time and resources for mandatory training. They highlighted a number of significant barriers. For example, IT failures were frequent and the team said there was no clear escalation pathway for this. One senior nurse said the computers in their area had needed a software update for over six months but the IT department were not authorised to do this, which meant staff had been unable to access mandatory training. There was also a significant backlog in the availability of some courses, such as moving and handling. This meant staff sometimes waited several months to access the training even if they planned in advance. The CPE team said the volume of new nurses presented a further challenge to ensure mandatory training was up to date. For example, 15 new nurses started working on ward 8E over a two-month period in 2018.

We asked 14 nurses, seven junior and four consultants about mandatory training, specifically about the poor completion rates amongst medical staff. They said there were broad differences in the approach to mandatory training depending on the ward. For example, some ward managers authorised study leave to complete training in their time off and others did not. This meant there were wide variances in completion rates.

We discussed our concerns with the divisional leadership team for the medicine and urgent care division. They had identified further problems in the administration system. For example, where staff moved between departments the system in their team did not recognise previous training. This skewed the data and meant local team leaders or ward managers were unable to identify specific levels of compliance. The divisional team acknowledged the IT challenges and said this was regularly discussed in governance meetings. They were actively seeking solutions although none were forthcoming at the time of our inspection. The team also said come trust computers had been reserved only for mandatory training completion although none of the staff we spoke with were aware of these.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it but completion rates were variable.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 at trust level for qualified nursing staff in medicine is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	501	535	93.6%	85%	Yes
Safeguarding Adults L2	489	535	91.4%	85%	Yes
Safeguarding Children L1	487	535	91.0%	85%	Yes
Safeguarding Children L2	463	535	86.5%	85%	Yes
Safeguarding Children L3	9	13	69.2%	85%	No

In medicine the 85% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 at trust level for medical staff in medicine is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	163	312	52.2%	85%	No
Safeguarding Adults L1	159	312	51.0%	85%	No
Safeguarding Children L2	152	312	48.7%	85%	No
Safeguarding Adults L2	151	312	48.4%	85%	No

In medicine the 85% target was not met for any of the four safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for qualified nursing staff in the medicine department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	267	286	93.4%	85%	Yes
Safeguarding Adults L2	262	286	91.6%	85%	Yes
Safeguarding Children L1	258	286	90.2%	85%	Yes
Safeguarding Children L2	249	286	87.1%	85%	Yes

At Royal Free Hospital medicine department, the 85% target was met for all of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for medical staff in the medicine department at Royal Free Hospital is shown below

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	92	188	48.9%	85%	No
Safeguarding Adults L2	87	188	46.3%	85%	No
Safeguarding Children L1	92	188	48.9%	85%	No

Safeguarding Children L2	87	188	46.3%	85%	No

At Royal Free Hospital medicine department, the 85% target was not met for any of the four safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
A dedicated safeguarding lead worked with ward staff to coordinate care and discharge plans for patients with complex social situations, including liaison with social workers and community nursing teams. Where patients had safeguarding needs in relation to specific conditions, such as long-term uncontrolled HIV, the safeguarding team worked with clinical specialists to coordinate complex care.

The adult safeguarding team was leading a programme to enhance safeguarding training provision in the trust in line with the safeguarding adults intercollegiate guidance, Adult Safeguarding: Roles and Competencies for Health Care Staff (2018). The programme included safeguarding level 3 training for an additional 2000 staff and the implementation of training more closely aligned to new guidance. The safeguarding lead was also the chairperson for London of the safeguarding adults provider leads forum, which meant they maintained links with a range of stakeholders and partners to support best practice.

Staff on the private patient's unit (PPU) wards frequently delivered care to international patients including those referred by an embassy. This presented staff with safeguarding challenges, such as in managing relationships between family members that would be cause for concern amongst domestic patients. We were not assured the trust safeguarding team had sufficient oversight of the processes and care on the PPU wards. This was because ward staff did not demonstrate appropriate knowledge of referral pathways to the safeguarding team or have a safeguarding lead dedicated to the specific safeguarding presentations in PPU. Staff told us they usually contacted language interpreters to resolve safeguarding concerns as these were sometimes caused by misunderstandings in language and culture and that it would be "very rare" to engage with the trust team.

There were limited safeguarding and security systems in place to stop unauthorised relatives visiting patients on wards. For example, the reception team at the hospital main entrance directed visitors to wards without routinely checking with ward staff if this was appropriate. Nurses said this presented frequent challenges to them and to the safety of their patients. One ward manager said they had required urgent help to manage a situation in which 20 people turned up to see a single patient who was unwell and whom they had safeguarding concerns about. Although all wards had locked entry and intercoms, we did not see these were consistently used and staff told us not all colleagues would challenge tailgaters.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
We reviewed the compliance of each inpatient ward with the Department of Health and Social Care (DH) Health Building Note (HBN) 00-10, in relation to infection control in the built environment. We found full compliance with effective cleaning processes in place.

Antibacterial hand gel was placed at the entrance to each ward and clinical area and at the entrance to each patient bedroom. Large signs were in situ in most areas to instruct visitors to gel their hands and sensors were in place at the entrance to most wards in the main building that triggered an audio warning for people to gel their hands when entering the ward. The audio was

clear to understand and we observed visitors noticeably react to it and subsequently use the hand hygiene facilities. We also observed ward staff routinely and frequently use antibacterial gel, including when they left the ward and returned. This was less noticeable amongst staff in wards on the 12th floor and gel dispensers at the entrance to two wards on this floor were empty. However, these wards scored consistently well in monthly hand hygiene audits, with between 98% and 100% compliance from September 2018 to December 2018.

Ward teams displayed their most recent hand hygiene audit results prominently on information displays for colleagues and patients. For example, the team on wad 10S had achieved 98% compliance and ward 11W achieved 95% in their most recent audit. All inpatient wards we visited achieved at least 86% in their most recent audit.

We reviewed the hand hygiene audit results for all medical inpatient areas from July 2018 to October 2018 and found consistently good standards, with 92% compliance measured against trust policy.

We observed consistently high standards of practice from cleaners and housekeepers in all areas we visited. For example, on ward 10E we observed the housekeeper clean the kitchen meticulously with attention to detail.

Each NHS ward had side rooms used to care for patients with an infectious condition who needed isolating, such as those with respiratory conditions. All PPU patients were cared for in single side rooms. Staff displayed notices on each side room entrance door instructing colleagues the infection control precautions they needed to take when entering the room. This included negative pressure rooms and where clinical staff entering the room were required to use specific personal protective equipment (PPE).

In most areas staff managed clinical sharps in line with the requirements of the Sharps Instruments in Healthcare Regulations 2013 and the DH Health Technical Memorandum (HTM) 07/01 in relation to the safe management and disposal of healthcare waste. For example, all sharps bins were labelled, signed and dated. The trust had adopted the use of a safer sharps needle-less system, which was compliant with EU Legislation 2010/32/EU in relation to the prevention of sharps injuries in hospitals. Staff followed this practice during all our observations.

The team on ward 11W had implemented new hygiene controls on food brought in by patients and relatives. This meant people had to label their food with their name and the opening date so staff could reduce the risk of foodborne bacteria. However, the fridge used for this had a pungent odour and there was evidence it had not been cleaned for some time. We spoke with a member of staff about this who said they would address it. On our unannounced weekend inspection this had not been addressed. There was discarded food on the pantry worktop surface partially covered with a paper towel and food that had expired the previous day. We spoke with the housekeeper about this who said they would address it.

Staff on ward 11W adhered to enhanced infection control measures in line with the safety needs of patients, such as those with compromised immune systems. This meant staff did not store clinical or hazardous waste in bed bays and removed all medical consumables immediately after use to a separate area of the ward.

A high-level isolation unit (HLIU) was connected to ward 11W and provided advanced levels of infection control to patients with life-threatening conditions, such as Ebola or monkey pox. The unit was one of only two in England and reflected the latest understanding of international infection control practice. The unit was segregated into distinct areas, each of which was independently controlled. This meant in the event of breach the team could contain the risk quickly. All staff working in HLIU had advanced infection control training and had been assessed using practical

competencies. Security systems were in place and staff regularly tested these. For example, staff had a panic alarm in each area that would alert staff outside of the unit to a potential infection breach. The area would be automatically sealed and staff in the control room could direct affected staff using a CCTV system.

Each sluice room had a cleaning schedule to maintain infection control standards. We checked two examples of these and found completion was variable. Staff had completed the checklist on ward 8E on seven days in the previous 16. On ward 6S staff had completed the checklist more consistently with one day missing in the previous 16, although the person completing the audit did not sign it, which meant there was a gap in assurance.

In the 2018 patient led assessment of the care environment (PLACE) the hospital scored 99.65%, which was better than the national average of 98.47% and similar to the 2017 score of 99.73%.

Environment and equipment

The service had suitable premises and equipment and looked after them well.
We reviewed the compliance of each ward with DH HBN 00-10 in relation to the standard and condition of flooring. All wards were fully compliant. Hand wash sinks complied with DH HBN 00-09 in relation to design that reduced the build-up of bacteria.

A dedicated team managed electrical equipment, including medical equipment, using planned maintenance schedules. Staff attached a sticker to each item to identify when it had been checked for electrical safety and when it was due for review. We checked 69 individual items of equipment in a cross-section of 12 wards and clinical areas. We found most items had an up to date safety check. However, two items of equipment on ward 10E were overdue for safety checks. We spoke with the nurse in charge about these items who arranged for testing immediately.

Staff understood how to contact the relevant department if an item failed or needed ad-hoc maintenance and each ward had link staff, such as a clerk, healthcare assistant (HCA) or nurse, who was responsible for maintaining a record of local maintenance.

The HLIU team had worked with specialist manufacturers to develop high level PPE suitable for staff to use in negative pressure areas and under high-risk clinical situations.

Staff had not undertaken evacuation training or practice for over two years and individuals we spoke with demonstrated different levels of understanding. For example, some ward staff said they knew where evacuation sheets were stored and how to use them to begin a vertical evacuation. Other staff said they had not been trained to use this equipment and had not had training in evacuation planning.

Staff stored flammable liquids and chemicals appropriately, such as in locked fireproof cupboards, in line with the Control of Substances Hazardous to Health (COSHH) Regulations (2002). Areas used to store medicines, equipment, cleaning materials and patient records were locked and secured in most areas. The door to the treatment room on ward 6S was fitted with a key code lock but on one day of our inspection this was unlocked with the door ajar and the room unattended. The medical consumables store was also unlocked and immediately accessible. On wards 8N, 8E and 12W storerooms containing chemicals were unlocked and unmonitored. This meant there was not continual assurance of environmental security in place. We escalated this issue at the time of our inspection and ward managers took immediate action in each case. We also found it was common practice for doors marked ‘fire door, keep closed’ to be propped or wedged open across the hospital. This meant the area would have reduced fire protection.

In most areas staff maintained appropriate hazardous waste storage and streaming. However, staff on ward 12W had not followed best practice in line with DH HTM 07/07, which requires hazardous waste to be secured with restricted access.

The hospital achieved a score of 96.05% in the 2018 PLACE measure for condition, appearance and maintenance of the environment. This was better than the national average of 94.02% and similar to the 2017 score of 96.54%.

We reviewed the fire risk assessments for medical wards, endoscopy and the discharge lounge. Each risk assessment was up to date and had documented areas of compliance and areas for improvement. However, none of the risk assessments included a quantifiable risk score or compliance percentage. In addition, risk assessments did not include a record of completion. For example, a fire risk assessment on ward 8W in January 2018 found some doors needed maintenance to ensure they could contain a fire. The risk assessment stated this must be completed by February 2018. However, there was no record of completion. Issues on other wards without a date of completion included safer storage of medical gases and local fire documentation such as evacuation plans.

Each clinical area had a resuscitation (crash) trolley with life-saving equipment for use in an emergency. Staff were required to document daily safety checks on the equipment, supplemented by more detailed weekly checks. We looked at the documentation for the preceding two months in all the areas we inspected and found consistent standards of recording with no unexplained gaps. Ward managers and divisional teams monitored this information as part of safety audits. From August 2018 to October 2018 inpatient wards achieved an average of 88% compliance with trust standards, which represented a range on individual wards from 100% to 75%.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

A dedicated risk and resuscitation team (PARRT) was available 24-hours in the hospital and responded to deteriorating patients. All ward staff we spoke with were aware of how to contact PARRT and said they provided on-demand support as needed. For example, one nurse said, “They give clear, immediate feedback and establish a plan of care.”

The trust had implemented the Royal College of Physicians national early warning scores (NEWS2) system shortly before our inspection. NEWS2 is a tool to help staff identify patients at risk of deterioration through early detection of changes in their vital signs and medical condition. This replaced the trust’s previous patient observation system for deterioration. Staff spoke variably about the system. For example, some nurses said it was easier to use than its predecessor and made them feel more confident in assessing deterioration. However, some nurses said they could not account for the specific conditions of some patients with it, including respiratory patients who received ventilation support and tuberculosis (TB) patients with more complex urinalysis needs.

The standard of NEWS2 calculations was variable. We looked at NEWS2 calculations for two patients on ward 6S. For one patient, 11 out the most recent 19 calculations had missing or inaccurate information documented. This included six instances of a missing staff signature and three instances of no total calculation. In another instance staff had not signed or completed totals in seven out of 17 recordings for one patient. On ward 11W staff had calculated one score as six and escalated this. However, the score was inaccurate and it should have been zero. There were missing or inaccurate calculations in the NEWS2 charts for six other patients on ward 11W during our announced inspection. In one instance staff had noted a patient was out of the ward at the time of their observation but had also noted their blood pressure, pulse and temperature. We

reviewed this again during our weekend unannounced inspection and found a much better standard of completion with higher consistency. The nurse in charge told us staff had become more confident and accurate in the use of the tool and the senior team had ensured staff had the training they needed in the new system.

We observed a swift response from a nurse on ward 11W when they noted during a handover that an agency nurse had failed to escalate a patient's elevated blood sugar to a doctor in line with the escalation policy. The ward nurse carried out a full review of the patient and escalated the incident to the temporary workforce team. Although this demonstrated appropriate action, staff said it was indicative of a lack of assurance over the training and competencies of agency nurses.

Nurses and HCAs undertook life support training commensurate with their area of work and level of responsibility. The matron for wards 11W and 11N had identified a need for more advanced training to meet the increasingly complex needs of patients and planned for all nurses on 11N to undertake advanced life support (ALS) training and all nurses on 11W to complete immediate life support (ILS) training.

Specialist staff managed the opening of HLIU in advance of a planned admission. Patients admitted to this unit presented with high-consequence infectious conditions, such as the Ebola virus, and required advanced care. HLIU was adjacent to ward 11W, which staff would close to non-urgent elective admissions to reduce infection risks. Overnight medical escalation for patients on the PPU wards was managed by the resident medical officer (RMO). Staff said they could also contact the medical registrar on duty in the NHS wards or the PARRT team in urgent situations.

Staff on the PPU wards held a daily safety huddle and reviewed the needs of each patient, including those who needed enhanced care, and the current DNAR status of each patient. The team discussed the changing needs of each patient and ensured services were coordinated to deliver safe care. For example, during a huddle we attended staff discussed the transfer of a patient to critical care overnight following a deterioration in their condition and a patient whose DNAR status had changed in line with their condition.

We observed a nurse handover on ward 11W and found the nursing team carried out a succinct, detailed review of each patient that included their clinical safety and multidisciplinary needs. For example, patients on ward 11W were typically cared for by different medical speciality services but the same nursing team. The handover was therefore an important tool to help nurses maintain oversight of the needs of each individual. During the handover staff identified patients on the ward who had the same or similar names and noted this to avoid the risk of medicine errors. The nurse in charge discussed the skill mix of the team collaboratively and assigned nurses to patients based on their qualifications and experience, such as those with intravenous medicine training.

The trust had a standard that staff complete a venous thromboembolism (VTE) risk assessment for 95% of patients on admission. From January 2018 to September 2018 medical inpatient wards achieved an average of 91% compliance. This reflected variable performance and none of the 11 inpatient wards met the standard in every month in this period. However, some wards achieved highly in overall performance. For example, ward 10W achieved 99% compliance, 10E achieved an average of 97% and 9N achieved 95%. Ward 6S achieved four months of 100% and four months of 99% and had one month of low compliance, at 28%. Ward 6E contributed data for only five months during this period, which demonstrated a compliance range from 63% to 99%.

Ward 8N had worked with colleagues in urgent and emergency care to receive patients following a major incident. Staff told us the major incident procedures had worked as planned and demonstrated to them the value of their training and practice.

We saw staff consistently used the situation, background, assessment, recommendation (SBAR) tool when carrying out risk assessments and monitoring patients. The team on ward 8N had introduced a one-to-one handover system between the nurse in charge and each nurse following the board round, which included a review and update of each patient's SBAR. This meant the team always had an up to date view of each patient's condition.

Staff used the national Sepsis 6 tool to assess patients for sepsis and to begin treatment in line with established guidance. We saw staff had completed this correctly in all 25 records we looked at.

Clinical staff said they did not always feel care for patients cared for as outliers was safe. For example, CPEs said they often received calls from ward teams who needed support to deliver care to patients who were accommodated on their ward but their condition was outside of their skill mix. Support was not always available and staff said they felt care was unsafe in such instances.

Staff used an established policy for chemical restraint when patients became violent and clinical staff and security staff had been unable to de-escalate the situation. The enhanced care assessment included a structured flowchart for staff to follow in the event they used chemical restraint. Staff said the hospital did not have any dedicated registered mental health nurses but ward managers said they could sometimes source a nurse from agency or the bank team to provide one-to-one care after a restraint incident. After our inspection the trust told us registered mental health nurse cover was available seven days a week. We were not able to establish why ward teams we had spoken with were unaware of this.

During our inspection an emergency alarm was activated by a nurse on ward 10E. Staff provided a very fast, well-coordinated response. This reflected the quick response time we observed to call bells and emergency alarms by ward staff throughout our inspection.

The hospital assessed compliance with National Institute of Health and Care Excellence (NICE) national guidance 51 in relation to the recognition, diagnosis and management of sepsis as part of a commissioning for quality and innovation national goal (CQUIN). Auditing took place on a rolling quarterly basis and the most recent data available related to the period April 2018 to June 2018. In this period a sample of 150 patients found 91% compliance with full screening and 100% compliance with the standard that antibiotics we started within one hour.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, vacancy rates in some wards were high and weekend cover was variable.

The trust has reported the following qualified nursing staff numbers in medicine from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	271.7	197.8	72.8%	274.4	188.9	68.8%
Chase Farm Hospital	32.7	48.6	Over-established by 48.6%	31.4	44.7	Over-established by 42.1%

Royal Free Hospital	371.4	290.1	78.1%	395.5	288.8	73.0%
Total	**675.8**	**536.5**	**79.4%**	**701.3**	**522.3**	**74.5%**

From April 2017 to March 2018, the trust reported a staffing level of 79.4% for qualified nursing staff in medicine. This had decreased to 74.5% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

From September 2017 to August 2018, the trust reported a vacancy rate of 21.6% in medicine. This was higher than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Ward managers demonstrated good understanding of the local vacancy rate and the factors contributing to this. For example, the ward manager on 9W identified the high turnover rate of new staff caused by the increasing complexity of patients' conditions as a key factor in vacancy rates. They had implemented a new recruitment strategy with divisional support and as a result expected the nurse vacancy rate to reduce from 50% in July 2018 to 30% by January 2019.

From September 2017 to August 2018, the trust reported a turnover rate of 22.4% in medicine. This was higher than the trust target of 13%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 3% in medicine. This was lower than the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 22% of nursing staff shifts in medicine were filled by bank staff and 3% of shifts were filled by agency staff. In addition, 6% of shifts were not filled by bank and agency staff to cover staff absence.

The trust reported an over establishment in bank and agency usage, they explained the negative values are for areas where total hours plus agency and bank hours have exceeded the establishment (effectively unfunded hours).

The breakdown by site is shown in the table below.

Site	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Barnet	816,179	205,554	25%	37,820	5%	Over-filled by 12,232	Over-filled by 2%

Chase Farm	76,366	20,874	27 %	227	0%	Over-filled by 86,101	Over-filled by 113%
Royal Free	1,064,355	210,223	20 %	28,490	3%	Over-filled by 22,048	Over-filled by 2%
Total	**1,956,900**	**436,651**	**22 %**	**66,537**	**3%**	**Over-filled by 120,381**	**Over-filled by 6%**

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Minimum nurse staffing levels were established by divisional teams using evidence-based assessments from the National Quality Board safe staffing levels guidance. This helped matrons and ward managers plan staffing for each shift in line with planned patient acuity and demands on the service. Ward managers used additional guidance relevant to their specialty to ensure staffing levels were planned safely. For example, the team on ward 10E used the European Federation of Critical Care Nursing guidance to ensure staffing levels would meet the needs of step-down patients from intensive care. Each ward worked to specific criteria for the availability of supernumerary staff, clinical nurse specialists and staff with specific training competencies. For example, nurses assigned to work on ward 9N were required to have competencies in colonoscopies and hepato-encephalopathy.

Ward managers increased planned staffing levels where patients were confused or needed one-to-one supervision, such as for mental health needs. However, although the trust told us registered mental health nurses were available seven days a week, none of the staff we spoke with knew about this. Instead they redeployed HCAs from planned work or asked a security officer to stay with the patient.

The nurse team on ward 11W had introduced twice-daily nurse-led reflection sessions on Saturday and Sundays. This provided nurses the opportunity to review patients and discuss treatment plans with doctors and enabled them to maintain the safety culture fostered on weekdays through daily board rounds.

Specialist services operated with an established minimum staffing level. Two nurses trained in chemotherapy and a clinical nurse specialist (CNS) led care on the haematology--oncology day unit on ward 12.

Nurse staffing on PPU was based on levels of patient acuity, which was highly variable. The nurse team worked flexibly and nurse to patient ratio ranged from 1:1 to 1:4 as a result.

One registered nurse and two HCA’s staffed the discharge lounge from 9am to 8pm, Monday to Friday.

Each ward had a nurse in charge that was allocated to be supernumerary. This meant they were not allocated their own patients and could maintain oversight of the running of the ward and support the team, including new nurses and HCAs. However, short staffing meant nurses in charge were often allocated patients in addition to their leadership responsibilities.

There was limited continuity between agency nurses as senior ward nurses said they were no longer allowed to block book them. This meant ward teams did not have the opportunity to build

relationships with agency colleagues.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust has reported the following medical staff numbers in medicine from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	137.4	120.8	87.9%	140.7	115.3	82.0%
Chase Farm Hospital	7.7	11.0	Over-established by 42.9%	7.3	8.0	Over-established by 9.6%
Royal Free Hospital	164.1	196.8	Over-established by 19.9%	174.0	192.5	Over-established by 10.7%
Total	**309.2**	**328.6**	**Over-established by 6.3%**	**321.9**	**315.8**	**98.1%**

From April 2017 to March 2018, the trust reported an over-established staffing level of 6.3% for medical staff in medicine. This had decreased to 98.1% from April 2018 to August 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

From September 2017 to August 2018, the trust reported an over-established vacancy rate of 15.8% in medicine. This was lower than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 5.5% in medicine. This was lower than the trust target of 13%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 0.8% in medicine. This was lower than the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 7% of medical shifts in medicine were filled by bank staff and 1% of shifts were filled by locum staff.

The breakdown by site is shown in the table below:

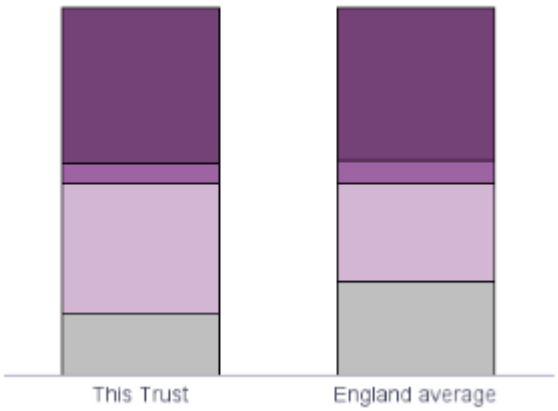
Site	Total hours available	Bank Usage		Locum Usage		NOT filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Barnet	249,402	27,659	11%	5,598	2%	1,063	0%
Chase Farm	4,387	789	18%	0	0%	341	8%
Royal Free	306,336	10,188	3%	568	0%	Over-filled by 49,259	Over-filled by 16%
Total	**560,125**	**38,636**	**7%**	**6,165**	**1%**	**Over-filled by 47,854**	**Over-filled by 9%**

The trust reported an over establishment in bank and agency usage, they explained the negative values are for areas where total hours plus agency and bank hours have exceeded the establishment (effectively unfunded hours).

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In July 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 442 whole time equivalent staff working in medicine at Royal Free London NHS Foundation Trust



	This Trust	England average
Consultant	42%	42%
Middle career^	6%	6%
Registrar group~	35%	27%
Junior*	17%	25%

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

(Source: NHS Digital - Workforce Statistics - Medical (July 2018))
Medical staffing levels varied between wards and specialties and in most cases staff felt these were sufficient to meet patient's needs. For example, two consultants, one specialist registrar (SpR) and one senior house officer (SHO) were on shift during the day on the elderly care wards. During the daytime on weekends a consultant was typically available in each medical specialty with on-call cover overnight. Medical SpRs and junior doctors provided on-site overnight cover as

part of the hospital at night team. In cardiology, one consultant was on call for the ward and cardiac care unit (CCU) at all times. One SpR was always on the ward with an additional SpR on-call overnight. One FY1 was on the ward from 8am to 6pm and one FY1 provided on-call cover overnight.

A consultant and SpR were always on-call to lead the HLIU in the event of an activation, which meant existing staffing levels were not reduced because of this.

At weekends one acute medicine consultant worked from 8am to 5pm to review patients admitted from emergency care with support from one SpR. One SHO was dedicated to patient outliers from 8am to 6pm and one SHO covered the same period for acute inpatient wards. Two foundation year 1 (FY1) doctors covered the wards from 8am to 6pm although they told us one FY1 was regularly redeployed to the emergency department. Overnight one SpR was on call and one SpR, one SHO and two FY1s worked from 6pm to 8am. All the doctors we spoke with said this felt like a safe level of staffing.

Consultants and SpRs managed care for patients in their clinical specialty when they were accommodated as outliers on other wards and included them in ward round reviews. This ensured patients cared for in areas outside of the specialty for their medical condition had appropriate consultant-led care.

Care in the PPU was led by consultants from the existing medical specialties in the hospital. A small proportion of care, less than 1% annually, was delivered by consultants from other trusts working under practising privileges. Practising privileges means the trust is satisfied the consultant has the experience, capacity and medical insurance to deliver care to patients on their site. The PPU board approved all PPs before a consultant could practice.

Consultants primarily led care and treatment on the PPU wards with support from a team of seven resident medical officers (RMOs), with two doctors during the day and one doctor overnight.

Medical review for NHS patients cared for on PPU wards as outliers was inconsistent. For example, nurses said the duty medical SpR was responsible for reviewing patients daily and ensuring they had treatment and discharge plans. However, there was no system in place to ensure the process always happened. Nurses said they had to continually remind the duty medical team that patients were waiting on PPU wards, who could wait several hours for review. All staff knew how to escalate to the site manager but said patients cared for as outliers were often “forgotten” by doctors in the specialties due to a lack of tracking.

A guardian of safer working monitored the safety of doctors’ working hours and reviewed exception reports, which junior doctors submitted when they had worked excessive or unsafe hours. Between November 2017 and December 2018, 306 exception reports were submitted by junior doctors in medicine and urgent care. Of the reports, 60% related to doctors in general medicine. In the same period doctors in the transplant and specialist services (TASS) division delivering medical services submitted 26 reports. The guardian reviewed each report and identified areas for improvement in support and flexibility and led work schedule reviews and engagement exercises.

Records

Staff did not consistently keep detailed records of patients’ care and treatment. Records were not always clear and up-to-date but were easily available to all staff providing care

Staff used a combination of paper records and electronic records for patient observations and assessments. The trust had a project in place to move to a fully digitised system in the future.

Nurses and HCAs documented regular safety observations, called rounding, on each patient in addition to admission checks. These included risk assessments for falls, pressure ulcers and VTE. We reviewed 25 sets of notes on six wards and found variable standards. For example, staff had identified a patient on ward 10E as being at high risk of falls but there was no documentation to evidence their calculation or what they had done to address it. Also on this ward VTE assessments were missing from two out of three records we looked at and staff had not always signed and dated their entries.

During our weekend unannounced inspection, the completion of nursing documentation was inconsistent in the areas we checked. On ward 6S one patient had several areas of missing or overdue records. For example, staff had identified the patient needed daily fluid balance calculations but there were no records for the previous 24 hours. Staff had also not completed the patient's SSKIN bundle for 24 hours and there was a six-hour gap in completing two-hourly nurse rounding checks. Another patient on this ward had no documented rounding in the previous five hours although their care plan noted they required hourly monitoring. We discussed these issues with the nurse in charge who acknowledged the additional pressures staff were under due to short staffing. However, there was no clear escalation pathway for them to manage short staffing effectively and as a result we were not assured patients were monitored appropriately.

Ward managers monitored the standard of patient record completion through the ward quality and performance system. This included a monthly sample of patient records on each ward, based on criteria such as the completion of essential patient details and the frequency of nurse observations. We looked at a sample of four audits for November 2018, for wards 6S, 8E, 8W and 10N. Average compliance was 84%, with a range from 78% on ward 8E to 90% on ward 10N. The audit highlighted key areas for improvement such as more complete admission details and more consistent documentation of regular nurse observations. A monthly patient records audit on ward 10E identified on-going inconsistencies, with compliance ranging from 65% to 94% from January 2018 to November 2018. The auditing nurse implemented an action plan each month to address areas of low compliance although there was no overall trajectory of improvement during this period.

An audit team carried out a comprehensive audit of the standard of completion of patient records in September 2018, which included a sample of 57 records across medical inpatient services. The audit found an overall deterioration of standards based on the results of the previous audit in November 2016. For example, the audit team found 44% of records had significant omissions with less than 75% completion. The team issued 12 recommendations and noted several of these had been raised previously with no evidence of improvement.

Medicines

The service did not consistently follow best practice when prescribing, giving, recording and storing medicines. Documentation did not indicate patients always received the right medication at the right dose at the right time.

During our inspection we reviewed medicines management on wards 6S, 8N, 8E, 10E, 11W, 12W, 12E and 12S. We looked at processes and practice for medicines handling, staff training, policies, storage, record keeping, administration and ordering. We spoke with nine members of the pharmacy and nursing teams. Staff we spoke with had good knowledge of medicines management

and had received induction training and annual refresher training. Controlled drug (CD) registers were correctly completed and balances checked were correct. The CD cabinets were adequate for the amount of stock in them and access was restricted to appropriately qualified members of staff. We found medicines storage areas were well maintained and each had a copy of the British National Formulary.

We reviewed medicine charts for two patients in each of the eight wards we inspected for medicines management. In each case we found consistent standards in line with trust policy, adherence to the principles of antimicrobial stewardship and good oversight of therapeutic medicines.

A named pharmacist was dedicated to each ward and supported by a team of pharmacy technicians. Pharmacists visited wards daily Monday to Saturday daytimes and overnight and on Sundays a satellite pharmacy was available on call and the site manager had access to emergency medicines.

Pharmacists carried out regular safety audits on wards to evaluate practice against trust standards, However, it was not evident this was an effective system to drive improvements. For example, the pharmacist for 8N, 10W and 10N found persistent problems in four months in 2018. This included significant gaps in recording of storage area temperatures, unsecured medicine storage areas and labels on medicines written in retrospect. In each case the pharmacist had noted the concern had been escalated to the matron but there was no evidence this led to a sustained improvement in practice. After our inspection the trust told us matrons and ward managers had carried out spot checks and discussed the issues in meetings to improve compliance. Subsequent pharmacy audits indicated improvements in practice.

Staff were required to record the temperature of medicine storage areas, including medicine fridges, every day. This was to ensure medicines were stored in the safe temperature range identified by the product manufacturers. We checked the standard of recording in 19 areas and found overall staff recorded consistently in 18 of these. For example, staff on ward 10E had documented 12 consecutive days where the temperature of the medicine storage room had exceeded 25 degrees Celsius, the maximum safe temperature for medicine storage. They had documented the escalation action they had taken, including using a fan to control the temperature and liaising with the matron. However, in ward 10S staff had not clearly recorded the action they had taken when fridge temperatures exceeded the safe range. The medicines fridge on 8N was over-filled and there was insufficient space for air circulation. Items were in contact with each other and in contact with the sides and back of the fridge walls. In November 2018, there were several missing documented fridge temperatures and temperatures that were recorded to be above 8 degrees Celsius. This was in excess of the safe maximum temperature advised by medicine manufacturers. We spoke with a senior pharmacist about this who said the issue had been reported and dealt with although ward staff were unable to provide evidence of this.
Medicines were stored in locked cabinets and each nurse held their own key, which reduced delays in administering medicine and accessing them in urgent situations.

Staff used a mental capacity and risk assessment tool to identify if it was safe for patients to self-medicate. We saw three examples of this in practice and noted assessments were comprehensive and nurses maintained an up to date understanding of the patient’s capacity.

During our weekend unannounced inspection, we found the completion of medicine administration charts was inconsistent. For example, on ward 6S there was missing information for four prescribed medicines for two patients and on ward 8E there was missing information for one dose

of prescribed medicine for a patient. It was not immediately evident why staff had not given the doses. We spoke with the nurse in charge in each area who found staff had given the medicine but not recorded it. They addressed the issue immediately and nurses responsible for the patients completed the documentation retrospectively.

Staff used an established process to ensure safety when patients were admitted to PPU wards with prescribed medicines that were not licensed in the UK. The consultant and RMO worked with the pharmacy team to identify UK or European counterpart medicines and directed nurses in their administration to ensure the patient was not at risk of missed doses.

Stock rotation systems on PPU wards were not always effective. On one day of our inspection we found a strip of medicine on the medicines trolley on ward 12E that had expired in October 2018. We asked the nurse administering medicines if they had administered it without noticing it had expired or if it was ready to be discarded. The nurse did not know and escalated this to the nurse in charge as an incident. We spoke with the divisional director of nursing about this who said they would investigate and rectify the situation. However, we found two further medicines out of date on ward 12W, which was part of the PPU service, during our unannounced weekend inspection.

The pharmacy team carried out an annual point prevalence audit as part of an inpatient ward audit of antibiotic prescribing. The team used the audit to benchmark trends in antibiotic prescribing within services year-on-year and against the national average. The most recent data related to October 2017 and reflected a significant reduction in antimicrobial prescribing since the audit began in 2011. In elderly care, 21% of patients were prescribed antimicrobials, which was a reduction of 34% since 2011. The prevalence in general medicine was 23%, which was 23% lower than in 2011. Both figures were significantly lower than the national average of 37%.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support

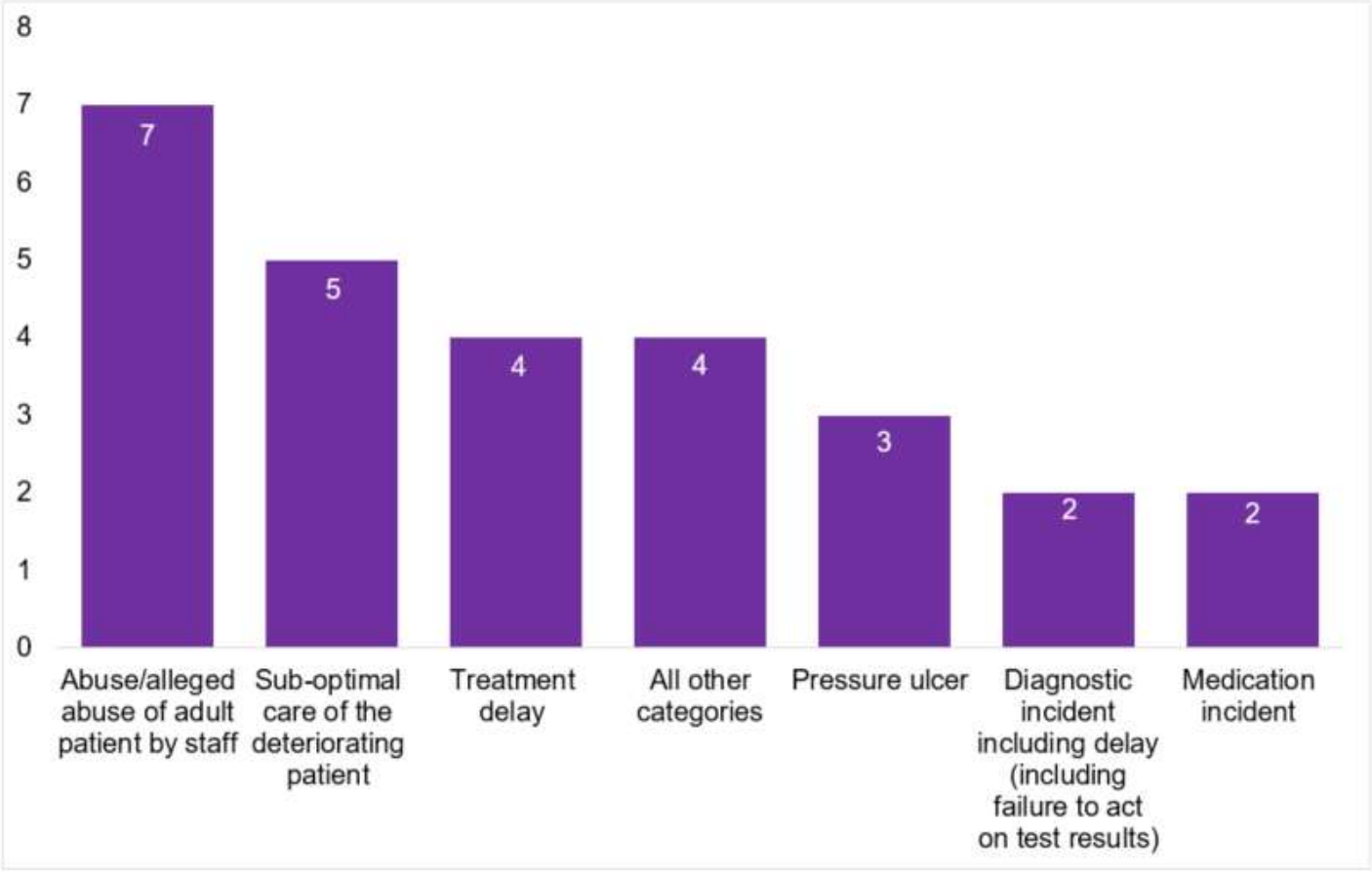
Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From September 2017 to August 2018, the trust reported two incidents classified as never events for medicine.

These were both for treatment delay meeting serious incident (SI) criteria (unintentional connection of a patient requiring oxygen to an air flowmeter). One never event was at Barnet Hospital and the other never event was at Royal Free Hospital.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 27 SIs in medicine which met the reporting criteria set by NHS England from September 2017 to August 2018.



Of these, the most common types of incident reported were:

- Abuse/alleged abuse of adult patient by staff with seven (25.9% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with five (18.5% of total incidents).
- Treatment delay meeting SI criteria with four (14.8% of total incidents).
- All other categories with four (14.8% of total incidents).
- Pressure ulcer meeting SI criteria with three (11.1% of total incidents).
- Medication incident meeting SI criteria with two (7.4% of total incidents).

Site specific information can be found below:

- Barnet Hospital: 16 incidents
- Royal Free Hospital: 11 incidents

(Source: Strategic Executive Information System (STEIS))

All the staff we spoke with had a good understanding of recent incidents reported in their ward or clinical specialty and the outcomes of investigations. Staff on ward 11W had implemented more stringent spot-checks for medicine documentation after a series of incidents that involved incorrect recording. This was critically important as patients on this ward typically received anti-retroviral medicines, which could not be missed. The CPE identified a general deterioration in documentation following an audit in September 2018 and implemented strategies to address this.

An SI had occurred on ward 11W that involved a blood transfusion. In response the matron and CPE carried out a whole-ward stress index exercise for staff in recognition of the pressure the team had been under following a period of staff shortage. In response the senior team offered

more advanced training, including an accredited communicable diseases course, and resilience training.

From our discussions with staff we were not assured they always documented incidents. This meant senior divisional and trust staff were unaware of risks to staff, patients and the service. For example, staff on ward 8N said an allied health professional had identified a fracture on an x-ray that had been missed by an acute physician. They said this was not documented as an incident and it was not discussed with the ward team. Staff also said they did not always document instances of violence against them because they did not feel the trust would act on these. However, after our inspection the trust said they were assured all staff knew how to submit an incident report and would do so when needed.

CPEs led competency assessments and training sessions following incidents, including SIs, to ensure staff had the expected skills and knowledge to prevent a recurrence. The trust had previously experienced two never events in which staff connected patients to air flowmeters instead of oxygen. The trust had sourced caps for the flowmeter ports to prevent accidental use but they did not fit all models in use, such as those in ward 11W. To address the on-going risk, designated nurses were required to carry out daily checks on equipment and the facilities team had displayed bright yellow warning signs next to each port.

We reviewed the root cause analyses for five SIs that occurred in medical care. The investigations highlighted a number of areas for attention in trust procedures and resources, in addition to individual staff action. The lead investigator for each incident worked with specialty teams to prepare a comprehensive action plan based on the contributing factors and needs of staff identified during the process. In each case governance committees and groups had specific accountability for each action and these were completed within the prescribed timeframe. However, we were not assured this always resulted in substantive change. For example, one investigation identified there was no central tracking system to check the competencies of bank and agency staff. Although the lead CPE had added recording criteria to a new electronic ward quality system, not every ward was equipped to use the system. Another incident investigation indicated a need for senior nurses to be better informed of human resources policies and support although most staff we spoke with during our inspection spoke highly negatively of the trust’s human resources function.

The quality governance team were in the process of developing new incident dashboards for each ward that would help teams to track trends and themes in incidents. When implemented in January 2019 the system could be used to plan preventative work and to identify risks to the service.

Safety thermometer

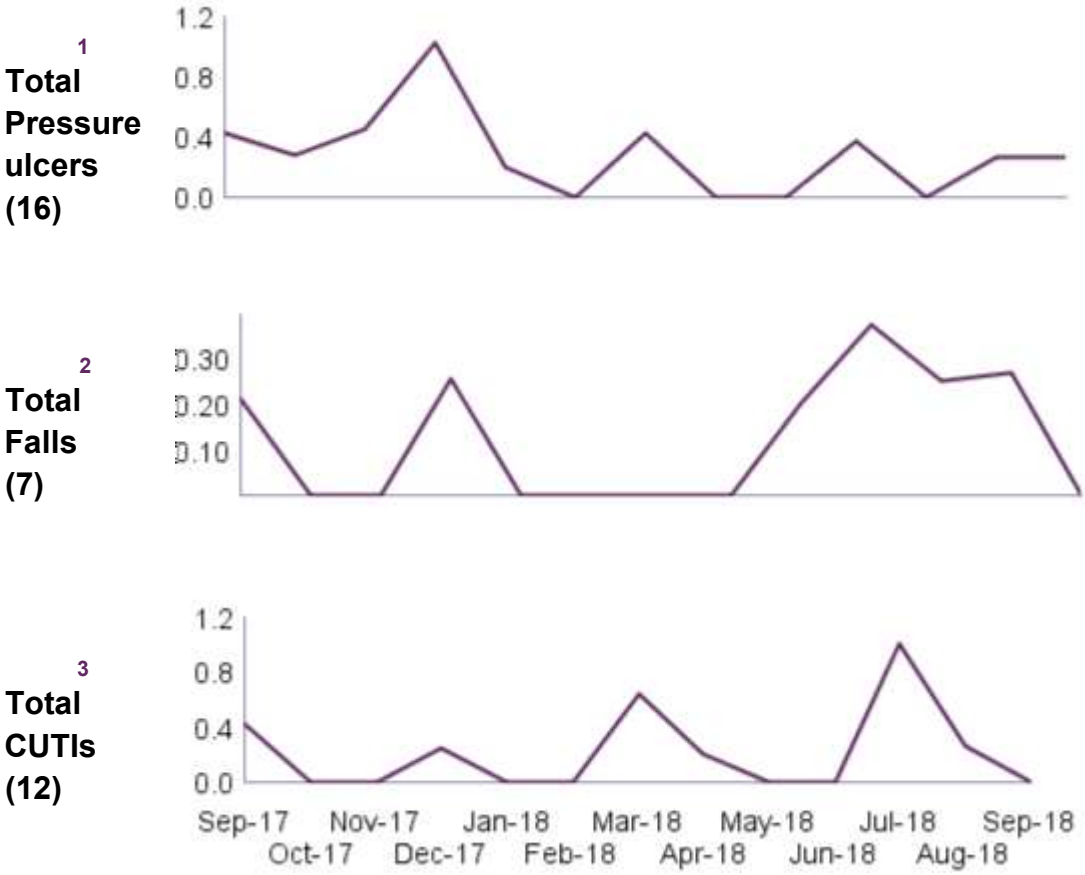
The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 16 new pressure ulcers, seven falls with harm and 12 new urinary tract infections in patients with a catheter from September 2017 to September 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Royal Free London NHS Foundation Trust



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

10S: 1x no evidence falls risk assessment done for the first four days of admission.

Staff on each ward displayed local Safety Thermometer performance using the visual safety cross system, which used colour-coding to identify when the last incident took place.

Ward teams demonstrated awareness of the prevalence rates for falls, hospital-acquired pressure ulcers and catheter urinary tract infections and had implemented training and awareness projects to address these. For example, staff on elderly care wards worked to educate patients to call for them to help rather than trying to move themselves and risk falling.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff delivered care and treatment in line with national guidance, including from the National Institute of Health and Care Excellence (NICE) and the Royal College of Physicians (RCP).

The specialist respiratory physiotherapy team worked with respiratory consultants to deliver care in line with British Thoracic Society (BTS) quality standards for acute non-invasive ventilation (NIV) in adults, including effective intubation.

Staff used established national tools to assess and deliver care. For example, staff assessed patients for skin integrity using the SSKIN care bundle. Staff used a structured rounding tool to complete observations of patients based on four key factors; continence, analgesia, position and environment.

Nurses carried out audit training as part of leadership development pathways. This ensured they developed the skills needed to ensure care in their medical specialty was evidence-based and followed the latest national guidance and local understanding. For example, a nurse on a leadership pathway on ward 11W had carried out an audit into the effectiveness of care pathways for rheumatology patients who were admitted out of hours.

The private patients unit (PPU) team benchmarked care standards against both NHS services and other private healthcare providers to ensure standards of care reflected both.

The trust dementia lead had worked with the volunteer-led radio station to implement daily ‘sundown’ sessions for patients as part of dementia action week in 2018. This was an evidence-based project to address the clinical phenomenon of ‘sundowning’, which refers to the increase of confusion in patients with dementia or delirium typically experience in late afternoon. The dementia lead produced an informative booklet to help staff understand the benefits of the radio programmes, which broadcasted music and news bulletins relating to a specific point in time. Ward staff matched this with the date of birth of their patients and use the show to help the patient relax and orientate themselves.

A lack of existing protocols or procedures, or the failure to follow these when they were in place, were significant contributing factors in all five serious incidents (SIs) we reviewed that took place in 2018. They included issues such as a failure to follow blood transfusion safety checklists and nurse handover protocols and inadequate complete of the SSKIN tool. Investigations also highlighted a need for improved dissemination and embeddedness of patient safety information as an evidence base for improving practice.

The endoscopy service monitored patient outcomes and care standards in line with the Global Rating Scale (GRS). This meant the service leads maintained assurance of standards against Joint Advisory Group (JAG) benchmarks in lieu of formal accreditation, which could not happen without substantive structural changes to the unit. The most recent GRS assessment in October 2018 acted as a gap analysis against the 19 key criteria and found only three areas in which improvements were needed: separation of patients by gender and alignment with national waiting times for cancer screening and general surveillance. Out of the 19 criteria, the service scored a maximum A rating in 14, a B rating in three criteria and a C rating in two criteria.

The endoscopy team used a series of local safety standards for invasive procedures (LocSSIPs) to benchmark treatment practices against established safety standards. The LocSSIPs were

embedded in the endoscopy care plan and included a pre-procedure pause, a peri-procedure pause and a post-procedure pause. Each pause consisted of a checklist to be completed by the treatment team to ensure they consistently followed expected safety processes. We looked at a sample of eight completed care plans and found staff had fully completed all three pause checklists in each. The endoscopy team audited completion of LocSSIPs using a sample of five records each week. We looked at three audits completed in October 2018 and November 2018, which demonstrated overall compliance with the pause checklists of 90%.

The hepatology team had identified the service non-compliance with NICE clinical guidance 115, relating to alcohol dependence, as an extreme risk to the service. This was because there was no coordinated alcohol screening programme, staff education programme or seven-day service.

Therapies teams were research active and at the time of our inspection were leading 20 distinct research projects. Each project was aimed at exploring a specific condition or treatment with the intent of improving care and treatment. The projects reflected the diverse range of conditions in the local population and provided staff with the opportunity to develop new care pathways and standards.

In December 2018 therapies staff were leading nine distinct audit projects to benchmark and assess care against national standards. For example, the team was participating in the national diabetic foot audit and in the UK Parkinson's physiotherapy audit in addition to local audits to identify opportunities for improvements in care.

The learning disabilities team was participating in a national audit to benchmark care against the NHS Improvement learning disability improvement standards in England. This would contribute to national improvement work and the team planned to use the outcomes to tailor training and resources locally.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences

Staff used the malnutrition universal scoring tool (MUST) to assess and monitor patients for malnutrition. In all 25 of the patient records we looked at staff had updated MUST regularly and carried out associated risk assessments, such as waterlow and fluid balance scores.

Staff on wards focused on mealtimes as key times for patient support to promote good nutrition and hydration. They used red trays to identify when a patient needed extra support. Staff in elderly care wards had furnished communal rooms to look like restaurants for patients living with dementia and serviced meals in these areas to promote better intake.

The catering team provided menus in a range of formats and worked with clinical staff and dieticians to provide food appropriate to nutritional and cultural needs. Food appropriate for the local population, such as Kosher and Halal meals, were readily available.

Nutrition nurses were available in the hospital although awareness of the service varied between wards. None of the ward staff we spoke with had the same understanding of the availability of nutrition nurses or the referral process.

The October 2017 pressure ulcer prevention audit found 70% of patients had undergone a nutritional screening.

In the 2018 patient led assessment of the care environment (PLACE), inpatient wards scored 86% for the quality of food. This was worse than the national average of 91% and worse than the 2017 score of 91%.

Staff on 8N and 10W, HSEP wards, had carried out a nutrition audit to identify the standards of care using NICE guidance. The audit found MUST screening on admission and during a patient's stay was inconsistent. For example, staff did not always fully complete and the team found some records were subjective. However, the audit found good evidence of nutritional support and referral to the specialist dietician team. As a result of the audit, HSEP staff focused on offering smaller portions of food more often, rather than adhering to larger meals at set times. This enabled them to more readily engage with patients on the topic of nutrition and helped to maintain consistent intake.

Two clinical nurse specialists carried out an audit into the effectiveness of a strategy to improve nutrition for patients with a specific type of liver disease by providing bedtime snacks. This was one example of a wide range of specific projects to assess and improve nutritional input amongst patients with various clinical needs, including complex conditions. The audit team, ward nurses and clinical practice educators (CPEs) worked together to implement improvements based on the findings. For example, a healthcare assistant was assigned to ensure patients received the appropriate quantity of snacks and CPEs prepared improved training materials.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Nurses demonstrated detailed awareness of understanding and responding to pain based on individual patient needs. For example, a nurse on ward 11W had adapted new conversation strategies with older patients after they found they were less inclined to report feeling pain. The neuro-therapy team had developed detailed guidance for staff on how to ask patients with cognitive needs if they were in pain. This included guidance on how to interpret unusual or difficult-to-understand responses from patients.

Nursing cared bundles included a pain assessment and in 20 of the 25 records we looked at staff had completed these and kept them up to date. However, we were not assured agency nurses were appropriately skilled or monitored in this area of care. For example, we reviewed the documentation of three patients who had been the responsibility for an agency nurse overnight on ward 11W. The nurse had not updated any of the pain scores in the previous 12 hours. We asked them about this and they said one of the patients had been in pain and so they had started a pain assessment booklet. However, this was blank with no recorded observations and the agency nurse added their observations in retrospectively. The nurse in charge on ward 11W addressed this issue immediately but it demonstrated a lack of oversight of the competencies of agency nurses.

A nurse-led acute pain team was available on referral with support from a consultant. The palliative care team was available on call to support patients with chronic pain.

Patient outcomes

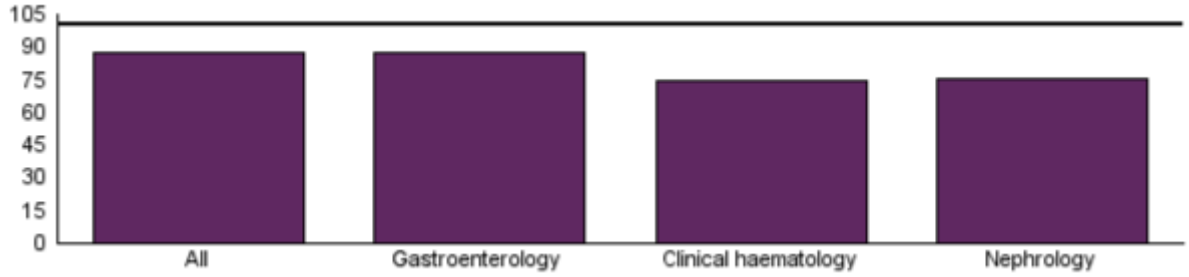
Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

From June 2017 to May 2018, patients at the trust had a lower than expected risk of readmission

for elective admissions and a similar to expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions – Trust Level

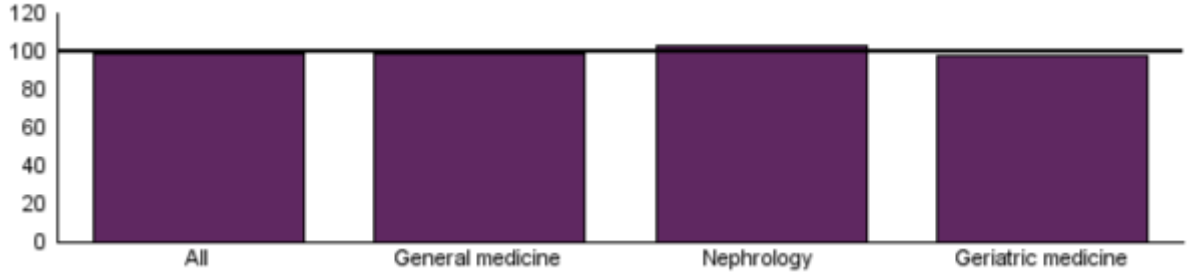
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in nephrology had a lower than expected risk of readmission for elective admissions



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

Non-Elective Admissions – Trust Level

- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in nephrology had a similar to expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a similar to expected risk of readmission for non-elective admissions

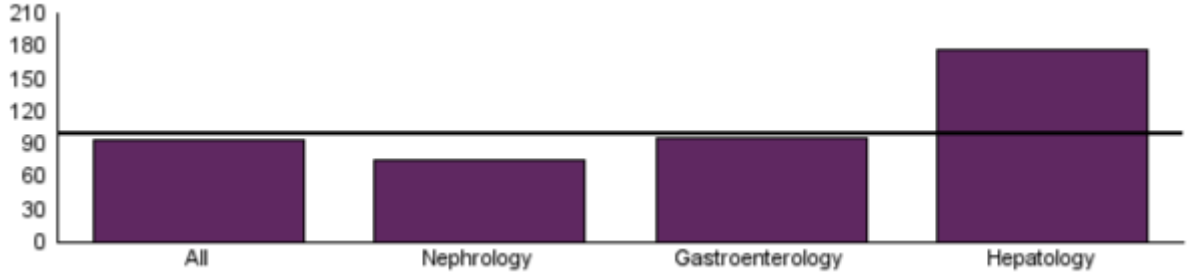


Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count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

From June 2017 to May 2018, patients at The Royal Free Hospital had a lower than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - *The Royal Free Hospital*

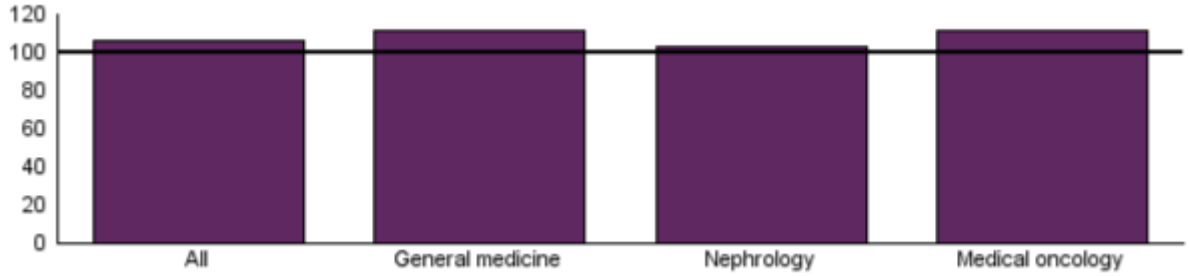
- Patients in nephrology had a lower than expected risk of readmission for elective admissions
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in hepatology had a higher than expected risk of readmission for elective admissions



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

Non-Elective Admissions - *The Royal Free Hospital*

- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in nephrology had a similar to expected risk of readmission for non-elective admissions
- Patients in medical oncology had a higher than expected risk of readmission for non-elective admissions



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

(Source: Hospital Episode Statistics - HES - Readmissions (June 2017 – May 2018))

Royal Free Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A grade in latest audit, December 2017 to March 2018.

Overall Scores	Dec 16 - Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18
SSNAP level	**A↑**	**A**	**B↓**	**A↑**
Case ascertainment band	**A↑**	**A**	**B↓**	**A↑**
Audit compliance band	**A↑↑**	**A**	**C↓↓**	**A↑↑**
Combined total key indicator level	**A**	**A**	**A**	**A**

- For case ascertainment band at Royal Free Hospital has seen an improvement from grade B to grade A in the latest audit.
- For audit compliance band at Royal Free Hospital has seen an improvement from grade C to grade A in the latest audit.

Non-routine patient centred performance	Dec 16 - Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18
Domain 1: Scanning	B↓	A↑	B↓	A↑
Domain 2: Stroke unit	E↓	D↑	C↑	C
Domain 3: Thrombolysis	C↓	A↑↑	A	B↓
Domain 4: Specialist assessments	C	B↑	B	B
Domain 5: Occupational therapy	A	A	A	A
Domain 6: Physiotherapy	A	A	A	A
Domain 7: Speech and language therapy	A	A	B↓	A↑
Domain 8: Multi-disciplinary team working	C↑	B↑	B	B
Domain 9: Standards by discharge	B	B	B	A↑
Domain 10: Discharge processes	B↓	A↑	A	A
Patient-centred total key indicator level	B	A↑	A	A

- Domain 1: Scanning has seen an improvement from grade B to grade A in the latest audit for non-routine patient centred performance.
- Domain 3: Thrombolysis has seen a decline from grade A to grade B in the latest audit for non-routine patient centred performance.
- Domain 7: Speech and language therapy has seen an improvement from grade B to grade A in the latest audit for non-routine patient centred performance.
- Domain 9: Standards by discharge has seen an improvement from grade B to grade A in the latest audit for non-routine patient centred performance.

Non-routine team centred performance	Dec 16 - Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18
Domain 1: Scanning	NA	NA	NA	NA
Domain 2: Stroke unit	A	A	A	A
Domain 3: Thrombolysis	NA	NA	NA	NA
Domain 4: Specialist assessments	NA	NA	NA	NA
Domain 5: Occupational therapy	A	A	A	A
Domain 6: Physiotherapy	A	A	A	A
Domain 7: Speech and language therapy	B↓	B	B	A↑
Domain 8: Multi-disciplinary team working	NA	NA	NA	NA
Domain 9: Standards by discharge	B	B	B	A↑
Domain 10: Discharge processes	A	A	A	A
Team-centred total key indicator level	A	A	A	A

- Domain 7: Speech and language therapy has seen an improvement from grade B to grade A in the latest audit for non-routine team centred performance.
- Domain 9: Standards by discharge has seen an improvement from grade B to grade A in the latest audit for non-routine team centred performance.

(Source: Royal College of Physicians London, SSNAP audit)

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 82.4%, which did not meet the audit minimum standard of 90%. The 2016 figure was 34.4%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC)

receiving surgery was 18.2%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 78.3%, which represents good practice compared to other hospitals. The 2016 figure was not significantly different to the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 82.9%, which represents good practice compared to other hospitals. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 was 43.1%, which represents good practice compared to other hospitals. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

Royal Free Hospital participated in the 2017 National Audit of Inpatient Falls and the crude proportion of patients who had a vision assessment (if applicable) was 42.4%. This did not meet the national aspirational standard of 100% and was worse compared to other hospitals.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 15.4%. This did not meet the national aspirational standard of 100% and was worse compared to other hospitals.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 17.6%. This did not meet the national aspirational standard of 100% and was worse compared to other hospitals.

The crude proportion of patients with a call bell in reach (if applicable) was 56.7%. This did not meet the national aspirational standard of 100%. Compared to other hospitals the trust performed similar, in this context ‘similar’ means that the result was between 50% and 79%.

(Source: Royal College of Physicians)

Although we saw consistent use of risk assessments in nursing records, this was not always replicated by care plans. There were missing or incomplete care plans in three records we looked at in ward 10E. This included for one patient who did not speak English. Although staff had noted this, they had not included information in their care plan to help colleagues deliver care or communicate. We spoke with a senior nurse about this who said the ward had not performed well in monthly records audits and it was an area of priority for improvement. They had implemented spot-checks of care plans during ward rounds to try and address this but said high use of agency and bank nurses contributed to inconsistent standards.

The endoscopy service did not have a dedicated pre-assessment facility and clinicians relied on the information in a referral and during the consenting process to understand each patient’s needs. This meant patients with multiple morbidities were at risk of missed diagnoses and opportunities to provide a good outcome. The divisional team had documented this as a high-level risk in September 2017 and were in on-going planning to address it. Staff used the trust’s formal

pre-assessment process for patients with complex needs who required a general anaesthetic and dedicated lists were scheduled each week for specific conditions.

The tissue viability team collected local wound and patient review data weekly and supported an external annual review to demonstrate patient outcomes. The most recent available report was from October 2017, which found a 1.9% prevalence of hospital-acquired pressure ulcers. This was significantly better than the expected prevalence of 3.5% based on national data. The audit found 90% of patients had a waterlow risk assessments within the first six hours of admission although only 33% of patients at risk had been reassessed in the previous 24 hours. The same audit identified 87% of patients had a documented skin assessment within six hours of admission and 68% of those at risk had been reassessed in the previous 24 hours.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

From April to September 2018, 75% of staff within medicine at the trust received an appraisal compared to a trust target of 85%. Nursing staff had a 77.8% completion rate and medical/dental staff had an 82.8% completion rate.

Trust wide

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Medical and Dental	128	106	85%	82.8%	No
Healthcare Assistants	238	193	85%	81.1%	No
Estates and Ancillary	10	8	85%	80.0%	No
Nursing Registered	445	346	85%	77.8%	No
Healthcare Scientists	9	6	85%	66.7%	No
Administrative and Clerical	83	45	85%	54.2%	No
Allied Health Professionals	61	33	85%	54.1%	No
Additional Clinical Services	23	12	85%	52.2%	No
Add Prof Scientific and Technic	6	3	85%	50.0%	No
Total	**1,003**	**752**	**85%**	**75.0%**	**No**

Royal Free Hospital

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Nursing Registered	235	195	85%	83.0%	No

Healthcare Assistants	119	94	85%	79.0%	No
Medical and Dental	75	59	85%	78.7%	No
Estates and Ancillary	9	7	85%	77.8%	No
Additional Clinical Services	12	9	85%	75.0%	No
Healthcare Scientists	8	5	85%	62.5%	No
Add Prof Scientific and Technic	5	3	85%	60.0%	No
Administrative and Clerical	55	27	85%	49.1%	No
Allied Health Professionals	1	0	85%	0.0%	No
Total	**519**	**399**	**85%**	**76.9%**	**No**

At Royal Free Hospital, nursing staff had an 83.0% completion rate and medical/dental staff had a 78.7% completion rate.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The trust had developed an education strategy in medicine and urgent care (MUC) services for all specialties and had progressively rolled this out over the previous 12 months.

Most staff we spoke with were positive about the appraisal process and said it was a good opportunity to review their achievements and to identify what they could work on next. Allied health professional (AHP) therapists spoke positively of their improved appraisal system and said they had a structured approach to identify opportunities for professional and clinical development. All new AHPs underwent a preceptorship, which had contributed to improved retention and more advanced service delivery.

Nurses in some specialties had access to rotation pathways that enabled them to gain skills and experience in other services. For example, nurses in medical transplant wards could work in the dialysis unit and nurses in PPU worked across medical specialties. The team on ward 11W, an infectious disease and HIV ward, worked closely with colleagues in the Ian Charleson Day Centre (ICDC), an HIV outpatient service. A nurse from ICDC had completed a rotation on ward 11W and was returning to the outpatient unit to complete a non-medical prescribing bursary and a physical assessment course. New nurses on ward 11W spent time with ICDC colleagues to understand the differences in HIV services and completed community visits with the HIV clinical nurse specialist. This helped the team to understand the different symptoms and needs around the infection and to identify how it could progress without treatment.

This was evidence of a range of nurse development opportunities, which enabled individuals to progress to higher grades through more advanced training, such as in critical care. Healthcare assistants (HCAs) worked bank shifts in other clinical areas, which helped them to expand their skills. This was not part of a formal rotation, which they said would be a good extension of their role if the trust offered it.

A CPE was dedicated to each clinical specialty or group of specialties and a lead nurse for practice development worked within the corporate structure. CPEs worked autonomously within their medical specialty and planned education and training based on feedback from ward teams

and matrons. This system meant CPEs also planned training based on learning from incidents, complaints and local case reviews of conditions not often seen in their specialty.

Staff described limited use of the simulation centre in the hospital and CPEs said there was variable engagement with the opportunities the centre provided in medical specialties.

CPEs delivered specialist training to staff as the needs of their patients became increasingly complex or as staff identified competency needs. For example, staff on ward 11W had completed training in managing tracheostomies, non-invasive ventilation and continuous positive airway pressure (CPAP). The matron for this ward had arranged places on a training course for staff, which would take place in June 2019 and would provide their team with considerable additional skills in managing alcohol-related withdrawal and sickness.

HCAs had access to ad-hoc teaching and development on their wards. On ward 8E, HCAs said they had spent time with nurses developing their skills in oxygen therapy, disease management, infections and the use of more advanced equipment.

Staff spoke highly of the support they received from CPEs and said the team helped them to identify courses and study opportunities to help improve their practice and develop their career. For example, two HCAs we spoke with said educators had helped apply for the clinical adult healthcare apprenticeship programme.

One HCA on ward 10S said their line manager had encouraged them to apply for an associate practitioner programme and they felt able to ask for access to development and training whenever they felt this would be beneficial. One HCA on ward 11W was completing an accreditation course as part of a development pathway that would result in a band 4 practitioner role.

Ward 11W contained the high-level infection unit (HLIU). This was a specialist treatment unit for high-consequence infectious disease and was the only unit of its kind in London. Specialist nurses led a rolling training programme for staff to enable them to work in HLIU, including in advanced infection control and waste management. Critical care consultants had delivered simulation training for staff on managing emergency scenarios, such as cardiac arrests, highly distressed patients and staff contamination. The patient at risk team (PARRT) supported the training and provided nurses with case-based scenarios such as managing anaphylaxis with unlicensed medicines in the event a patient was admitted with a condition that could not be treated with medicine known to the UK. The ward team had engaged with specialist international aid organisations to organise advanced training on managing emerging infectious threats.

The learning disability team had developed targeted training for ward staff based on a combination of the content of the national care certificate and their understanding of the needs of the local population. The dementia implementation group had arranged for a local theatre group to visit the hospital and deliver role-play training in empathy and care for extended staff groups, including porters. This involved actors playing roles in an environment set up as a clinical area, complete with equipment, to provide an immersive training opportunity for staff.

A day-case oncology treatment room was based in the PPU haematology-oncology ward and worked with the site operations team to provide additional chemotherapy capacity for the NHS outpatients clinic in the hospital.

Nurses delivered care to patients who were living with conditions of interest to their professional and medical development. For example, during our inspection staff were caring for a patient with experimental treatment. A nurse with an interest in the area of treatment was providing care for them with oversight from the medical team.

Senior nurses described a significant challenge in ensuring enough nurses had complete NIV competency training to deliver effective care. The physiotherapy and CPE team worked collaboratively to address this and had introduced additional training opportunities in acute medical areas to support new staff.

The respiratory team worked with CPEs to establish an accredited respiratory course for new nurses, which provided them with structured education and support for the first 18 months of their post. This was part of a joint strategy to improve competency and to improve retention of nurses. CPEs worked with other specialties to develop a standard template from the course that each specialty could use as part of their training programme.

The CPE on ward 11W had developed training opportunities to address the large intake of new staff and the trust's reduction in protected teaching time. This included arranging for external specialists to visit the ward and deliver teaching during shift hours, such as the safeguarding team and trust learning disability lead. They had also arranged for educational visits from drug companies and evening lectures outside of the hospital.

The neuro-therapy team had prepared specific guidance for nurses on caring for patients who needed specialised moving and handling care to avoid pressure ulcers and to maintain their comfort and reduce pain. This included photographs to guide staff in effective moving techniques and language support to help them frame questions to the individual patient in a way they would clearly understand.

Nurses and doctors did not always have access to the training and skills required to support patients with preparation for a successful discharge. For example, AHPs found discharges were regularly delayed because nurses had not been trained to carry out simple movement exercises and doctors were unable to carry out swallowing assessments.

Senior nurses and CPEs in oncology had introduced a number of new training opportunities. This included a new multidisciplinary approach to induction whereby new staff met colleagues from the professions and teams they would routinely work with, such as the palliative care, radiotherapy and hospice teams. The lead chemotherapy nurse provided weekly teaching sessions on focused topics and the acute oncology team had developed two new online learning packages for emergency care. The senior oncology nursing team had led a staff development day that enabled all staff in the service to meet colleagues from other teams and engage to identify new ways of working together.

The trust had provided additional training for staff in the medicine and urgent care division, such as dedicated study days for band two staff in HSEP and training for HCAs working towards a care certificate.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Care and treatment was demonstrably multidisciplinary. The multidisciplinary team on each ward held a daily board round for all patients and used this to plan treatment and discharge. The teams typically included a physiotherapist, occupational therapist and discharge coordinator in addition to the ward's HCAs, nurses and doctors. Speech and language therapists, dieticians and pharmacists attended board and ward rounds when needed.

Dedicated leads for mental health, dementia and learning disabilities were based in the hospital and provided a same-day service for referrals. Ward-based staff told us they found each lead easy to contact and said they considered each patient's care plan when coordinating treatment.

Clinical nurse specialists worked independently of wards and provided an on-referral service for patients. This included the tissue viability team and lead nurses in dementia, learning disabilities and specific conditions such as HIV and drug and alcohol addiction.

A dedicated cardiology physiologist provided care to patients in the PPU and ward teams had access to specialist input on-call through relationships established with the cardiology service.

The PPU team held a daily meeting Monday to Friday to coordinate the operation of the wards between the multidisciplinary team. We attended a meeting and found it was an effective strategy to ensure the skills and experience of all staff were deployed appropriately and to ensure care was well coordinated.

An AHP team of physiotherapists, occupational therapists and therapies assistants delivered care on ward 8N, a short stay acute medical assessment unit. Patients typically stayed on this ward for three days or less and the multidisciplinary team focused on ensuring discharge would be safe and appropriate.

Speech and language therapists were available five days per week and ward staff referred to them using an electronic system. Respiratory and cardiac physiotherapists and occupational therapists were available on-call on weekends.

The HLIU team worked closely with military clinicians and other worldwide infectious disease specialists to develop the unit and its operating procedures. When activated, a multidisciplinary team coordinated care, including critical care and resuscitation specialists.

Nurses and AHPs in the stroke service had developed a shadowing project that enabled staff from each specialist role to shadow a colleague. This enabled the team to build understanding of each other's roles and develop strategies for more effective ways of working together.

A geriatrician, AHPs, nurses and community colleagues provided a triage rapid elderly assessment team (TREAT). This enabled staff in elderly care services to assess patients and coordinate a multidisciplinary care plan.

A team of HIV consultants, a psychologist and clinical nurse specialist provided support to HIV-positive patients anywhere in the hospital and included them in ward rounds as part of coordinated care with ward-based teams. Tuberculosis (TB) clinical nurse specialists worked with this team to coordinate care for patients with multiple infections.

Oncology clinical nurse specialists worked in tumour site specific roles, which meant they were dedicated to specific types of cancer and support oncology nurses across the service. Nurses said there was noticeable difference in patient outcomes for those with a dedicated CNS. For example, they said there was no CNS in post for metastatic tumours, which meant those patients did not receive a comparable level of advanced care.

The tissue viability and vascular teams worked together to deliver a weekly clinic as part of the legs matter campaign.

Seven-day services

The clinical standards and innovation committee maintained oversight of performance against the national seven day services standard through an annual audit. The 2018 audit demonstrated an improvement of 17%, to 73%, of the proportion of patients seen by a consultant within 14 hours of admission. This reflected 72% on weekdays and 76% at weekends. Although this reflected an

overall improvement, performance between clinical specialties varied significantly. In oncology, 33% of patients admitted on a weekday were seen by a consultant within 14 hours, which worsened to 0% at a weekend. Renal medicine, respiratory medicine and haematology achieved 100% in the audit. The trust was planning to introduce a board assurance model to replace the existing audit tool, which would enable divisional teams responsible for specific clinical services to establish local assurance for performance and service improvement.

In 2018 the trust performed below the London commissioning and national averages in the seven-day services audit for once-daily and twice-daily consultant review. Out of patients who were required to need a once-daily consultant review, 57% of patients received this on weekdays and 36% received this at weekends. Performance was better where patients needed twice-daily consultant review and on weekdays 72% of patients received this and at weekends 53% received this. During our weekend unannounced inspection consultants were on site in most specialties and were systematically reviewing patients.

A speech and language therapist was on-call for stroke and respiratory patients on Saturdays with no cover available on Sundays. Physiotherapy cover on the PPU wards at a weekend was unpredictable and nurses were not able to confirm when therapists would be on the ward or how to check.

Inpatient endoscopy services operated seven days a week with support from a medical agency team on a weekend. This team operated to the same service standards and within the same safety protocols as the trust team and we saw a coordinated, cohesive working relationship in place.

Health promotion

Staff encouraged patients to leave their ward with appropriate safety measures in place and to access hospital facilities to keep active and move around. External contractors that provided catering on-site in shops and cafes had adopted the NHS healthy eating strategy and actively promoted healthier food choices for patients and their visitors.

Ward teams had implemented the national PJ Paralysis campaign, which aimed to improve patient wellbeing and health by encouraging them to get out of bed and follow a routine each day they were in hospital. Staff prepared informative, visual displays for patients and relatives to help them understand the purpose of the campaign and in some areas staff had demonstrated extended efforts to improve patient experience. For example, the housekeeper and ward sister on ward 11W had been instrumental in embedding the principles of the campaign in the ward. They spoke with each patient, built a rapport and encouraged each to get out of bed and move around safely. They also prepared cutlery and place settings for each patient to encourage them to actively take part in mealtimes. On ward 8N the AHP team contributed to the PJ Paralysis campaign as part of a multidisciplinary approach to helping patients achieve better wellness ready for discharge.

Staff from ICDC and ward 11W had led an HIV awareness event for World AIDS Day and promoted better understanding of the virus amongst staff, patients and hospital visitors. The team provided HIV testing during the event and displayed information posters around the hospital to promote a more open culture of discussing the condition and dispelling the myths associated with HIV.

The ward 8N team had planned a smoking cessation quality improvement project and planned to implement this early in 2019.

The neurorehabilitation team led scheduled health promotion activities as part of long-term care plans. This included a two-weekly education session for patients being treated for an acquired brain injury and a weekly relaxation group led by a clinical neuropsychologist.

The 11W team provided a range of health promotion activities. This included activities and education to prevent blood clots, psychological support for patients newly diagnosed with HIV and support sessions for patients with an alcohol dependency.

The team on 8E had established a relationship with a local smoking cessation group to enable staff to achieve validated smoking cessation qualifications to National Centre for Smoking Cessation and Training level 1. The ward manager and trust smoking cessation officer were working similarly to improve staff training in this area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The trust reported that from April 2018 to August 2018 Mental Capacity Act (MCA) training and deprivation of liberty (DoLS) training was completed by 79.3% of staff in medicine compared to the trust target of 85%. Nursing staff had a completion rate of 90.1% and medical/dental staff had a completion rate of 48.4%.
A breakdown of completion rates by site and staff group is below:

Site	Nursing staff	Medical/dental staff	All staff
Chase Farm Hospital	97.8%	85.7%	93.8%
Barnet Hospital	90.6%	48.7%	80.2%
Royal Free Hospital	89.5%	46.3%	77.2%
Edgware Hospital	66.7%	100%	74.4%
Total	**90.1%**	**48.4%**	**79.3%**

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff used discreet symbols on patient tracking boards to identify those living with dementia, memory loss, a DoLS authorisation or other cognitive impairments.

We checked a sample of five DoLS authorisations on three different wards. We found consistently good standards with appropriate, documented best interests meetings and clear justification for the authorisation.

HCA's completed a training day on dementia, MCA, DoLS and learning disabilities as part of care certificate training. HCAs demonstrated good observational skills of patients and escalated concerns about changing behaviour or deteriorating capacity to more senior staff.

There were some inconsistencies amongst understanding of do not attempt resuscitation (DNAR) documentation. For example, on an elderly care ward staff had completed mental capacity assessments for patients but not always documented if a DNAR was in place. Staff we asked said they did not know how to find out this information.

Staff in infectious disease services used enhanced care tools to assess the mental capacity of patients with complex comorbidities such as HIV-related encephalitis. This service sometimes provided care for patients with post-intensive care delirium and the CPE arranged spot-check teaching for this as it was not a common occurrence. This meant staff maintained their skills ready for an admission.

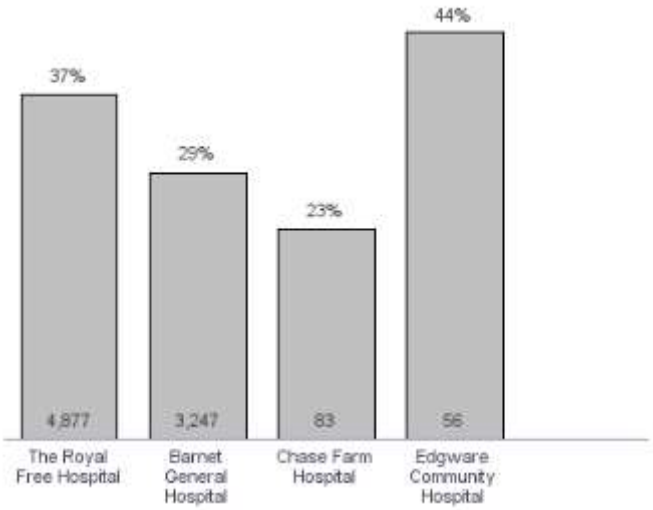
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

The Friends and Family Test response rate for medicine at the trust was 33% which was better than the England average of 25% from September 2017 to August 2018.

Friends and family Test – Response rate from September 2017 to August 2018 by site



A breakdown by ward is below:

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	
BH-CDU	791	33%	85%	89%	83%	82%	87%	86%	82%	92%	88%	91%	96%	89%	87%
BH-MSSU	739	26%	81%	92%	82%	87%	78%	83%	73%	90%	83%	91%	90%	86%	86%
10 SOUTH A	692	47%	96%	92%	93%	85%	89%	82%	77%	86%	94%	88%	88%	75%	88%
10 WEST	651	44%	100%	95%	90%	98%	98%	90%	93%	98%	97%	98%	94%	88%	95%
8 NORTH	605	35%	89%	86%	85%	91%	84%	90%	83%	87%	77%	95%	86%	83%	86%
9 NORTH	564	47%	88%	87%	91%	85%	94%	86%	88%	90%	90%	91%	87%	80%	88%
11 EAST	467	44%	98%	97%	91%	93%	97%	91%	92%	98%	98%	100%	91%	95%	95%
BH-ROWAN	340	38%	94%	84%	100%	92%	97%	96%	78%	85%	96%	83%	94%	89%	91%
11 WEST	339	35%	97%	95%	94%	85%	96%	88%	86%	93%	96%	90%	89%	100%	93%
10 EAST	325	33%	78%	93%	88%	72%	89%	85%	90%	89%	88%	90%	78%	83%	86%
8 EAST	319	34%	93%	96%	97%	91%	96%	87%	93%	87%	88%	87%	81%	95%	91%
BH-WALNUT	319	35%	68%	100%	87%	91%	85%	91%	84%	83%	82%	94%	96%	85%	87%
10 NORTH	243	24%	86%	100%	100%	62%	82%	89%	100%	80%	78%	87%	84%	93%	88%
8 WEST	236	23%	71%	90%	82%	86%	79%	72%	89%	91%	89%	85%	96%	69%	84%
BH-CCU	235	52%	88%	100%	95%	93%	94%	100%	100%	95%	100%	100%	100%	94%	97%
BH-	226	31%	91%	82%	91%	88%	91%	73%	67%	89%	86%	85%	75%	77%	84%
6 SOUTH	220	31%	90%	92%	94%	89%	82%	94%	86%	58%	93%	90%	88%	88%	88%
BH-OLIVE	184	26%	94%	94%	88%	92%	100%	94%	100%	92%	87%	100%	88%	78%	92%
6 EAST	184	27%	100%	100%	100%		80%	90%	81%	86%	96%				82%
11 SOUTH	128	44%	87%	87%	96%	88%	91%								90%
BH-JUNIPER	118	20%	86%	79%	100%	100%	58%	78%	87%	56%	88%	77%	100%		81%

Highest score to lowest score

Key 100% 50% 0%

[1] The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).

[2] Sorted by total response.

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

Note: sorted by total response

Ward BH–CCU (coronary care unit) had the highest response rate with 52% and ward 8-West had the lowest response rate with 23%.

(Source: NHS England Friends and Family Test)

Staff on PPU had developed patient feedback surveys that included elements of the FFT and incorporated elements more relevant to private care.

During all our observations we observed staff speak to patients with respect. They addressed them by their name or with an informal greeting if this had been agreed. Staff at all levels demonstrated care, compassion and empathy and we observed staff respond patiently and with kindness when patients were frustrated, confused or upset.

Staff used privacy curtains when delivering personal care or an intimate examination and used side rooms and meeting rooms for confidential conversations.

The endoscopy unit team were unable to ensure each patient's privacy and dignity due to the environment and demands on capacity. This was listed as a risk on the service risk register and although staff worked on an ad-hoc basis to maintain each patient's dignity, the divisional team said they would be unable to fully address this without a new department.

Staff on each ward displayed cards and letters of thanks from patients and their relatives. We looked at the comments of over 55 notes, which demonstrated the opinions of care people had received. For example, cards on ward 11W stated, "11W has some secret ingredients that make this ward very special" and, "How can I begin to thank you for everything you have done."

One patient being cared for on ward 8N said, "I've been here five days and had excellent care. I've seen the physio, the medical team and the microbiologist and they've all introduced themselves. The nurses are second to none."

The approach of staff outside of the clinical environment did not always reflect compassion and kindness. During our weekend unannounced inspection, a homeless person was sleeping in a

coffee shop. Hospital cleaners, clinical staff using the coffee shop and operational staff ignored the person despite their being in clear need of intervention and presenting an unknown risk to others in the environment. We escalated this to the site manager after the person had been left sleeping for five hours. The site security team removed the person but did not identify if they needed help.

In the 2018 patient led assessment of the care environment (PLACE), inpatient wards scored 86% for privacy, dignity and wellbeing. This was better than the national average of 84% and the 2017 score of 85%.

Therapies staff carried out a patient satisfaction questionnaire in 2018 for those who attended structured therapy groups for upper limb and communication rehabilitation. The audit included 32 patients, of which 100% said they enjoyed therapy with other people and would to return.

Emotional support

Staff provided emotional support to patients to minimise their distress.
Healthcare assistants (HCAs) took a lead role in providing emotional support to patients. We spoke with an HCA on ward 10S, a transplant ward, who said they felt the emotional care they provided patients was equal to the medical care nurses and doctors provided. They said this helped promote wellbeing beyond clinical outcomes and promoted recovery by ensuring patients' emotional and spiritual needs were met.

An HIV nurse specialist worked closely with patients and their relatives to help them understand the psychological impact and implications of the illness. For example, they spent time with the partner of a person recently diagnosed to help them understand the illness and to reduce the anxiety and stress caused by stigma. This provided the person with reassurance and the nurse helped them to identify reliable sources of online information for their own understanding.

A specialist non-profit organisation based in the hospital provided counselling and emotional support to patients living with cancer and their relatives. The centre was well resourced and trained volunteers provided on-demand support, which ward teams could refer into. The team provided complementary therapy including reflexology, Pilates and massage in addition to talking therapies.

A multi-faith chaplaincy and spiritual care team and chapel was available 24-hours, seven days a week. Ward teams knew how to contact the duty chaplain and information was prominently displayed around the hospital. The chaplaincy team provided a range of worship sessions on a weekly basis and provided support for people of no faith.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.
Staff demonstrated awareness of the needs of patients, relatives and carers during handovers. For example, on wards 10S and 11W the multidisciplinary team strategised support for a patient who needed a complex discharge plan with social care provision. Staff shared their knowledge and understanding of the patient to establish next steps to help them return home.

Staff demonstrably valued the contribution of carers and made sure they were welcomed and accommodated. Ward teams involved carers in care delivery as far as possible and provided informal training and guidance to help them carry out tasks important to patients such as making their bed and helping with personal hygiene.

In response to feedback from family members, staff on ward 12S had designed and launched a care plan specifically for carers. The team recognised patients on the ward were often admitted for substantial periods of time, which their carers often spent with them. The care plan helped staff to

get to know carers, understand their needs and develop strategies to support them during the patient's admission.

The tissue viability team worked with patients and relatives to help them understand wound management and pressure care. For example, they provided one-to-one education on how to manage pressure for patients who used wheelchairs. This was a strategy to more fully include people in basic elements of care.

The tuberculosis (TB) team worked with patients to ensure they understood their condition and how to manage their medicine and therapy. For example, the team had prepared an instructional video and carried out observed therapy sessions to ensure they were confident patients understood their own needs. Where patients did not understand the process or the team felt they needed more frequent involvement from staff, they implemented a monitoring plan on an outpatient basis.

The discharge lounge team had increased working with the triage rapid elderly assessment team (TREAT) team and British Red Cross to ensure they better understood patient's needs once they left the hospital. For example, they found patients often returned to hospital because of a lack of support at home and that patients were at risk of malnourishment because they did not have access to food at home. The discharge lounge team established points of escalation and liaised with non-profit services to ensure agencies that could help were aware of the patient's needs and involved patients in discussions about what they would find difficult at home.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.
Staff planned and adapted care and treatment to meet the changing needs of patients in their medical specialty. For example, ward 11W, an infectious diseases, rheumatology and HIV ward, provided enhanced care to patients with rapidly changing or unpredictable conditions. This including planning to support patients with activities of daily living, which could be compromised when they experienced certain symptoms.

Three private patients unit (PPU) wards provided care within multiple core specialties, including health services for elderly people (HSEP), oncology and post-transplant medical care. PPU also offered a joint haemodialysis and peritoneal dialysis (PD) service, which was the only service of its kind in London. The team achieved this because each patient had a consultant dedicated from a specialty, which enabled them to deliver care to people with widely differing needs. However, this presented a significant challenge to the nursing team as they were required to develop skills in a range of clinical areas and fields. To ensure they could plan and meet patient needs staff moved between the wards as needed by patient admissions.

Staff coordinated the service to enable patients to plan around their personal and social lives, such as by scheduling clinic visits around holidays and work commitments. The PPU unit had two 'hot' rooms for radioactive patients and staff worked with colleagues in outpatient services to ensure capacity was used appropriately.

A dedicated business development team worked with consultants to plan the expansion of clinical services in the PPU, which had resulted in the introduction of more specialist care. For example, the unit had introduced post-operative medical care for patients following anterior hip surgery. In

addition, a team of staff worked with embassies and international medical professionals to coordinate care and ensure staff had access to information such as medical histories.

Care and treatment pathways were in place to help staff plan care for patients wherever they were accommodated in the hospital. This meant staff working within a medical specialty provided a range of care to patients in addition to their primary medical needs. For example, all ward staff were able to offer an HIV test to patients and had access to a team of trained on-call specialists in the event a test returned positive, to discuss the results with the patient.

There were limitations on service provision in the endoscopy unit and the team could not offer single sex accommodation, a dedicated paediatric area or a bowel cancer screening service. This remained on the service risk register and senior divisional staff were aware of it but there was limited opportunity to fully address the issues. As measures towards mitigation, a business case had been submitted to build a new seven-room endoscopy facility, which would improve the service provision and address capacity issues. In addition, the senior matron worked with cross divisional colleagues to risk assess the environment. Adjustments included drawing of privacy and dignity curtains and allocation of designated paediatric bays with support from paediatric trained recovery nursing staff for twice weekly morning lists.

There were four coronary care unit (CCU) beds in ward 10W, a cardiology ward. The CCU provided step-down care for patients who had been cared for in critical care services and the unit was equipped with level 2 beds and equipment. Level 2 refers to patients who need enhanced care, including mechanical life support for one organ, as defined by the Intensive Care Society. The CCU and ward 10W were part of the trust's heart attack service, which included cardiac catheter laboratory (cath lab) support 24-hours, seven days a week. The senior divisional team highlighted significant risks to the sustainability and daily operation of the heart attack service due to aging infrastructure that had led to 80 days of down time for the cath lab. There was a future plan to address this but there were no immediate assurances it was being contained.

The acute medical unit, ward 8N, was equipped with equipment for monitoring level 2 patients, including those with a tracheostomy and those who required cardiac monitoring.

Ward 10E, a renal ward, was equipped for step-down patients leaving critical care and each bed space was equipped with equipment for haemodialysis treatment. The ward also had one side room reserved for emergency dialysis or acute kidney injury admissions as part of a tertiary referral service.

Four side rooms on ward 11E, a haematology-oncology ward, were reserved for a weekday hot clinic for day patients as part of the medical oncology service.

Staff in some medical specialties demonstrated understanding of population-based health amongst their patient groups and how this impacted care and treatment needs. For example, the hepatology team recognised their case mix had begun to include younger patients, including patients who were treated initially in critical care for lifestyle-related liver disease. Where this was the result of chaotic lifestyle factors, such as homelessness, staff established an earlier ceiling of care and liaised with community services to plan future care. Staff on ward 9N had implemented a quality improvement project to reduce the risk of falls amongst patients experiencing withdrawal from alcohol or drug addiction. The team on ward 8N were also leading a falls project.

Staff had contributed to improvements in ward environments as a result of their work to understand and better meet the needs of patients. For example, the team on ward 8E had established a treatment room for chest drains and plural procedures following planning and coordination exercises.

The tissue viability team lead was planning future service expansion to ensure the service could meet the changing needs of the local population. For example, the team had noted an increase in the presentation of patients with conditions resulting from a lack of support at home, such as severe pressure ulcers, uncontrolled diabetes and escalating mental health conditions. The team had implemented monthly mobile teaching for staff on wards that saw a large number of patients with wound management care needs and had developed in-house self-care leaflets for patients. The team had also developed a weekly homeless outreach clinic to support patients with skin integrity and wound management and prevent hospital admissions.

The tuberculosis (TB) and respiratory teams planned care to meet the needs of patients in the local community, including those with complex social care needs relating to homelessness. The teams arranged temporary accommodation for patients during their treatment and worked with community organisations to establish a more sustainable arrangement. Patients had access to weekly meetings with staff to answer questions and discuss their clinical progress.

During our weekend unannounced inspection staff in endoscopy said a lack of IT and administrative resource in the service had resulted in reduced capacity. For example, no facility to print patient's records. Staff said they had also lost pharmacy support to draw up medicines, which further reduced their capacity. However, after our inspection the trust said the department had adequate pharmacy resource.

There were significant pressures on the cardiology service, which impacted the ability of staff to deliver the service. Staff had entered the risks associated with a backlog of echocardiogram results on the divisional risk register. However, on-going staff shortages and problems with the reporting system meant the backlog had increased and there was no resolution in place. Other specialties noted their concerns about the cardiology service, including AHPs who said it was often, "chaotic and challenging to engage with".

Meeting people's individual needs

The service took account of patients' individual needs.

Teams in the HSEP wards were carrying out refurbishment programmes to create a more inviting and calming environment for patients. Refurbishment on ward 8W was in progress and included the creation of day rooms decorated with items designed to stimulate reminiscence and memory, a fish and chip shop and dining room to encourage social interaction at mealtimes and a barbershop. The dementia lead nurse maintained oversight of this project to ensure refurbishment would better meet the needs of patients living with dementia.

The trust had implemented the national John's Campaign as part of dementia care, which meant staff provided enhanced care and resources for carers. This included free parking and refreshment vouchers. The dementia lead nurse had published guidance for ward teams on how they could use John's Campaign as a structure to support and help carers. Volunteers were trained to provide dedicated support to patients living with dementia, such as spending time with them off the ward in one of the hospital's cafes. Ward teams arranged for activities such as carol singers and pet therapy visits and the trust had launched a dementia handbook for relatives and friends of patients. This reflected a substantial body of work to improve care and services for patients living with dementia and the people close to them.

Nurses on ward 11W were trained in motivational interviewing, which helped them to support patients prescribed antiretroviral drugs but who refused to take them consistently. A clinical psychologist based in the Ian Charleson Day Centre provided on-call support for the ward and worked collaboratively with HIV specialist organisations to meet the increasingly complex needs of patients.

Staff demonstrated resourcefulness in securing language translators for patients when the trust's contracted provider were unable to help quickly. For example, ward teams communicated with each other when they had staff with specific language skills available to support each other and patients. An Arabic translator was available on-call for PPU patients 24-hours, seven days a week.

Volunteers provided a range of services to medical inpatients to help make their stay more pleasant. This included working with the chaplaincy and providing bedside trolley services with library books and personal comfort items such as toiletries.

A dedicated embassy and interpreters team worked in the PPU to coordinate language support in advance and to coordinate care with embassies when they sent their staff to be treated.

Patients admitted to the PPU wards were cared for in private side rooms all with en-suite bathrooms.

Staff on inpatient wards said they regularly struggled to meet the needs of patients with mental health conditions whilst they were waiting for a mental health bed placement. Some staff told us their training was insufficient to meet patient need and this led to an increase in incidents, including a vulnerable patient absconding and a suicide attempt. We were not assured that arrangements for the one-to-one supervision of patients at risk were fit for purpose. For example, during our weekend unannounced inspection we observed a security officer who had been assigned to a patient who needed one-to-one supervision sleeping outside of their bedroom. We spoke with the nurse in charge about this who dealt with the situation immediately and appropriately.

Patients on ward 11W could spend significant periods of time as an inpatient. The team recognised this and worked with patients to arrange resources to keep them occupied and mentally active. For example, they sourced a laptop for one patient so they could continue to work and communicate with people important to them whilst being treated.

Staff accommodated patient requests for female or male staff as far as possible. For example, staff on the PPU wards displayed notices on bedroom doors where the patient had requested a specific gender of staff. On other wards patients often requested a specific gender of staff for personal care and intimate examinations. Where the ward team was unable to accommodate this, they offered patients a trained chaperone, in line with trust policy.

HCAs in some wards said shortages in their teams meant they were unable to meet patient needs. One HCA showed us they were the only member of staff at that grade for 28 patients, which meant most patients who needed help with personal care did not receive this during the shift. We spoke with two ward managers who said this was a common occurrence and that the use of HCAs to provide one-to-one care for patients with mental health needs and for cohorted patients (those with similar risks), meant there was a lack of resource for the rest of the ward. This was also apparent in the outcomes of serious incidents. For example, in September 2018 one patient had suffered multiple unstageable pressure ulcers that staff had failed to notice because the patient had not been bathed for several days.

Allied health professional therapists were significantly under-resourced to be able to meet the needs of patients who presented with highly complex, long-term needs. Therapists said consultants increasingly relied on them to facilitate and plan discharges but a lack of capacity in the team, a lack of knowledge of their role amongst the medical team and incomplete, late referrals resulted in discharge delays and unnecessarily extended length of stays.

In the 2018 patient led assessment of the care environment (PLACE), inpatient wards scored 78% in the dementia measure and 83% in the disability measure. Both results were within 1% of the

national average. The dementia score represented a 3% deterioration from the 2017 result and the disability score represented a 2% improvement.

Learning disabilities specialist nurses had implemented core principles of care for people living with a learning disability. This was a guide for staff to support them with effective communication and to identify opportunities to make reasonable adjustments in their area of work.

Staff used a tool called, '8 things about me' to document important information about a patient, such as their career or important life events. This was interchangeable with the, 'This is me' booklet and staff chose the most suitable option based on the patient's level of communication and support need.

Staff on ward 11E had adapted the environment to better meet the needs of patients who typically spent up to three days in isolation whilst receiving specialist treatment. For example, the team had secured funding for a 'wall glamour' project, which included the installation of detailed, engaging wall murals. This was an evidence-based project to help reduce boredom and feelings of isolation.

Dedicated psychology support varied between services and there were 29.3 whole time equivalent (WTE) staff in post for medical and specialty services. This varied from four WTE staff in pain management to 0.2 WTE for respiratory medicine. A psychological services review was underway at the time of our inspection as part of a business case to provide a dedicated service.

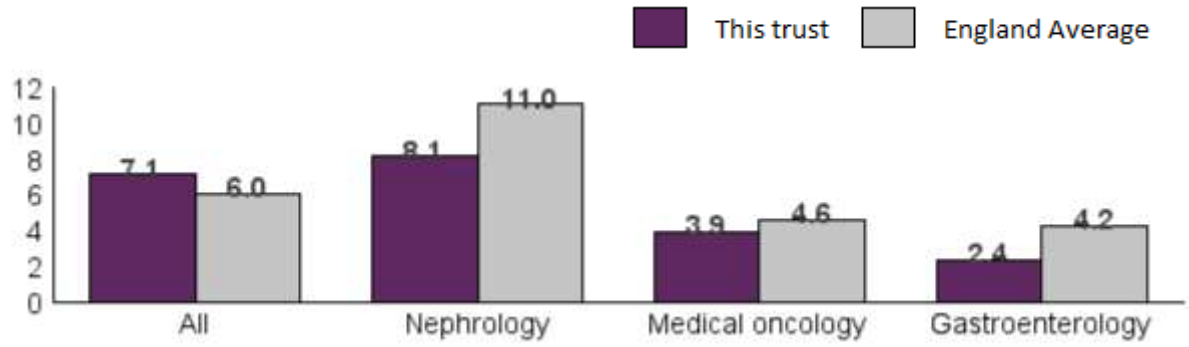
Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

From July 2017 to June 2018 the average length of stay for medical elective patients at the trust was 7.1 days, which is higher than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 7.7 days, which is higher than the England average of 6.3 days.

Elective Average Length of Stay – Trust Level

- Average length of stay for elective patients in nephrology is lower than the England average.
- Average length of stay for elective patients in medical oncology is lower than the England average.
- Average length of stay for elective patients in gastroenterology is lower than the England average.

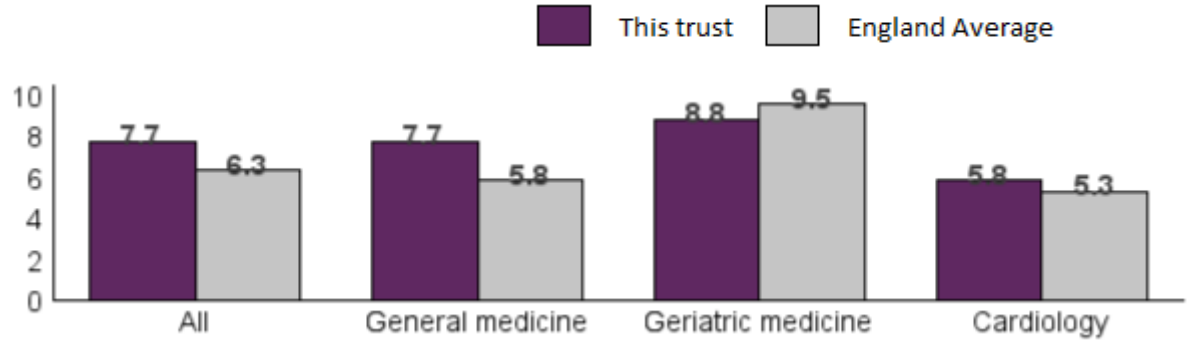


Note: Top three specialties for specific trust based on count of activity.

Non-Elective Average Length of Stay – Trust Level

- Average length of stay for elective patients in general medicine is higher than the England average.

- Average length of stay for elective patients in geriatric medicine is lower than the England average.
- Average length of stay for elective patients in cardiology is higher than the England average.

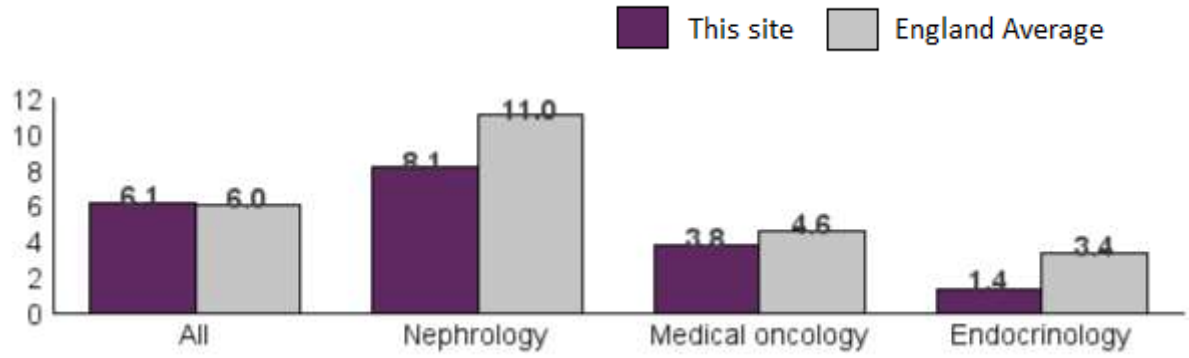


Note: Top three specialties for specific trust based on count of activity.

From July 2017 to June 2018 the average length of stay for medical elective patients at The Royal Free Hospital was 6.1 days, which is similar to the England average of 6.0 days. For medical non-elective patients, the average length of stay was 7.6 days, which is higher than the England average of 6.3 days.

Elective Average Length of Stay - The Royal Free Hospital

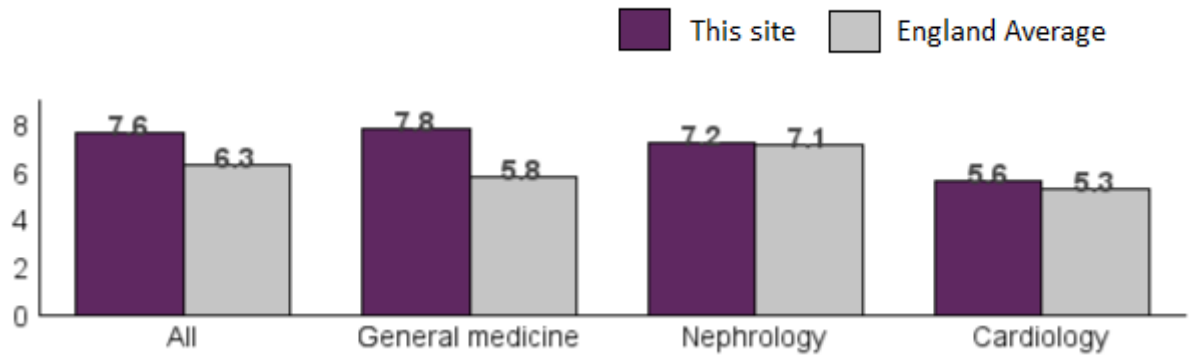
- Average length of stay for elective patients in nephrology is lower than the England average.
- Average length of stay for elective patients in medical oncology is lower than the England average.
- Average length of stay for elective patients in endocrinology is lower than the England average.



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

Non-Elective Average Length of Stay - The Royal Free Hospital

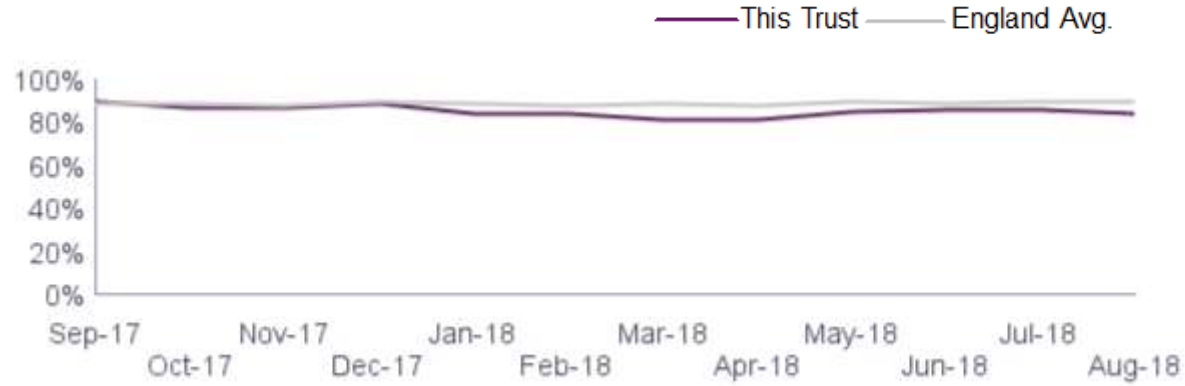
- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in nephrology is similar to the England average.
- Average length of stay for non-elective patients in cardiology is similar to the England average.



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

(Source: Hospital Episode Statistics)

From September 2017 to December 2017 the trust's referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average. However, from January 2018 to August 2018, performance was slightly worse. In the latest period, August 2018, the RTT rate was 84.2% compared to the England average of 90.0%.



(Source: NHS England)

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

Specialty grouping	Result	England average
Geriatric medicine	100%	97.0%
Thoracic medicine	98.8%	93.0%
General medicine	98.0%	96.4%
Neurology	97.1%	91.1%
Dermatology	82.9%	82.2%

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

Specialty grouping	Result	England average
Gastroenterology	91.3%	93.7%
Rheumatology	88.0%	94.5%
Cardiology	77.7%	82.1%

(Source: NHS England)

The trust did not provide a date range for the below data.

Patient moves	Number of patients	% share of all patients
1	18,452	67%
2	7,524	28%
3	1,045	5%
4+	273	1%
Total	**23,545**	**100%**

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

From August 2017 to July 2018 there were 1,315 patient ward moves at night.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)
From November 2017 to December 2018 the average length of stay for patients in the discharge lounge was 1.6 hours, with daily averages ranging from 63 minutes to three hours.

Trained staff were always on call for a planned admission to the high-level infection unit (HLIU). A senior nurse trained in the HLIU activation checklist was always on shift on ward 11W, which enabled them to commence a rapid response in the event a patient was transported there in line with the six-hour preparation standard.

Bed managers admitted patients and flow coordinators discharged patients. Discharge and flow coordinators, the nurse director and representatives from each specialty held weekly 'stranded patient' meetings to review those medically fit for discharge but who needed complex social care plans in place before it was safe for them to go home. Divisional lead nurses worked with discharge coordinators where they needed to engage with other organisations to facilitate a safe discharge, for example with homeless organisations. The meetings enabled staff to coordinate discharge planning between the multiple local authorities staff had to deal with, each of which had their own requirements.

Divisional operations managers worked with discharge coordinators to facilitate discharge planning and reduce delays caused by a lack of capacity in diagnostic services and community social care.

Senior staff from PPU attended hospital bed meetings and worked with flow coordinators to offer additional capacity to NHS patients.

A supernumerary nurse coordinator was on shift daily in the PPU wards to plan admissions and discharges and worked with colleagues in NHS wards to ensure patient care was not delayed where bed capacity was available.

A dedicated flow coordinator was allocated to each ward and provided local coordination with clinical teams to support overall flow in the hospital.

A dedicated bed manager worked between haematology-oncology inpatients and chemotherapy outpatients for PPU patients to ensure continuity of care between services. This individual also ensured services were planned to meet capacity and could open chemotherapy outpatient spaces for inpatients to meet demand at weekends. They also worked with their counterpart for NHS inpatients and shared staffing and capacity resources to minimise delays and cancellations.

The discharge lounge team had been part of broad service improvement that included a more strategic role in access, flow and discharge planning. A working group met monthly to review

progress and opportunities for further improvement. The team used care pathways to plan discharge into the community and were proactive in chasing to take away medicines from wards and the pharmacy team to reduce delays.

Staff in PPU wards routinely made beds available for NHS patients in coordination with flow coordinators when the hospital experienced high levels of demand. This included sharing capacity between clinical services. For example, both the main hospital and the PPU had a chemotherapy day unit. Where a staff shortage occurred in one clinic, the teams coordinated resources and ensured patients were seen according to their appointments by sharing capacity. This meant trained staff from one unit could cover shifts in the other unit or patients could receive care in the unit they had not been originally scheduled into.

Nurses with discharge and flow responsibilities said they were concerned about the lack of structured discharge resources at a weekend. For example, the discharge lounge was closed on a weekend but nurses said cardiology patients were often moved there to provide capacity on the wards. One nurse said, “We have patients sitting in a unit that’s essentially closed. It’s part of the pressure to discharge that causes this but it’s not a good use of our time or a good experience for the patients.”

Each medical speciality and service was compliant with the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients. Patients were admitted under a named consultant who had overall responsibility for their care and a named nurse was responsible for each patient on every shift.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From September 2017 to August 2018 there were 399 complaints about medical care. The trust took an average of 30.4 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 35 working days.

The most prevalent types of complaints were those relating to all aspects of clinical treatment (183, 45.9%), appointments, delay/ cancellation (out-patient) (65, 16.3%) and communication/ information to patients (written and oral) (57, 14.3%).

A breakdown of complaints by site is below:

Site/location	Number of complaints	Proportion of total complaints
Royal Free Hospital	209	52.6%
Barnet Hospital	140	35.3%
Chase Farm Hospital	39	9.8%
Edgware Hospital	3	0.8%
Mary Rankin Dialysis Unit	3	0.8%
Royal Free London Community Service	3	0.8%
Total	**397**	**100%**

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

From July 2018 to December 2018 medical services received 33 formal complaints. Of which, neurology received eight complaints, elderly medicine received seven, cardiology received four, cardiology, three in dermatology, three in nephrology, two in general medicine, and one complaint each in gastroenterology, endoscopy, neurophysiology, oncology and immunology. The trust had extended the investigation period of six complaints, including three of the complaints received in cardiology.

From September 2017 to August 2018 there were 228 compliments within medicine.
A breakdown by site is below:

- Barnet Hospital: 105
- Royal Free Hospital: 107
- Chase Farm Hospital: 13
- Edgware Hospital: Three

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Each division had a complaints assistant who maintained timelines within trust policy, facilitated communication and arranged meetings between staff and complainants. We reviewed 20 complaints and the associated timelines, investigations and final responses in the transplant and specialist services division (TASS); five each from wards 9N, 10E, 11E and 11W.

We saw evidence of improved practice as a result of complaint outcomes. For example, following a complaint regarding comfort in the discharge lounge, the service purchased recliner chairs and introduced the hourly nurse observation system used on inpatient wards.

The team on ward 10E, a renal ward, were acting on a number of concerns raised by patients that they found it difficult to sleep because of the noise of equipment. The team had identified a cohorting strategy that would enable them to treat patients who needed machines that produced noise to be cared for in the same area. This would help to create designated quiet spaces on the ward.

The patient advice and liaison team (PALS) provided a dedicated service to patients, including a drop-in office and support by phone and e-mail. PALS staff liaised with ward teams and visited patients in person on request to discuss and resolve issues. The PALS team had conflict management training to help diffuse challenging situations or emotional conversations with patients and relatives. The team held regular debrief sessions to identify learning for clinical services from complaints and they readily shared these with ward teams.

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.
Medical and clinical specialties were structured in divisions. The medicine and urgent care (MUC) division included eight specialties delivered in nine wards or clinical areas. This included the acute assessment unit (AAU), which we inspected as part of our urgent and emergency care framework. The transplant and specialist services (TASS) division included six specialist service groups delivered in 13 wards or clinical areas. Each division had a triumvirate leadership team formed of a divisional director, a divisional director of operations and a divisional nurse director. Clinical directors, operations and service managers and matrons led individual specialties within this structure. Senior divisional staff had formed a new structure in July 2017 and convened an ongoing series of leadership development workshops to establish operational standards.

A private patients unit (PPU) director and clinical director led the private wards with leadership support from the divisional director of nursing, operations manager and senior business development, finance and governance staff. An embassy manager liaised with foreign embassies to ensure patients they referred were cared for safely. A therapies lead, clinical operations manager, a matron and ward managers led day to day care on the PPU wards.

The endoscopy service was part of TASS and the discharge lounge was managed by the director of operations.

Most ward-based staff spoke positively of the local leadership and said they felt supported to do their job and received guidance on improvement and development. They said ward managers and other senior staff were readily contactable and regularly visited wards and clinical areas.

Allied health professional (AHP) therapists spoke highly of their day-to-day leadership and said joint clinical sessions with managers encouraged them to develop and progress.

Leadership structures were at both ward level and service level. For example, matrons managed multiple wards or clinical departments within their specialty and ward managers led specific wards.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Staff used a strategy triangle to structure their focus, four core values, governing objectives and mission in line with the board committees that maintained oversight. Divisional teams mapped objectives and areas of focus to ensure teams within each service and ward had clear targets and standards. For example, the clinical standards and innovation committee maintained oversight of divisional goals based on standardising and benchmarking clinical practice.

MUC and specialist services had established 42 goals with the aim of achieving these between December 2017 and December 2021. Divisional leadership teams engaged with staff through quarterly away days to identify and establish their roles in achieving the strategy through local quality improvement projects. This helped to clarify strategies and goals specific to each specialty and to build resilience. Individual specialties used quality improvement methodology to improve care pathways and delivery.

In 2016/17 each medical service published a 10-year vision that was aligned with the overall division and trust goals and strategy. This helped staff in specialist teams to plan service development within their service and to meet the changing needs of patients into the future.

The chaplaincy team delivered care and spiritual support within a four-point commitment that structured the standards they expected people to receive. This ensured patients, relatives and visitors received spiritual or pastoral care without prejudice to their personal beliefs.

The dementia implementation group worked towards a well-defined dementia strategy across all three of the trust's hospitals. This included establishing care standards that incorporated guidance from national campaign work and research and progressing refurbishment work to ensure wards were dementia friendly. The group met monthly to review their achievements and challenges and there were demonstrable improvements in care as a result of the strategy.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. However, there was limited evidence this contributed to improved staff wellbeing and experiences.

We carried out a series of meetings and small focus groups to find out how staff felt about working for the trust and to ask about the working culture. This was because at our last inspection in 2016, we received numerous reports from staff with regards to bullying, harassment and workplace negativity. Staff provided highly variable feedback. Staff who worked in some areas told us they felt the trust had addressed most areas of bullying and that effective support systems were in place with matrons and other senior staff. For example, one healthcare assistant (HCA) said, “I always feel motivated and enthusiastic, I think the support we get is just right.” Nurses in elderly care spoke positively about their work and said they felt supported and happy in their roles. Staff who worked on ward 10E said they felt the senior team had an active interest in their health and wellbeing. They said they were able to work flexible shifts to meet family and childcare needs and the senior nurse held regular meetings to find out what they needed to help them do a good job. This included a daily informal coffee meeting to talk about work and to help foster a strong team-working ethos. One nurse who worked between different areas said, “Bullying is not endemic here. But it does depend which ward you’re on, they each have a different culture and type of leadership. The better wards are those where staff are confident to speak their minds. You have to stand up for yourself, show an interest and show how committed you are.”

The trust had introduced a bullying toolkit to help staff address such issues. However, staff we spoke with were critical of this. For example, one individual said, “The toolkit guidance starts off by asking you what you did to cause the bullying. This places the blame on the person who feels bullied and is totally inappropriate.” Another member of staff said, “The toolkit was introduced without a requirement to use it, so it’s usually just ignored.” After our inspection, the trust told us a bullying and harassment pathway had been in place since 2012 and that the workforce department provided advice to staff and managers during times of need.

Some ward teams had introduced strategies to help maintain a consistent standard of communication and team-work. For example, the team on ward 11W used a ‘big three’ schedule during daily handovers to identify the priorities of the day to help them focus on the challenges and tasks ahead. We observed this worked well in practice and staff identified areas that had worked well in the previous days that they wished to continue.

Some staff felt the trust’s efforts to engage with them and improve working conditions had been temporary. For example, staff talked about a ‘joy at work’ project in which they discussed three key things they would like to change. However, the project had not run to completion and some staff said they felt this reflected their lack of value to the trust. One individual said, “It was a tick box exercise that wasn’t finished. It’s stopped a number of us from contributing to other things they [the trust] have asked us to since then.” After our inspection the trust told us they had operated several joy at work projects and that the programme lead had not left. We were unable to resolve the discrepancies between what staff told us and the information supplied by the trust.

Thirteen members of staff said they had experienced poor conflict management from the trust. One person said, “There is no process for conflict management. Our line managers are excellent at things like appraisals and development but there’s no way for us to get help or mediation when things go wrong. Human resources either won’t help or don’t know how to. It can be an isolating place to work.” Staff said where they had raised conflict issues or grievances with human resources, this had been ignored or not acted upon. When team managers changed they said they had to start again in trying to get help. After our inspection the trust provided evidence of the opportunities for mediation they provided, including facilitating meetings with trained staff and online access to policies.

Most staff we spoke with said there was a strict hierarchy in the trust that reduced respect between staff of different grades and meant junior staff were less likely to challenge poor practice.

One HCA said, “Communication is not free. Some doctors aren’t interested in your opinion and some nurses want things to stay the way they are. There’s not much interest in changing things for the better.” One nurse said, “This is a very hierarchical place to work. There’s a hierarchical mentality that makes it unpleasant most of the time.” Nurses and HCAs in some areas said relationships with doctors were good. However, this was varied and one nurse said, “A consultant comes to our ward and refuses to follow the bare below the elbow rule. We challenge him but he just ignores us.” This was specific to some wards and in some areas nurses said they felt empowered to challenge this. During our weekend unannounced inspection, we observed a doctor in a clinical area wearing a wristwatch went unchallenged by nurses working with them.

Staff on PPU wards described a recent change in the relationships with some resident medical officers (RMOs) and described bullying, shouting and insulting communication during recent interactions. Two members of staff said some RMOs shouted at nurses if they were disturbed during the night to deteriorating patients because the RMOs did not consider the escalation appropriate. They said this resulted in junior nurses being scared of escalating patients, which meant more senior nurses had to spend more time checking patient observations. After our inspection the trust told us nurses had not reported any instances of conflict with RMOs and the escalation process had been reiterated to staff on PPU wards.

Some specialty teams said relationships and communication were more positive and had improved. For example, the cardiology team said external team days had fostered good relationships and more respect between staff. The team had participated in a quality improvement project with the patient at risk (PARRT) team, which they said helped to improve nurse empowerment and confidence.

Some HCAs we spoke with described reduced job satisfaction and feelings of self-worth and said they believed the trust was, “a dishonest place to work”, because of conflicts over their role once they completed a care diploma. They said the trust had reneged on the offer of more senior posts if they achieved their diploma, which meant they were working at a more advanced level for a lower level of pay. This was confirmed by several senior nurses, one of whom said, “We really disadvantage our HCAs. We push them to study then undervalue them with a lack of recognition so they leave.” Another senior nurse said, “We’re missing a huge opportunity with HCAs. We should be developing them for our future workforce but the trust mostly ignores them.” After our inspection the trust provided details of opportunities to HCAs they had provided included dedicated study days and support to achieve their care certificate. In addition, they had arranged well-being services for staff, including massage.

A Freedom to Speak Up Guardian was in post and their role and contact details were widely advertised to staff. Staff also said they appreciated staff working and support groups such as the black and minority ethnic (BME) group and the lesbian, gay, bisexual and transgender (LGBT) group as avenues of support.

The trust had a five-year staff experience and retention plan (SERP) to improve staff wellbeing and experience across all specialties and divisions. Workforce committees monitored progress and staff had access to events in their specialties to identify and implement positive changes. In June 2018 the trust held a ‘What matters to you’ day, which reflected a national campaign and arranged a Freedom to Speak Up event.

Staff on the PPU wards said verbal aggression and abuse from the relatives of patients was frequent, which they said often occurred in the context of cultural differences. Senior nurses said most staff had the confidence and ability to explain why some requests were inappropriate and to

explain the conduct they expected in the wards but noted there was limited training or support for staff in this area.

There were established links between teams on NHS wards and those working on PPU wards and nurses were positive about the combined roles they played. One nurse described this by saying, “We are connected as teams but the services are separate. We share bed meetings and help each other out in care delivery.”

Staff said the trust had organised an event in summer 2018 led by an external specialist organisation to address communication challenges between staff groups, as well as concerns around bullying and harassment. However, they said the event was not useful because the trust had not mandated attendance from doctors. One nurse said, “They [trust] organised an event to try and understand why some doctors speak so disrespectfully to us [nurses] but didn’t make the doctors come to it. They invited the doctors and not one of them turned up.”

During our weekend unannounced inspection, we observed it was difficult for relatives to gain access to wards to see patients as there were no receptionists on duty. Clinical staff told us there were no clear lines of responsibility for this. When trying to gain access to ward 10W staff failed to respond to three door entry buzzers and although two nurses saw our inspection team through the window they continued to ignore us. We observed this was common practice on some wards, which meant there was a culture of no accountability for visitors in these areas.

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Each division created divisional objectives from the trust’s board-approved goals. The objectives helped to structure governance processes to focus on achievement and development of the services within the division. To understand the effectiveness and leadership of clinical governance processes we reviewed the minutes and notes from over 100 meetings that took place in 2018. This included clinical governance, quality, safety and risk and operational teams and committees representing every medical service and specialty. The records demonstrated a methodical and robust approach to maintaining oversight of services and there was a consistent multidisciplinary approach to overcoming challenges. Specialty teams routinely involved staff and patient representatives in governance processes, which reflected the integrated approach divisional teams promoted.

The PPU service was delivered with a structured integrated governance framework, the active version of which had been implemented for 2017 – 2020. The framework provided divisional teams with assurance of quality and safety through a meeting and communications structure that enabled them to meet six ‘ambition statements’ established by the division.

Where teams were independent of medical specialties, there was limited governance in place. For example, clinical practice educators (CPEs) were assigned to medical specialties but did not have a clear leadership or governance structure. The team provided a high level of service to ward-based teams but had limited support themselves and the team was uncertain about the future of the service. A senior matron in TASS had set up a CPE forum across the division to standardise practice, education and shared learning across specialist services but this was discontinued following turnover in the team. When ward teams were short-staffed CPEs were often redeployed to patient care, which compromised their ability to carry out their role. This was indicative of the lack of governance around the team, including the lack of process for them to work collaboratively

cross-service. CPEs said senior trust staff had initiated a scoping project with them to address the gaps in governance and leadership but this was discontinued when the lead became unavailable.

After our inspection the trust provided more information on the governance arrangements for CPEs. The CPEs in MUC were managed by matrons who worked within clear line management responsibilities for the CPEs. The trust said CPEs met in a forum and as a group informally in the division. The trust also said CPEs had met with matrons in the previous year to clarify the education strategy in their specialities and had a meeting to update the planned structure for CPEs in the trust.

Similarly, allied health professionals (AHPs) described significant challenges in cohesion, leadership and governance. Staff said there was not a functioning relationship between AHPs and human resources and that when they needed support this had never been forthcoming. Some staff said the trust had failed to ensure a robust system was in place to support professional mediation and as a result there was a lack of confidence and trust amongst the team that the trust would support them when needed.

The trust had changed the organisation of training time and instructed CPEs to reduce training in clinical shift time by 50%. This meant staff were required to complete 50% of their training in their own time. Nurses told us this had resulted in reduced staff retention and the loss of technical skills in some areas, particularly in respiratory medicine.

The high-level infection unit (HLIU) team had established governance processes to ensure the unit remained ready to provide care for a patient in an emergency situation and that its continual operation remained safe and with senior executive oversight.

There was limited evidence the trust acted on feedback from staff regarding the extensive challenges with IT systems, despite these impacting on training compliance and access to critical systems. For example, one AHP said they had been unable to complete any patient observations or documentation for the first two months of their role because they had not been issued with an access card for the electronic system. After our inspection the trust provided details of plans underway to improve IT systems, including an extensive upgrade.

Appropriate, up to date governance processes were in place to maintain oversight of practising privileges in the PPU wards. This included a consultant contract maintained by divisional directors.

Management of risk, issues and performance

The trust did not have consistently effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
Divisional and senior clinical staff used risk registers to identify, assess and monitor risks to their service.

There were 20 active risks in the MUC division, of which staff had classified 14 as high risk and six as moderate risk. Of the high risks, four related to each of general medicine and neurology, three related to elderly medicine, one related to cardiology, one to pharmacy and one to MUC overall. TASS noted 16 risks, of which one risk was extreme, nine were high risk and six were moderate. The risk classified as extreme was in hepatology and related to the lack of provision for patients presenting with alcohol dependency and the lack of a coordinated care to address this. High risks were allocated to haematology and oncology (two), nephrology (two), oncology (two), pulmonary hypertension (two) and the dialysis service (one).

Staff had recorded nine risks in the endoscopy service, of which they classified five as high and three as moderate. One extreme risk was recorded and awaiting final approval. This risk related to the equipment and was subsequently downgraded to high following discussion at the December

2018 TASS divisional board. A risk related to the inability of the service to meet demand due to insufficient capacity, which also meant the service could not gain accreditation with the Joint Advisory Group on GI Endoscopy (JAG) was rated as high.

A business case had been approved for a new seven-room endoscopy unit with funding pending. A new centralised decontamination unit was scheduled to open in August 2019. There was an on-going risk relating to the suitability of the recovery area for paediatric patients, which provided limited segregation from adult patients. Nurses provided dedicated side rooms for recovery two mornings per week and administration staff cohorted paediatric patients to these times where possible. However, this was not sufficient to meet demand and the endoscopy directorate governance and performance, paediatric quality and safety board and the theatre safety board coordinated responsibility for this risk. In addition, the senior matron worked with cross divisional colleagues in SAS and paediatrics to further mitigate the risks. Paediatric trained nursing staff remained with children in the department until they recovered and escorted them back to the ward.

Staff also identified the age of the endoscopy ultrasound (EUS) machine, which was over 10 years old, as an extreme risk awaiting final approval for addition to the risk register. The machine frequently failed, which had resulted in one cancelled list and potential delays in the diagnosis of biliary cancers. The manufacturer of the machine had told the trust they would not support indefinite maintenance. This risk was discussed at the TASS Divisional Board and down-graded to high as it had been identified that to date only one list had been cancelled. The trust had not agreed a satisfactory resolution to this risk at the time of our inspection. After our inspection the trust told us the management team was drafting a business case to the medical equipment board for replacement.

The therapy services team identified seven risks in the service, of which they classified four as high and three as moderate. High risks related to insufficient numbers of trained staff to monitor patients fitted with a collar following a cervical spine fracture, a lack of secure data storage and unmanageable workloads. There was limited evidence of on-going risk resolution in this service and senior staff had not reviewed some risks, including amongst those classified as high, for over 18 months.

Staff were empowered to plan and implement quality improvement projects. For example, a physiotherapist in the elderly care wards was leading quality improvement projects on bed rails and on mobility.

The golden ward project aimed to reduce falls and pressure ulcers and promote discharges early in the day. Several wards had subscribed to this, which would be an on-going project through 2019.

Staff on ward 11W had worked with the security team and police to address the issue of patients being admitted and carrying illegal drugs with them. This had presented risks to housekeeping staff where patients used intravenous drugs and to others on the ward through drug-induced violence. Ward staff had worked with the security team to develop an algorithm to help staff identify when a patient’s behaviour was threatening or unacceptable.

A robust standard operating procedure (SOP) was in place for risk management of patients in the discharge lounge, including when they presented with an infection and when the area was used during times of escalation. For example, the discharge lounge team accepted patients without discharge summaries and to take away (TTA) medicines during times of extreme bed capacity pressure. During such periods staff used the SOP to ensure risks to patients and the service were minimised with key tasks allocated to named individuals to ensure patients were discharged safely.

Security arrangements to protect staff, patients and visitors were not robust or consistent. One nurse said they had waited 40 minutes for a response from the security team when an abusive relative became threatening and they needed help. Another member of staff said a security officer showed no sense of urgency and took 10 minutes to respond when a violent patient attacked them with a fire extinguisher. One nurse said, “We’re not equipped with the skills to deal with violence. It feels very much like we’re on our own.” Staff on PPU wards said they had intercepted unauthorised people walking around the ward lobby area during the night and had received a fast response from security but they were not assured that access controls were in place overnight. We asked 14 other nurses about this who spoke negatively of the security of the hospital out of hours. One ward manager said, “The security system is hopeless. It’s essentially an unmonitored site and it can be threatening and intimidating. My nurses don’t leave the ward overnight because you have no idea who is in the corridors who shouldn’t be there.” There was further evidence of poor security cover in the investigations of complaints and incidents. For example, urgent contact numbers for senior security staff were not kept up to date and security officers did not have the training or competencies to provide an alternative. Where senior medical staff were concerned unauthorised people would gain access to clinical areas based on evidence, the security team had refused to provide support. This had placed ward staff at risk of harm and highlighted that the trust did not have a functional escalation procedure to obtain help in urgent situations.

After our inspection the trust provided details of the security arrangements in place, including a security ‘crash call’ system that staff could use to obtain urgent help. All staff were required to undertake conflict resolution, fraud and security training to help them manage situations locally. Staff were also offered physical intervention training to supplement the support of the security team. Staff on wards 8N, 9N and 11W had completed this. The trust said there had not been an instance of the security team refusing to provide support when contacted within their remit. We were not able to establish why there were substantial differences between the feedback given by staff and information provided by the trust.

There was no sepsis lead in place and ward teams did not have sepsis link roles. A senior nurse said, “Sepsis isn’t really on our radar. We have a Sepsis6 phone app but not many people use it.” A CPE had created a Sepsis6 pocket guide for staff to address the lack of coordinated training and guidance from the trust and the PARRT team acted as a point of support for suspected sepsis.

MUC did not have a divisional morbidity and mortality (M&M) strategy. This meant clinician-led reviews of patient deaths and other outcomes was dependent on individual specialties, which had variable resources. In addition, consultants were responsible for reviewing their own patient mortality, which present an inherent risk of bias. Some specialties held regular M&Ms. For example, the respiratory team held monthly M&M meetings and created action plans to address areas for improvement. An educational fellow was working to implement a more robust cross-specialty M&M process and cross-site governance meetings took place every six weeks but there was no external challenge to M&Ms. We reviewed 29 M&M meeting records and presentations representing a range of specialties. Although each team approached this task differently, there was consistent evidence of a multidisciplinary approach to exploring patient outcomes with senior clinical leadership present. After our inspection the trust clarified their position on M&Ms and said the mortality review group provided site-level oversight of mortality as part of the learning from deaths process. This reflected standardised methodology across all specialties.

Two physician associate posts had been created in general medicine and the divisional leadership team were working with matrons to identify more opportunities for non-medical staff, such as medical assistants.

Divisional leadership teams had trialled and implemented a range of new strategies to improve recruitment and retention. This included self-rostering for nurses and re-developing the band two and band five training strategy.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff demonstrated a good understanding of information and data security. They locked computer screens when not in use and stored medical records in locked trollies and rooms.

The trust had recently introduced an electronic quality and performance monitoring tool, which staff accessed using software on mobile devices. This required them to input data based on ward performance and patient management so that senior staff could track standards over time. Although the trust had implemented the system, there were not enough portable electronic devices for all staff to record data. In some wards staff used their personal smartphones to record data but told us they were not aware if there were implications for data security and that they had not received IT training regarding data protection. This meant the programme was used inconsistently as some ward staff used their personal devices and some did not.

Staff on ward 11W used enhanced confidentiality processes to manage patient records and information that reflected the sensitive nature of the conditions patients presented with, such as HIV and other infectious diseases. For example, nurses completed a daily handover using a paperless system and adhered to a system that ensured they did not review medical records outside of bed bays. The nurse in charge allocated a dedicated key holder for medical records per shift, which ensured continual accountability for patient records.

Poor information access, control and management was reflected frequently in risks for services. This included a high risk of lost patient records in elderly care due to the lack of structure to the records scanning and storage system and a delayed turnaround time for IT administration, of up to four weeks, in neurology. All of the information management issues presented a significant risk of delayed diagnosis or treatment.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The trust and divisions provided multiple methods of engagement with staff at all levels of the organisation. This included printed and digital publications, chief executives' briefings and clinical audit awareness events. The trust's in-house charity produced a newsletter to promote staff, patient and volunteer involvement in events across the hospital, including inpatient medical services.

The trust had a staff recognition and rewards scheme that used a peer-nomination system to highlight individuals and teams for outstanding practice. Staff were enthusiastic about this and spoke with pride about their local nominations and achievements.

Staff worked with patients as part of the golden ward project to use their input to improve the service.

Ward teams actively engaged with patients and their relatives through the trust's 'you said, we did' programme. This enabled people to provide constructive feedback staff could use to implement changes and improvements. For example, the team on ward 11W had worked with the facilities

team to make the air conditioning and temperature control more responsive after patients said they did not feel the ward had enough fresh air.

Senior ward nurses attended weekly vacancy control and employee relations meetings to help support each other with staffing and human resources issues. Senior nurses from medical short stay had established fortnightly meetings with urgent care colleagues to coordinate the implementation of the new ward quality monitoring tool.

Staff in acute medicine held an awareness day for colleagues, patients and relatives to help raise the profile and understanding of the service. The event included an awards ceremony for peer-nominated teams who had demonstrated exceptional performance.

Clinical practice educators had established monthly forums to discuss their practice and identify opportunities for learning and improvement. The forums acted as scheduled engagement between each educator, which enabled them to obtain peer support.

The MUC divisional team had established a programme of quarterly away days for staff in all roles to discuss their feedback about working there and what they could do to support staff in their roles. This underscored feedback from staff that they wanted more face-to-face communication and less reliance on e-mails. This was based on the Institute of Healthcare Improvement 'joy at work' model although most staff we spoke with said they felt this had not yet delivered results.

The allied health professional therapies team was recruiting for therapy partners amongst patients who had used their services. The team planned this to be a working group to help shape the future of the service and to develop their practice. This was a new initiative and the first partner meeting was scheduled for November 2018.

The trust operated a 'you said, we did' scheme. This enabled patients and visitors the opportunity to engage with ward and specialist teams and see the difference their feedback made. For example, feedback in the coronary care unit led to improve discharge training for staff and more opportunities for relatives to be involved in care planning.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Senior staff encouraged their teams to engage in development and promotion pathways as a service continuity strategy and to improve staff retention by offering attractive future opportunities. For example, three staff nurses in health services for elderly people had recently been promoted into more senior posts. A nurse in the PPU wards was undertaking a secondment to a practice educator role following the promotion of the existing individual to matron. The PPU team offered training opportunities to colleagues in the rest of the trust as a strategy to improve awareness and help new nurses to consider the service as part of their career plans.

A clinical practice educator was leading a research project to set up cardiology and respiratory simulation training courses. This would establish more consistent use of the simulation centre and enabled clinical teams to access more advanced training.

The high-level isolation unit (HLIU) reflected the successful outcome of a specialised, multi-professional project to establish a unit and highly skilled team to meet the needs of patients with life-threatening and rare infections. HLIU was one of only two such units in England and the matron and their team had established robust standard and emergency operating procedures, including a six-hour activation time from the first point of escalation.

Surgery

Facts and data about this service

The Royal Free Hospital (RFH) is part of the Royal Free London NHS Foundation Trust and provides a range of elective (planned) and emergency surgical services to people mainly living in the London Borough of Hampstead. Surgical services are managed by two divisions: surgery and associated services (SAS) and transplantation and specialist services (TASS).

The SAS includes a range of specialties including plastic surgery, breast surgery, vascular surgery, general and colorectal surgery, ophthalmology, anaesthesia, operating theatres and breast screening.

The TASS provides services for nephrology, renal transplant and urology, haematology, oncology, and haemophilia, liver transplant, hepatology, endoscopy and gastroenterology, infection, microbiology, and virology, immunity, dermatology and rheumatology.

The RFH continues to be a national tertiary referral centre for complex aortic (the main artery of the circulatory system) disease specialising in endovascular (inside blood vessels) and open surgery for aneurysms (an excessive localized swelling of the wall of an artery), in addition to aortic dissection (a tear in the wall of the artery). The hospital offers a 24-hour vascular service at consultant level for all vascular and radiological emergencies.

The RFH has 19 operating theatres including three-day case theatres with associated areas for anaesthetics and recovery within the main theatre suite. The main theatres provide inpatient emergency and major elective surgery and are supported by a 16 bedded recovery unit.

The RFH is with a national leader in liver and kidney surgery. For example: the Sheila Sherlock Liver Centre is one of the UK's leading centres for treating liver disease and the RFH was the first hospital in the country to carry out kidney transplants with the help of a surgical robot.

The hospital provides 24-hour emergency care on the Royal Free hospital site and through links to other hospitals within the trust. The hospital has a wide range of outpatient clinics to support surgical services. There is a pre-operative assessment unit where patients due to have a general anaesthetic will have their fitness for surgery assessed. Patients undergoing day surgery attend a day-case unit which has 20 beds.

All services are supported by a multi-disciplinary team with some specific services linked to other specialist hubs. Anaesthetic services are also part of the surgery division providing anaesthetic cover for surgical specialties and a specialist pain management service.

The trust had 49,311 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 10,751 (21.8%), 30,275 (61.4%) were day case, and the remaining 8,285 (16.8%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Although the service provided mandatory training in key skills to all staff, not all staff had

completed it.
The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the surgery department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Resuscitation L1	264	269	98.1%	85%	Yes
Infection Control L1	258	269	95.9%	85%	Yes
BPAT	255	269	94.8%	85%	Yes
Basic Radiation Safety	251	269	93.3%	85%	Yes
Emergency Planning	249	269	92.6%	85%	Yes
Waste Mgt	242	269	90.0%	85%	Yes
Fraud & Security	241	269	89.6%	85%	Yes
Health & Safety Awareness	238	269	88.5%	85%	Yes
Moving and Handling	225	269	83.6%	85%	No
Information Governance	221	269	82.2%	85%	No
Fire Safety	219	269	81.4%	85%	No
Conflict Resolution	217	269	80.7%	85%	No
Equality, Diversity & Human Rights	216	269	80.3%	85%	No
RTT L1	59	74	79.7%	85%	No
Infection Control L2	211	269	78.4%	85%	No
Blood Transfusion	206	269	76.6%	85%	No
Resuscitation L2	188	269	69.9%	85%	No
IRR17	5	8	62.5%	85%	No

At the Royal Free Hospital (RFH) surgery department the 85% target was met for eight of the 18 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the surgery department at RFH is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	141	209	67.5%	85%	No
Fire Safety	136	209	65.1%	85%	No
IRR17	16	25	64.0%	85%	No
Infection Control L1	131	209	62.7%	85%	No
Health & Safety Awareness	130	209	62.2%	85%	No
Basic Radiation Safety	128	209	61.2%	85%	No
Fraud & Security	123	209	58.9%	85%	No
Waste Mgt	119	209	56.9%	85%	No
Emergency Planning	118	209	56.5%	85%	No
Resuscitation L1	118	209	56.5%	85%	No

Equality, Diversity & Human Rights	115	209	55.0%	85%	No
Moving and Handling	114	209	54.5%	85%	No
Information Governance	108	209	51.7%	85%	No
Blood Transfusion	106	209	50.7%	85%	No
RTT L1	102	209	48.8%	85%	No
Conflict Resolution	99	209	47.4%	85%	No
Infection Control L2	93	209	44.5%	85%	No
Resuscitation L2	52	209	24.9%	85%	No

(Source: Routine Provider Information Request (RPIR) – Training tab)

At the RFH surgery department the 85% target was met for none of the 18 mandatory training modules for which medical staff were eligible.
The trust told us the team had improved and in November 2018 surgery medical team was compliant with one module, above 85%, and with further four modules above 80%.

Senior medical staff told us mandatory and safeguarding training (MAST) performance information had been presented and discussed in the SAS monthly board meetings and then further discussed by the clinical director's at their departmental meetings. Further regular e-mail updates had been sent to all clinical directors regarding the level of MAST training. The trust had provided computers that enabled a timelier access to the training system and were also supported with face to face sessions in the medical library to increase the take up of MAST.

Safeguarding

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for qualified nursing staff in the surgery department at the RFH is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	249	269	92.6%	85%	Yes
Safeguarding Adults L1	248	269	92.2%	85%	Yes
Safeguarding Adults L2	242	269	90.0%	85%	Yes
Safeguarding Children L2	242	269	90.0%	85%	Yes

At Royal Free Hospital surgery department, the 85% target was met for all the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for medical staff in the surgery department at the RFH is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	136	209	65.1%	85%	No
Safeguarding Children L1	130	209	62.2%	85%	No
feguarding Adults L2	125	209	59.8%	85%	No
feguarding Children L2	119	209	56.9%	85%	No

At the Royal Free Hospital surgery department the 85% target was not met for any of the

safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. Nursing staff could demonstrate where this policy could be found on the trust's intranet system. Staff we spoke with knew how to contact the safeguarding leads and told us they were easily accessible.

Staff on the wards and theatres told us they were trained to level two for adults and children and had completed on-line and face to face training. All staff we spoke with were clear about what constituted a safeguarding concern and how to escalate a safeguarding referral.

Staff told us that patients living with a learning disability admitted to a ward received a passport which helped staff identify areas where patients may be at risk of harm. Staff would consult with the families and carers in order to maintain a consistent approach to their care.

Arrangements were in place to provide safeguarding intervention for patients at risk of, or who experienced, female genital mutilation. Staff demonstrated a clear understanding of how to access out of hours urgent crisis teams and when to escalate concerns to the trust's safeguarding lead.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

For 2015- 2016 the trust had a limit of zero Methicillin-resistant Staphylococcus

aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus (MSSA) cases and

66 Clostridium difficile cases (infections per 10,000 bed days) for the twelve month

period. As of 3 February 2018, the trust was on course to meet all three limits.

There had been three MRSA cases, none of which were attributable to surgery, 17

MSSA cases, three of which were attributable to surgery, and 54 Clostridium difficile

cases, 54 of which were attributable to surgery.

The trust had an antimicrobial stewardship committee which had representation from the SAS and TASS and reported to the infection prevention and control committee.

We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely, Disposal of and complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

We noticed posters and information cards explaining waste segregation procedures and waste segregation instructions.

There were regular waste collections in the operating theatres. Waste was collected five times a day including the night time period

The trust had started to use 'a perfect ward programme' approach for the SAS and TASS to audit its safety when caring for its patients. We saw evidence that showed a comprehensive approach to the audit of the environment, hand hygiene, medicines management, documentation, patient and staff experience and end of life care.

There was access to hand washing, hand sanitiser and drying facilities in patient areas and a good supply of personal protective equipment (PPE) was seen and in use which included disposable gloves and aprons.

We observed staff wash or cleanse their hands before, between and after patient care. All staff were observed as bare below the elbow for effective hand washing.

Staff followed National Institute of Health and Care Excellence (NICE) clinical guidelines (CG74) 2008 surgical site infections prevention and treatment within theatres. Theatre staff were observed to adhere to best practice principles for ‘scrubbing up’, prior to surgery and wore correct theatre attire.

We saw that all equipment used by patients was visibly clean and appropriate for use. ‘I am clean’ stickers indicated where equipment had been cleaned.

Throughout the service, all privacy curtains were disposable. The disposable curtains had dates on them indicating when they were put up and routine changes were scheduled in accordance with Health Building Note (HBM) 00-09: Infection control in the built environment regulations which states; there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known or suspected infection.

We saw there were programmes in place for the deep cleaning of operating theatres. The frequency of the deep clean was dependent upon the severity of risk of infection. For example: very high risk, severe risk and significant risk, which supported the trust infection control policies.

The trust monitored the ventilation systems within theatres and these met with the health building regulations at the time they were commissioned.

We observed the process for handling instruments throughout the surgical procedure. Instruments once used were packed and returned to the sterilising department via the use of hatches.

Decontamination and sterilisation of instruments continued to be managed in a dedicated facility on site that was compliant with the EU Sterile Services Medical Devices Directive.

The sterile instrument store was spacious and sterile instruments were stored appropriately with sufficient stock levels to meet service needs.

Single use sterile instruments and other disposables were stored appropriately and all checked were within their expiry dates.

Patients undergoing elective hip and knee replacements had on-going quarterly surveillance for surgical site infection (SSI) and results were reported to Public Health England. This demonstrated no SSIs over the last year in 151 cases.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

There were 19 operating theatres with 16 in the main operating area, two covering maternity care and one in ophthalmology.

In all patient areas we visited, staff had access to emergency resuscitation equipment. Resuscitation trolleys and emergency call bells were checked regularly by staff that were competent to do so. Resuscitation trolleys were locked with a breakable seal, which demonstrated the trolley had not been opened or equipment used or tampered with. Records we looked at

showed that the resuscitation trolleys were all checked daily with stocks of equipment and consumables maintained by designated staff.

There was piped oxygen and suction equipment in each bed space in the ward and in consultation rooms and recovery areas. Medical gas supplies were filled and turned off when not in use, and suction equipment was clean, working and ready for use.

At our last inspection we saw that there were no wipe boards within theatres to record swabs, needles and instruments used intraoperatively. At this inspection we saw white boards were in operation. Staff told us the white boards were helpful in ensuring checks were consistently carried out.
Most staff we spoke with told us they had the required equipment to care for patients' needs, although four members of theatre staff told us there was regularly a lack of some basic equipment such as cannulas, electro-cardiac (ECG) leads and infusion sets.

Surgical services continued to have a comprehensive equipment record which allowed for the monitoring of equipment. However, the service did not have an equipment replacement programme.
All anaesthetic machines within the anaesthetic room and theatres conformed to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance which was seen attached to each machine. We saw that anaesthetic machines were checked at the start of each operating list by staff trained to do so.

However, AAGBI guidelines : Safe management of anaesthetic related equipment, 2009, state a replacement programme which defines equipment life and correct disposal procedures should be in place. It is recommended that anaesthetic equipment must be condemned and replaced before it becomes unreliable and endangers the patient, should be phased over a number of years, and is continuously updated. As a guide electrical equipment should be considered at five years and mechanical equipment at eight years.

We saw that the ageing stock of anaesthetic machines which ranged between five and 19 years had been identified as a risk because replacement parts for faulty equipment might not be available. This had been identified on the trust risk register since 2015 and had been reviewed monthly. A business case for the replacement of anaesthetic machines had been submitted for approval. We were told there was a replacement programme for 2019/20 which included the rolling replacement programme that went to the asset management group.

At the time of the inspection we saw one anaesthetic machine being repaired which had taken five days for maintenance staff to address.

We observed the handling of instruments prior to, during and after surgery and their arrival at the sterilising department. There was a number of incidents recorded relating to the missing or loss of an instrument. Whilst we observed instruments being handled and returned to the sterile services department (SSD) appropriately, instruments were lost somewhere between the end of the operation and its arrival in the SSD. Staff in the operating theatres and the SSD were aware of these issues but seemed to think the responsibility lay with the other department.

The process for removing instruments from the theatre environment needed to be re-explored as the result of missing instruments could be a determinant for further never events. Also, when an instrument was found to be missing from an instrument tray, the tray would be put to one side until the instrument was either found or replaced. This then led to the tray being held back which resulted in a lack of instruments for the next days operating list.

There were plans in place for the SSD to move externally where all instruments would be cleaned, sterilised and returned off site. It was therefore paramount instrument checks were completed appropriately to ensure instruments would be ready in a timely manner.

We saw trolleys in the main theatre area and the day care theatre area, which contained emergency intubation equipment. The contents of the trolleys met national guidance and current best practice, and we saw daily checks were completed in line with trust policy

Intubation is the placement of a flexible plastic tube into the windpipe to maintain an open airway.

At our last inspection in 2016 we found the recovery area of the operating theatre did not protect children from witnessing upsetting sights and hearing frightening sounds.

At this inspection we found the recovery area ensured children's' lists took place on same day to reduce the number of adults in the area but the team recognised further work was necessary to ensure the environment was child friendly.

We saw documentation to support fire risk assessments being undertaken and documented.

Piped oxygen and suction equipment was available at each bed space, as well as call buttons for emergency use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Patients for elective surgery attended a pre-operative assessment consultation prior to their operation in line with national guidance. During the assessment required tests were undertaken; for example, MRSA screening and any specific blood test and risk assessments. The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient's level of risk. For example, ASA 1 was low risk. Nursing staff and anaesthetists recorded the levels of risk during pre-assessment and on admission for surgery.

NICE guidance (NG89) for March 2018 states that all surgical and trauma patients should be assessed to identify the risk of venous thromboembolism (VTE) and bleeding as soon as possible after admission to hospital or by the time of the first consultant review and that reassessments for VTE and bleeding should be at the point of consultant review or if their clinical condition changes.

VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis) and travels in the circulation, lodging in the lungs (known as pulmonary embolism). It is important that VTE assessments are undertaken prior to surgery so as to reduce the occurrence of an embolism.

Screening rates were audited monthly by one of the trusts pharmacists and reported to the surgical division monthly. Between May 2018 and October 2018, data provided by the trust showed the overall VTE screening rate for the surgical wards was 89%. Performance ranged between 82% for ward 5 North B (plastic surgery) to 99% for ward 7 West (trauma and orthopaedics).

We looked at 10 records and found that all patients had received their initial assessment.

The trust had a hospital wide approach to managing deteriorating patients. The national early warning score (NEWS) was used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). Staff used the NEWS to record routine physiological observations, such as blood pressure,

temperature, heart rate and the monitoring of a patient's clinical condition. There were clear directions for actions to take when patients' scores increased, indicating a deterioration and members of staff spoken with were aware of these. The trust patient at risk and resuscitation team (PARRT) visited surgical patients upon referral, to help with interventions to stabilise them and prevent them becoming more ill.

We reviewed 10 sets of surgical notes and found NEWS was recorded and acted upon appropriately in all cases.

In September 2018 the PARRT carried out a review of observation charts and patient notes on a number of wards within the Royal Free Hospital. A clinical nurse specialist collected data at every bed space on each ward reviewed. Areas included: evidence of escalation, current NEWS scores, number of observation over the previous 24 hours and the number of observations undertaken between 20.00 and 08.00.

Ward 5 East (urology) was included in this audit. The audit showed that the majority of observations were carried out with the appropriate frequency and completeness and escalation for those patients who required it took place.

The World Health Organisation (WHO) five steps to surgical safety checklist were used to check and approve all safety elements of a patient's procedure. This included, checking it was the correct patient, the correct operating site, and that all the staff were clear in their roles and responsibilities. We observed active involvement of all team members when following the checklist. The WHO checklists were reviewed at daily safety huddles as well as on a weekly basis during operating department team meetings.

We observed the daily theatre huddle which took place at 8.20am and included staff from all operating theatres, day surgery, recovery, SSD, procurement and portering staff.

The use of the WHO checklist was audited by reviewing 100 cases a month through reviewing documents. Paper checklists were completed by theatre staff in addition to entering electronic data. The outcomes were displayed on the divisional governance dashboard and reviewed at the surgical divisional board and perioperative governance meetings. The results showed in 2017-2018 that debrief was the only step reported as not consistently meeting at least 98% compliance.

We reviewed three sets of minutes from the mortality and morbidity meetings which were found to be comprehensive. There was a named member of staff allocated responsibility for disseminating information from these meetings.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, operating theatres found it a challenge to recruit and retain sufficient staff such as operating department practitioners.

The trust has reported their staffing numbers below for August 2018. Fill rate is up from March 2018 when it was at 85%.

	August 2018			March 2018		
Site	**WTE Scheduled**	**WTE in post**	**Fill rate**	**WTE Scheduled**	**WTE in post**	**Fill rate**
Royal Free Hospital	335.4	282.6	84.0%	343.6	307.4	89.5%

(Source: Routine Provider Information Request (RPIR) –Total staff tab)

From September 2017 to August 2018, the trust reported a vacancy rate of 11.6% in surgery. This is lower than the trust target of 12%.

RFH surgery department was 12.2%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 21.4% in surgery. This is higher than the trust target of 13%.

The RFH surgery department was 22.2%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 4.7% in surgery. This is higher than the trust target of 3.5%

The RFH surgery department was 4.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported a bank usage rate of 12% and an agency usage rate of 1.4% in surgery. There were 4.2% of hours available unfilled by either bank or agency staff.

Site breakdown can be seen below:

Site	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Royal Free	735,248	108,225	15%	10,179	1%	18,988	3%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

We saw staffing levels below:

TASS		
10 East Acute Kidney Injury, Dialysis and ITU Step downs	24 beds all equipped for dialysis	<u>Planned Day staffing</u> Monday to Sunday Five RNs and two HCAs <u>Planned Night Staffing</u> Monday to Sunday four RNs and two HCAs

		Both the ward manager and CPE were supernumerary.
10S South Upper tract renal Surgery, kidney transplant and peritoneal dialysis	25 beds including five side rooms	Planned Day staffing Monday to Sunday Five RNs and three HCAs Night Staffing Monday to Sunday four RNs and two HCAs Both the ward manager and CPE were supernumerary.
9 west Hepatobiliary surgery	29 beds (4 closed) Including five side rooms	Planned Day staffing Monday to Sunday Six RNs and three HCAs Night Staffing Monday to Sunday Five RNs and two HCAs Both the ward manager and CPE were supernumerary.
9 north Liver Transplant and Gastro intestinal surgery	32 beds including four side rooms	Planned Day staffing Monday to Sunday Six RNs and four HCAs Night Staffing Monday to Sunday Five RNs and two HCAs 5 Both the ward manager and CPE were supernumerary.
SAS		
5 east B Surgical Urology since summer - upper tract renal surgery (nephrectomy). This is a temporary measure	22 beds including six side rooms	Planned day staffing Monday to Sunday Four RNs and two HCAs Planned Night staffing Monday to Sunday Three RNs and two HCAs Both the ward manager and CPE were supernumerary.
7 West Vascular	28 beds High bay May have ratio 1.4, dependant on patient acuity and dependency	Weekday staffing numbers Six RN and two HCAs Nights

	General Ratios 1-5 1-6 Ward Manager supernumerary CPE supernumerary	Five RNs and one HCA Weekend days Seven RN s and two HCAs
7 North Colo-rectal and gynaecology surgery	32 beds	High bay - may have ratio 1.4, dependant on patient acuity and dependency 1.5 – 1.6 Weekday staffing numbers Seven RNs and two HCAs Nights Five RNs and two HCAs Weekend days Seven RNs and one HCA Both the ward manager and CPE were supernumerary.
5 North A Plastics & breast surgery Ratios 1.6	18 beds	Weekday staffing numbers Three RNs and three HCAs Nights Three RNs and two HCAs Weekend days Three RNs and two HCAs Both ward Manager and CPE were supernumerary
Day Surgery RN x 2	20 beds including one side room	Monday One coordinator band six nine RNs and two HCAs Tuesday to Friday days One coordinator band 6 Ten RNs and two HCAs

		Monday to Friday nights Two RNs and one HCA plus one additional post required Saturday Three RNs and two HCAs Sunday Two RNs Both the ward manager and CPE were supernumerary Monday to Friday
6 East Trauma and orthopaedics	20 beds. Can be increased to 24 beds to meet elective activity	Ratio 1 -5 – 1- 6 Weekday staffing numbers Four RNs and three HCAs Nights Three RNs and two HCAs Weekend days Four RNs and three HCAs Both the ward Manager and CPE were supernumerary

The wards we visited showed the above figures to match the current staffing levels

However, data provided by the trust showed there was a vacancy rate of 39% for operating theatre practitioners with an establishment of 35.5 whole time equivalent (WTE) versus 21.65 WTE.

Senior staff told us the vacancy rate across all theatre staff remained a concern and plans were continuing in working to retain staff.

At the time of the inspection there were five members of staff who were waiting for their visas to come through and one member of staff having to stay at home as their visa had not come through.

The trust undertook a recruitment campaign for theatre staff in November 2018 but only two people turned up for the posts. Staff told us that in general there had been a reduction in applications.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust has reported their staffing numbers below for the period September 2017 to August 2018. Fill rate in August 2018 was 94% a slight reduction compared to the March 2018 fill rate.

	August 2018			March 2018		
Site	**WTE Scheduled**	**WTE in post**	**Fill rate**	**WTE Scheduled**	**WTE in post**	**Fill rate**
Royal Free Hospital	213.3	214.6	101.4%	208.4	214.0	103.7%

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

From September 2017 to August 2018, the trust reported a vacancy rate of 2.4% in surgery. This was better than the trust target of 12%.

The RFH surgery department was 4.9%
The negative value indicates that there were more WTE in post than originally scheduled.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, the trust reported a turnover rate of 9.2% in surgery. This is better than the trust target of 12%

The RFH surgery department was 11.9%
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, the trust reported a sickness rate of 0.7% in surgery. This is better than the trust target of 3.5%.

The RFH surgery department was 0.9%
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported a bank usage rate of 3.1% and a locum usage rage of 1% in surgery. There were 0.8% of scheduled hours which remained unfilled by bank or locum staff.

Site breakdown can be seen below:

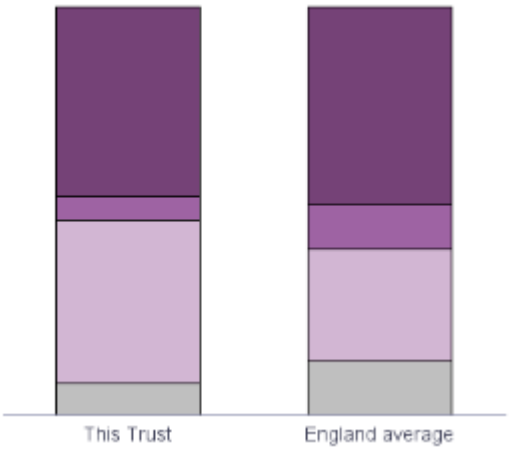
Site	**Total hours available**	**Bank Usage**		**Locum Usage**		**NOT filled by bank or locum**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Royal Free	409,219	13,343	3%	2,011	0%	-8,063	-2%

The trust told us that the negative values are for areas where total hours plus agency and bank hours have exceeded the establishment (effectively unfunded hours).

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

From July 2018 to July 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at Royal Free London NHS Foundation Trust



	is Trust	England average
Consultant	46%	48%
Middle career^	6%	11%
Registrar Group~	40%	27%
Junior*	8%	13%

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

(Source: NHS Digital Workforce Statistics)

All SAS surgical specialties had a daily ward round carried out by a consultant, including on Saturdays and Sundays.

During the week, the trauma and orthopaedic team consultant medical cover was a ‘surgeon of the week’ from 8am to1pm on site, 1pm to 6pm on call, with a separate consultant 6pm to 8pm.

There would be a specialist registrar (SpR) on call with no other commitments from 8am to 8pm daily on site and 8pm to 8am on call from home.

A senior house officer (SHO) was on site for all surgery from 8pm to 8am all of surgery, on site along with a foundation year one (FY1) from 8pm to 8am daily on site.

There would be consultant cover on call from home at weekends.

For routine emergency operating there was an SpR on call (8am to 8pm daily on site, 8pm to 8am) on call from home with an FY1 8am - 8pm covering trauma and orthopaedics and urology on site. There was also an SHO covering 8pm to 8am all of surgery, on site and an FY1 from 8pm to 8am daily all of surgery, on site.

There was a twenty four hour a day consultant on call and middle grade cover for all of the transplant services. Consultants in renal transplant, liver transplant, urology and hepato-pancreato-biliary surgery would carry out ward rounds daily.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and generally available to all staff providing care.
Staff told us there was a mixed system of record keeping which led to delayed or a lack of information in the outpatient clinics.

As part of our inspection, we reviewed the records of 10 patients. All those reviewed included patient biographical details, medical history and a range of clinical risk assessments such as cognitive functioning, screening to identify risks associated with dementia, pressure ulcers, nutrition, and falls. The records also included assessment tools to measure the patient's performance in activities of daily living
We reviewed seven patient records from the day surgery unit. All records included the intra operative care plans which recorded the instrument, needle and swab counts, bar codes for instrument and implants.

Patient care records were securely stored in lockable trolleys. Computer screens were attended when displaying patient information. Personal data was only accessible with a password or smart card access.

Pre-operative checklists were documented which included a record of consent. These checklists ensure certain safety elements were completed prior to any surgical procedure. For example, patient identification, allergies, correct consent and the time of last food and drink.

Discharge summaries were sent to patients' GPs to ensure continuity of care in the community. We also saw evidence that details of surgery including any implant used was included in the discharge letter to patients and their GPs.

Information provided by the trust showed monthly audits of record keeping were undertaken across the RFH site and reported to the trust board via the perfect ward programme.

Medicines

The service did not always follow best practice when storing medicines. Patients received the right medication at the right dose at the right time.

The operating theatres had a dedicated pharmacist who visited the unit daily, checking drug charts and providing advice. The pharmacist cross referenced to the British National Formulary to ensure medication prescribing was up to date.

The arrangements for the safe prescribing, dispensing (including pharmacist review), storage, administration and disposal of medicines was set out in the trust corporate medicines management policy (2015).

We saw evidence provided by the trust showed controlled drug (CD) audits were undertaken every three months across all ward areas including the surgical wards at the RFH. Areas such as crossings out and illegible signatures were picked by the pharmacy team and reported to the matrons for their action. Matrons told us these issues were brought up at group huddles and nurse meetings.

Controlled drugs (CDs) (medicines that require additional security controlled under the misuse of drugs legislation 2001), were stored appropriately in locked cupboards. The keys to the controlled drugs cupboard were kept by the nurse in charge, separately from the keys to the main medicines cabinet in accordance with local and national policy requirements.

In all clinical areas we visited, two registered health care professionals checked the actual stock of the CDs against the stock level recorded in the CD register(s) at least daily. CDs brought in by patients were also securely stored, checked daily, and recorded in a separate part of the controlled drugs register(s).

We saw two registered health care professionals checking a patients CD medication before giving the patient their pain killers.

In all areas we visited, medicines to be used in an emergency were stored on the resuscitation trolley in tamper proof packaging and were all in date. There was a separate box for medicines used if patients suffered a severe allergic reaction known as anaphylaxis.

Medicines were generally stored securely in locked cupboards; however, in the operating theatre department we found medicines stored in unlocked cupboards in a storage room that could be accessed by all staff. We also found intravenous infusions that were stored outside of the cardboard boxes they were supplied in, which could lead to confusion. We brought this to the immediate attention of the theatre co-ordinator and matron who told us corrective action would be taken.

Medicines that required refrigeration were kept at the correct temperature in designated medicines fridges. Staff checked and recorded the fridge temperatures daily in all clinical areas and these were all found to be within the required range. This ensured medicines that were temperature sensitive were stored correctly. Ambient room temperature levels for medicines stored in medicines cabinets and trolleys were monitored centrally. Temperatures outside of the correct range were reported and acted upon.

Pharmaceutical waste was segregated from pharmacy stock and promptly disposed of in specially allocated bins in line with trust and national policies.

Staff understood the processes in place for the safe transportation and storage of medical gases. We saw designated storage areas for this purpose with appropriate signage on the doors.

We reviewed 10 medicines administration records and found they were completed in accordance with the trust medicines management policy. Medicines would only be dispensed against an instruction by an authorised prescriber, created or written on the Royal Free Hospital approved document system. Staff clearly recorded known allergies in all of the patient records we reviewed, and relevant action was taken to ensure they were acted upon.

Incidents

Staff recognised incidents and reported them appropriately and learning was shared. When things went wrong, staff apologised and gave patients honest information and suitable support.

However we reviewed the surgery's NEs provided by clinicians to support the completion of actions. There was limited evidence to support shared learning across the trusts on the records and there was little documentation to show how the evidence could be followed through to where learning was shared.

The evidence we saw was not robust for example an email with minimal response to support actions had been signed off as completed.

Senior staff told us the governance staff would write the NE and SI reports and then they were looked at by the clinical team. There appeared to be no process/named individuals to collate all

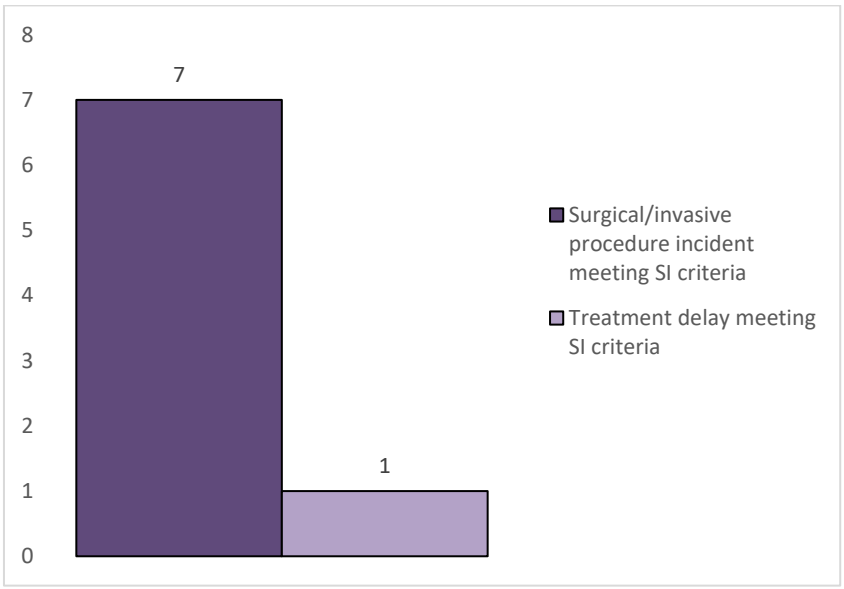
the actions and ensure actions were completed in timely fashion or followed up when not competed as planned.

We interviewed all the governance staff across sites and they were responsible for making the decision about whether action was complete. They were also under pressure to meet deadlines. They told us the first four actions were always the same and those we saw on NE were.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

At the last inspection we found that between December 2014 and November 2015 the RFH had three never events.

At this inspection it was confirmed the trust had reported eight never events for surgery, four of these occurred at the RFH site. These included: a retained swab following abdominal surgery, unintentional connection of a patient requiring oxygen to an air flow meter, injection in to the wrong eye and a knee implant in to the wrong knee.

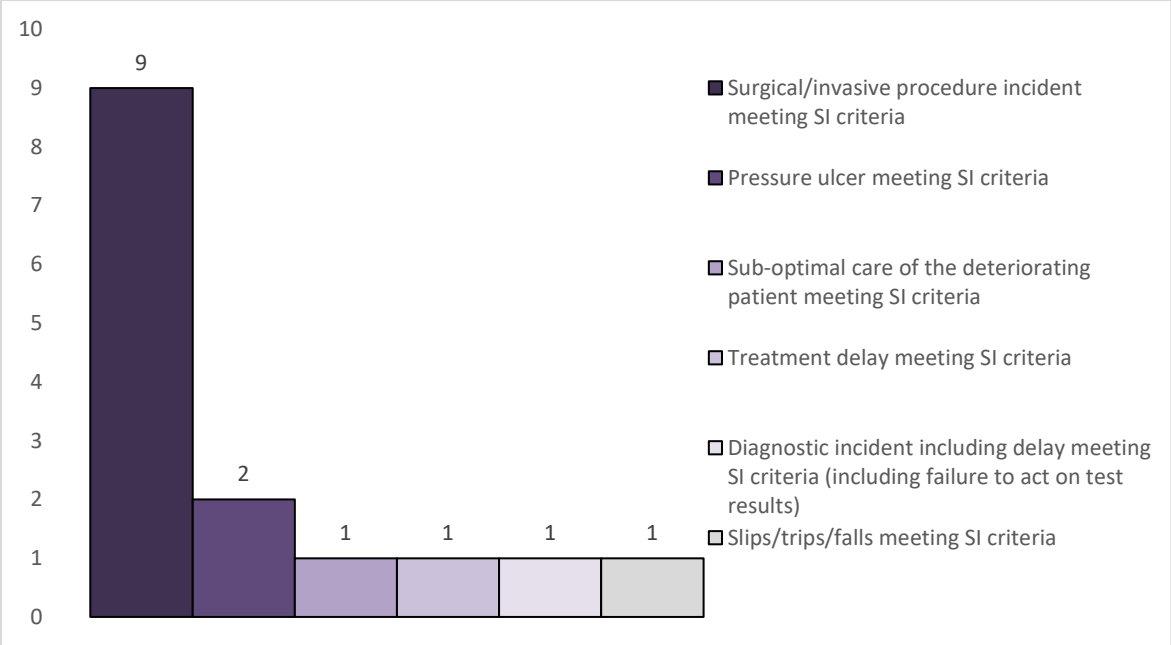


(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2017 to September 2018.

The breakdown of the different types of incident reported were

- Surgical/invasive procedure incident meeting SI criteria with nine (60% of total incidents)
- Pressure ulcer meeting SI criteria with two (13.3% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (6.7% of total incidents)
- Treatment delay meeting SI criteria with one (6.7% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (6.7% of total incidents)
- Slips/trips/falls meeting SI criteria with one (6.7% of total incidents)



(Source: Strategic Executive Information System (STEIS))

Incidents were disseminated via safety newsletters across the divisions and hospitals.

The trust used a safety needs and incident learning (SNAIL) blog which started in July 2018 as a result of the number of never events that had occurred over the previous year. Weekly updates included key areas of learning from incidents and near misses. This had a circulation of about 450 staff including medical, nursing and other staff across the organisation.

Information provided by the trust showed operating theatre staff were undertaking the new training for the management of swabs, needles and instruments. We saw posters were displayed across the operating theatre suites to remind staff about to when and how to count swabs, instruments and needles.

All staff we spoke with were able to correctly describe the principles of the duty of candour and provide examples of when the duty of candour had been applied.

Between August 2017 and July 2018 the surgical divisions had applied the duty of candour on 40 occasions.

There was a variety of initiatives in place such as implementing safety huddles in the operating theatre before the lists started.

The business unit provided updates to the weekly executive-led safety huddles, where challenges were made and teams were supported to gain solutions. The clinical standards and innovation committee had oversight on behalf of the board and received a regular update on the status of never events, their investigation and action plans.

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The aim of the blog was to improve the sharing of the learning from serious incidents by 5% and would be measured by staff survey data, by the end of March 2019.

Information by the trust showed that in the 2017 NHS staff survey 68% showed RFL staff agreed/strongly agreed that “When errors, near misses or incidents are reported, my organisation

takes action to ensure that they do not happen again." This question had now been added to their quarterly internal staff survey, to help measure whether they were improving or not.

A monthly newsletter 'Free Way to Safety' was also used which included key safety learning from serious incidents and a health and safety monthly newsletter which included health and safety information and was emailed to health and safety champions for their attention and action.

The RFH site had established a safety programme for managing the implementation of invasive procedures outside of the operating theatres. At the time of our inspection there group had identified 31 areas where the surgical specialities undertook invasive procedures outside of the operating theatres and were in various stages of development.

We saw evidence of the trust's patient and safety clinical practice group which was established in April 2018 with the purpose of developing pathways for the implementing the local safety standards or invasive procedures (LocSSiPs) for radiology, cardiology and endoscopy.

The trust was undertaking a review of areas where invasive procedures took place and was developing a database so that the trust would have a clear oversight of the development and implementation of all its LocSSiPs

Safety thermometer

There were quality and safety boards on display in all the wards we visited. These displayed information about nurse staffing, how long it had been since there had been an MRSA infection, when the last patient fall had taken place and the time since a patient had developed a pressure ulcer. This information was updated daily after the lunch time period.

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 18 new pressure ulcers, two falls with harm and eight new catheter urinary tract infections from September 2017 to September 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Royal Free London NHS Foundation Trust

Total Pressure ulcers (18)

Total Falls[2] (2)

Total CUTIs[3] (8)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

We saw evidence that safety thermometer data was routinely used to improve the quality of care. For example, the numbers of days since last infections and falls was clearly displayed in each area we visited.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of Its effectiveness. Managers checked to make sure staff followed guidance.

We saw the TASS and SAS had comprehensive clinical audit programmes which included national, regional, and local projects, based on research evidence.

We found information about the outcomes of patients' care and treatment were routinely collected and monitored.

The surgical division participated in a number of clinical audits based on national and local guidance. Some of these were joint audits across the hospital site and included critical care, emergency care, acute medicine, respiratory medicine, general surgery.

Information relating to the operating theatre audit programme included regular audits covering WHO checklists, hand hygiene, CD safety checks, recovery staff safety checks

and fridge temperature checks.

The SAS division had initiated a clinical practice group (CPG), October 2018, to develop clinical pathways for a variety of specialisms such as; vascular surgery, pre-operative assessment, epistaxis (nose bleeds), acute tonsillitis, benign breast pathway, lower gastro-intestinal disorders and elective hip and knee replacements.

The aim of the clinical pathway development was to reduce any variation in clinical practice and process, leading to worse patient outcomes and to implement evidence based standardised clinical practice and processes as core operating standard across RFL group of hospitals.

Nurses and assistant practitioners adopted link roles to specialise in certain areas, such as pressure area care, infection control and end of life care. Link nurses attended meetings and training with specialist teams and used critical care meetings and training days to deliver up to date information and guidance.

Evidence provided by the trust and discussion with staff showed there was continuous learning, improvement and innovation amongst staff.

We saw a number of examples of staff participating in international, national, regional and local research projects and recognised accreditation schemes in order to ensure patient care was evidence based.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Prior to surgery, patients were given information about when to stop eating and drinking before their operation. Depending on the surgical procedure, patients could drink clear fluids up to two hours before surgery and eat up to four hours before surgery. Patients were instructed not to eat for six to eight hours before a general anaesthetic and were encouraged to drink sips of water up to two hours prior to a surgical procedure. Staff confirmed patients would be encouraged to drink when ready, providing there were no contraindications.

We saw there was consistent input from speech and language therapists and dieticians. Staff from each team worked together to assess each patient's dietary needs, including risks for malnutrition and dehydration. Where patients had complex comorbidities, dieticians worked with nurses to ensure nutritional needs were assessed and met. Staff used evidence-based assessment tools to assess patients' nutrition such as the malnutrition universal scoring tool (MUST).

We saw the trust had parental nutrition guidance date March 2016 which outlined the nursing care required for patients who were receiving parental nutrition. The guidance included a list of all the underpinning infection control guidelines, explained who can undertake each aspect of care and why, as well as describing the procedures used to administer the parental nutrition.

Parenteral nutrition, or intravenous feeding, is a method of getting nutrition into your body through your veins. Depending on which vein is used, this procedure is often referred to as either total parenteral nutrition (TPN) or peripheral parenteral nutrition (PPN).

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed pain and prescribed pain medicine in line with the Core Standards for Pain Management Services Faculty of Pain Management (2015). We saw that patients' pain assessments were carried out by staff correctly and patients told us they had access to pain control medication when required.

In 2018 senior anaesthetists carried out a gap analysis against the Faculty of Pain Medicine's Core Standards for Pain Management (2015). This resulted in identifying gaps which the anaesthetists had developed action plans to close these gaps. For example: the recruitment of a clinical psychologist.

There continued to be one band eight pain nurse specialist who led the pain team across the RFL trust. The RFH site also had three band sevens and one band six pain nurse specialists.

Pain was managed effectively. We saw patients provided or offered pain relief regularly and without delay.

All the patients we spoke with said they were asked if they were in any pain usually during most interactions with staff. We observed staff discussing pain during handovers and any concerns would be raised with relevant clinicians.

At our last inspection in 2016 there was no standardised trust wide pain tool in place. At this inspection we saw the evidence of a pain assessment tool in use which incorporated a pain score and an algorithm for prescribing analgesia.

Staff chose appropriate pain relief using the 'pain hierarchy' (starting with common medicines and moving to more powerful medicines some of which were controlled drugs). Commonly used medicines were prescribed routinely but if these were not effective, the pain team could be contacted for advice and additional medicines to be prescribed to ensure patients were pain free and comfortable.

In 2017 the pain service carried out an audit introducing oral Ketamine as an alternative for patients who were experiencing uncontrolled pain.

The audit showed that oral Ketamine was used in the majority of cases for patients undergoing treatment in the vascular service, and reduced the majority of the patients overall pain scores. It also reduced the usage of additional opiates in the majority of patients in the first 24 hours following oral Ketamine being prescribed.

Ketamine is a type of pain killer and is often use in anaesthesia.

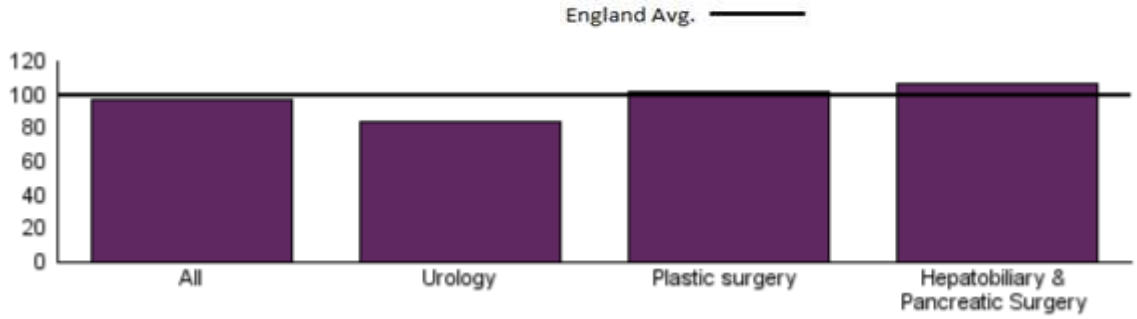
Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

From June 2017 to May 2018, all patients at The Royal Free Hospital (RFH) had a similar expected risk of readmission for elective admissions when compared to the England average.

Of the top three specialties based on number of admissions:

- Urology patients at The RFH had a lower expected risk of readmission for elective admissions when compared to the England average.
- Plastic surgery patients at The RFH had a similar expected risk of readmission for elective admissions when compared to the England average.
- Hepatobiliary & pancreatic surgery patients at The RFH had a higher expected risk of readmission for elective admissions when compared to the England average.

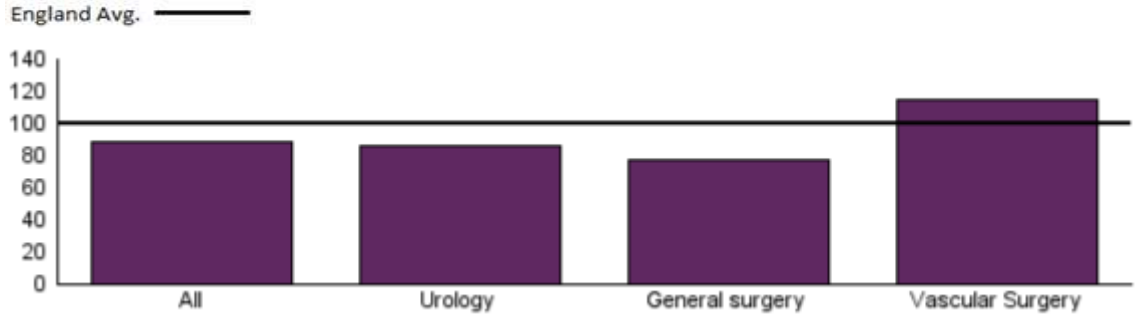


Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count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

All patients at The RFH had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Of the top three specialties based on number of admissions:

- Urology patients at The RFH had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- General surgery patients at The RFH had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Vascular surgery patients at The RFH had a higher expected risk of readmission for non-elective admissions when compared to the England average.



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

(Source: Hospital Episode Statistics)

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 4.7% which was within the expected range. The 2016 figure was 7.2%.

The proportion of patients having surgery on the day of or day after admission was 73.4%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 71.6%.

In order the improve performance in the proportion of patients having surgery on the day of admission, senior staff told us they had reviewed operating theatre lists against time per procedure to ensure lists do not get overbooked, bed capacity had been reviewed and the SAS team were developing patients pathways as part of the clinical pathway group (CPG) work.

The perioperative medical assessment rate was 99.5%, which failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 94.7%.

The proportion of patients not developing pressure ulcers was 95.7%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 93.9%.

The length of stay was 15.3 days, which falls within the best 25% of trusts. The 2016 figure was 15.4 days.

(Source: National Hip Fracture Database 2017)

In the 2017 Bowel Cancer Audit, 79.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate of 69.5%. The 2016 figure was 72.5%.
The risk-adjusted 90-day post-operative mortality rate was 2% which was within the expected range. The 2016 figure was 3.4%.

The risk-adjusted 2-year post-operative mortality rate was 15% which was within the expected range. The 2016 figure was 40.1%.

The risk-adjusted 30-day unplanned readmission rate was 6.6% which was within the expected range. The 2016 figure was 7.6%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 50.7% which was within the expected range. The 2016 figure was 53%.

(Source: National Bowel Cancer Audit)
The senior medical team had reviewed the bowel cancer data to further understand the figures and outcomes for patients. Whilst the data overall showed a steady state, the team were working with other medical specialities to improve patient outcomes through their CPG work. For example, the team had introduced pre-operative antibiotics for bowel cleansing which was supposed to achieve a 3% reduction in SSI rate and should reduce length of stay.

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.9% for abdominal aortic aneurysms. The 2016 figure was 2%.

Within carotid endarterectomy, the median time from symptom to surgery was 6 days, which was better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 0%, which was within the expected range.

(Source: National Vascular Registry)

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 5.7%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 15.

Senior staff told us the rates for 2017 and 2018 were 7% and 7.5% respectively so there was no evidence of a persistent issue. The numbers were relatively small so a small number of cases could account for variation from year to year.

The 90-day post-operative mortality rate was not applicable.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 37.4%. This was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

The National Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), the site achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 108 cases.

The site achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 82 cases.

The site achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 60 cases.

The site achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 43 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 108 cases.
(Source: National Emergency Laparotomy Audit)

At the last inspection in 2016, the national emergency laparotomy audit the Royal Free Hospital's self-reported data indicated that the provision of facilities required to perform emergency laparotomy was available for 19 out of the 28 measures reported on. The facilities not available;

operating theatre reserved for emergency general surgery (EGS) 24/7, have an emergency surgical unit (ESU), minimum four tier EGS rota at all times, policy for surgical seniority according to risk, explicit arrangements for review by care of elderly doctor, policy for deferment of elective activity to prioritise emergencies, pathway for enhanced recovery of EGS patients and single pathway for adult EGS patients.

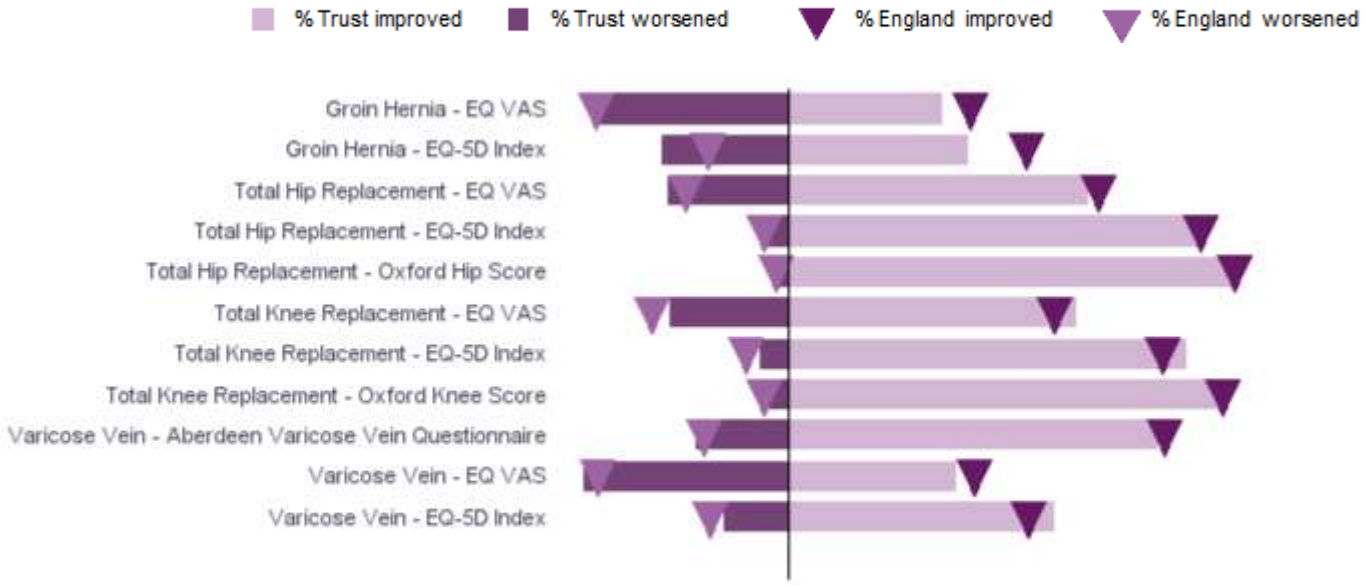
Senior staff told us in order to improve this performance they had: increased hours of second emergency theatre capacity, developed a cancellation policy to prioritise in case of staff shortages; planned to open a new surgical high dependency unit in January 2019 which will increase capacity and increased consultant anaesthetist numbers.

Also the lead clinician was working on an initiative to improve outcomes using an enhanced recovery pathway approach. The first meeting was to be held in January 2019.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.



In 2016/17 performance on groin hernias was worse than the England average.

For varicose veins, performance was about the same as the England average. Performance in the EQVAS indicator was worse than the England average but in the EQ-5D index performance was better.

For hip replacements, performance was about the same as the England average.

For knee replacements was better than the England average for both the EQ VAS and EQ-5D Index indicators.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Staff had the skills, knowledge and experience to deliver effective care and treatment to patients. Supervision meetings were carried out with them to provide support and monitor the effectiveness of the service. However managers did not consistently appraise staff's work performance.

From September 2017 to August 2018, 75.8% of staff within urgent and surgery care at the trust received an appraisal compared to a trust target of 85%.

Staffing group	Appraisals required	Appraisals complete	Trust target	Completion rate	Target met?
Additional Clinical Services	9	8	85%	88.9%	Yes
Allied Health Professionals	19	16	85%	84.2%	No
Add Prof Scientific and Technic	17	14	85%	82.4%	No
Medical and Dental	151	121	85%	80.1%	No
Estates and Ancillary	14	11	85%	78.6%	No
Healthcare Assistants	144	108	85%	75.0%	No
Nursing and Midwifery Registered	478	354	85%	74.1%	No
Administrative and Clerical	26	18	85%	69.2%	No
Grand Total	**858**	**650**	**85%**	**75.8%**	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Royal Free Hospital appraisal completion rate: 72.4%
Data provided by the trust showed that appraisal rates for trained nursing staff ranged from 68% (ward 7 West) to 100% (renal and liver transplant services).

Operating theatre staff average appraisal rate was 68% and ranged from 43% (anaesthetic staff), 89% (recovery staff) and 74% (operating theatre staff).

Senior medical staff told us they ensured that the objectives of The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients were through a named consultant taking overall responsibility for their care. There was also a named nurse allocated to each patient.

At the last inspection we found the anaesthetics departments at the Royal Free Hospital was preparing for accreditation with the Royal College of Anaesthetists However; the accreditation had financial implications which were still under discussion.

At this inspection this was still the case. However there had been significant changes in the directorate management structures which had meant the anaesthetic departments were managed in a different manner. Senior staff told us this would be reviewed in the longer term.

There were several other examples of where staff were being supported to develop, including health care assistants (HCAs) supported to become nurses via the trust's internal apprenticeship programme and several leadership programmes including 'step up to lead' and 'license to lead'.

New employees undertook both corporate and local induction with additional support and training when a need was identified. Staff told us their induction was comprehensive.

We saw each area continued to have clinical educators who were senior nurses who worked clinically with staff to support training and supervision.

Data provided by the trust showed that level one basic life support (BLS) training ranged from 43% to 100% and level two BLS ranged from 21% to 100%.

For example, 96% of staff on ward 5 east had completed their BLS level one training and 67% had completed their level two BLS training. There were also six members of staff who had competed their ILS training.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

The RFH worked closely with its commissioners and its local authority partners to ensure surgical services were responding to the needs of the local population. We were told by senior staff there were good relationships with health watch Camden who provided a collective voice for health and social care issues in Camden and they also sat on the health and wellbeing board.

There was a multi-disciplinary approach to the discharge of patients via board rounds. These were made up of doctors, nursing staff, physiotherapists, discharge coordinators, occupational therapists and pharmacists. Discussions would take place about the patients' social needs, mobility issues, the provision of district nurses and their requirements for returning home.

Nursing handovers were completed at the start and end of each shift. Handovers we observed included all relevant patient information. The ward matron attended the weekly transfer review meeting in order to review any patients who had been transferred out to another hospital.

For most inpatient wards, the ward administrator will post the discharge summary at the time of discharge. However, 7 West, the discharge summaries were e-mailed directly to the GP when the staff had finalised it on the trusts patient information system at time of discharge.

Seven-day services

At the last inspection in 2016 the trust had undertaken a self-assessment exercise to review the extent to which services were provided seven days a week in accordance with the national seven day clinical services standards 2017.

The trust under took an audit in 2018 to review its progress against these standards and information provided by the trust showed an improvement in the standards compared with 2017.

The overall proportion of RFL patients seen and assessed by a suitable consultant within 14 hours of admission was 80%, compared with 56% in 2017.

The overall proportion of RFH site patients seen and assessed by a suitable consultant within 14 hours of admission was 73%.

One of the areas to improve outcomes for patients via the national seven day clinical services standards 2017 was to improve swallowing assessments out of hours as the speech therapy team were not available out of hours. Action was taken train staff and site managers to carry out these assessments and so ensure patients had a more timely intervention.

Physiotherapists were available Monday to Friday 08:00 to 17:00 and covered the orthopaedic services on a Saturday.

Speech and language therapists, dietetics, podiatry and occupational therapists were available Monday to Friday 08:00 to 17:00.

Health promotion

We saw the trust used leaflets and other information to raise issues about obesity and alcoholism and how to prevent blood clots in veins. There were also other information on the wards we visited such as information about keeping active in order to reduce the incidence of falls and information relating to preparing to leave the hospital.

Staff told us some patients were taught how to give themselves injections prior to their discharge in order for them to be more in charge of their care and well-being.

Consent

Although staff understood how and when to assess whether a patient had the capacity to make decisions about their care, they did not consistently follow the trust policy to ensure the consent process was appropriately documented.

The trust's policy on consent was under review at the time of our inspection. The current policy consent recommended a two-stage consent process for all surgical procedures. The first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

The two-stage process was not documented on any of the consent forms checked during the inspection. Consent was done on the day of surgery in all cases. Senior nursing staff told us that currently the two-stage process was only be completed for spinal surgery but this was under review with plans to expand this to all elective procedures.

The trust's policy also stated that patients receiving elective treatment or investigations for which written consent was appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process. We did not see evidence that this was happening in practice.

We saw 10 sets of notes which showed consent forms were completed and signed (authorised) forms for treatment and exploratory investigation during the inspection.

Patients we spoke with told us they were given all the information they needed in order to make a decision about the treatment being provided. They felt medical and nursing staff had fully explained the procedure at their initial appointment, they were given further information at their pre-operative assessment and when they were admitted for surgery it was explained again. Patients were also informed about the possible complications to their surgery such as excessive bleeding and some pain.

The Deprivation of Liberty Safeguards (DoLS) protects people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Training in MCA and DoLS was included within safeguarding training.

Staff said that elective patients with a learning disability or those living with dementia would be involved in a pre-operative meeting with the carer or family member in order to ensure there was a plan in place for their admission. Staff said that carers or family members were encouraged to help complete their relative's passports so their care would be more informed.

The trust reported that from April 2018 to August 2018 Mental Capacity Act (MCA) and DOLS training was completed by 81.8% of staff in surgical care compared to the trust target of 85%.

Royal Free Hospital surgery department was 79.6%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

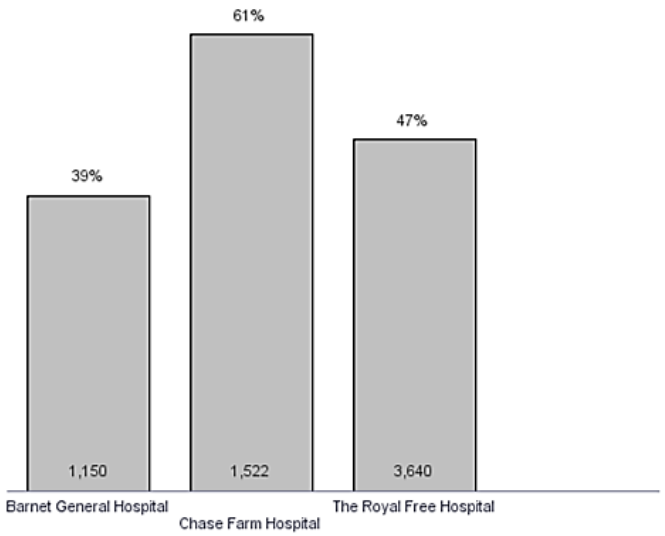
Is the service caring?

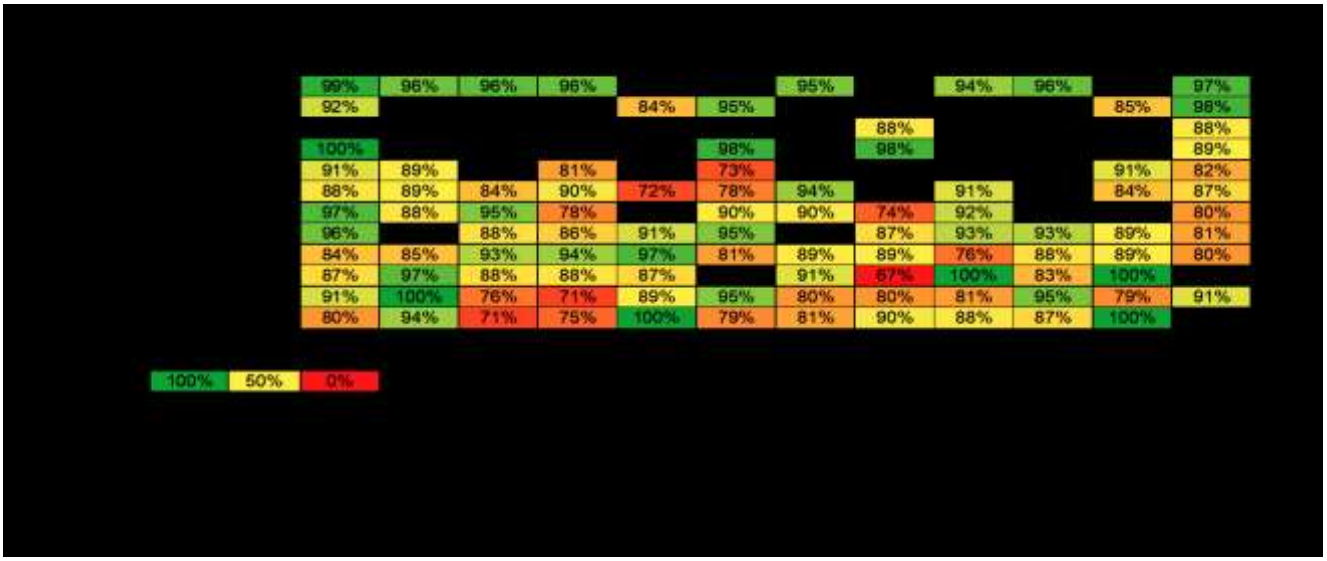
Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

The Friends and Family Test (FFT) response rate for surgery at Royal Free London NHS Foundation Trust was 45% which was better than the England average of 27% from September 2017 to August 2018.
Friends and family feedback forms were given to patients on discharge; comments were displayed on the friends and family monthly poster and reviewed by the nursing team. Staff told us and we saw staff had recently introduced rounding post complaints re waiting times, lack of communication and fasting.
FFT data was displayed on notice boards in patient areas we visited.

Friends and family test response rate at Royal Free London NHS Foundation Trust, by site.





(Source: NHS England Friends and Family Test)

Staff cared for patients with compassion. During our inspection we spoke with 10 patients, who consistently described staff as kind and informative. Patients felt treated with respect. All patients described the nursing staff as 'first rate, caring but very busy'.

We observed staff were caring and compassionate with patients and their relatives throughout our inspection. We saw patients in the operating theatres were treated with care and patient's dignity was maintained.

We observed all staff spent time with the patients, and interacted with them during tasks and clinical interventions. We saw staff explained what was happening and what actions were planned, and that patient's questions and concerns were addressed.

Staff on the day surgery unit carried out two hourly comfort rounds and kept patients informed about their position on the operating list.

We saw nursing staff pulled curtains around the bed space during personal intervention.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Patients' spiritual needs were taken into account irrespective of any religious affiliation or belief. There was a trust wide multi-faith chaplaincy service available for patients, their families and staff which enabled delivery of spiritual, pastoral and religious care.

Post-operative care within the recovery area was empathetic and staff did everything they could to ensure patients were comfortable and free from any pain. One patient told us about their stay in the recovery where they had to stay longer than usual due to needing to be stabilised. The patient told us the recovery staff were constantly coming to see how she was and informing her about her stay. The patient felt she was safe and well looked after.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients would be given a booklet in the pre assessment clinic or prior to attending the hospital for their operation. This booklet was called ‘Having an Operation: Information for patients coming to the Royal Free London for surgery’. The booklet included general information about having an operation in one of the trusts hospital sites. There was also a short video explaining what to expect on the day of operation and about what will happen when going home.

Data provided by the trust showed in accordance with the national seven day clinical services standards 2017, the overall proportion of patients made aware of their diagnosis, management plan and prognosis within 48 hours of admission was 76% on the weekend and 76% on a weekday. The overall RFL was 96% on the weekend and 82% on a weekday.

Staff told us patients were involved in planning their surgery at their first pre-assessment clinic. Information about their surgery was given verbally and through information leaflets and other written information.

Where patients were having their surgery as a day case patients or staying less than 24 hours, their pathways of care were completed with the pre assessment nurses. Discharge planning started at this point which included sick notes and escort planning.

Physiotherapists were involved with their patients on the day of admission and patients would be part of planning their discharge for follow up or rehabilitation.

Patients were being involved in the planning and development of services for example: as patient representatives on the renal priorities meetings and quality improvement meetings relating to the management of controlled drugs.

Other examples of patient involvement included weekly matron’s surgeries for patients and relatives and involvement in multi-disciplinary discharge meetings.

Staff on Level 12 (private patients unit) had developed a care plan for carers. Family members were asked to help to complete their relatives care plan so staff could offer the best possible care.

Questions included:
What matters to you during your time with us?

How often do you want your relatives to visit?

Is there anything about your family member’s lifestyle that you would like to be continued during their stay with us?

Do you have any concerns about yours or your family member’s home/social situation while they are with us?

Staff on the PPU intended to share this form with other ward staff.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the

needs of local people.

The SAS and TASS and worked with the external partners to continue to develop its services based on its local population. Breast services had moved to the RFH site, vascular services were provided to seven other hospitals as a hub and spoke model, the colorectal team were working

towards undertaking more complex surgery at the RFH site and urology had become a specialist supra- renal centre for renal cancer.
Elective orthopaedic surgery had moved to Chase Farm, although patients with more complex needs would continue to be treated at the RFH site for those patients not suitable for elective surgery.

There were a number of joint working arrangements across the surgical division such as: a diabetic foot team with weekly clinic, joint diabetic and vascular ward rounds, microbiology ward rounds on surgical wards, nutrition team working with the colorectal team for parenteral nutrition and the pain teams close working across all surgical wards.
The RFH had an orthopaedic geriatrician who worked with surgery and assisted with complex admissions and discharges and would give advice on older patients with complex needs.
A pilot in the use of a medical/surgical consultant post for 10 months had resulted in a business case to make this post permanent.

Meeting people's individual needs

The service did not always take account of patients' individual needs.

At our last inspection in 2016, we found two patients were cared for overnight in the theatre recovery area due to no beds being available on a ward. At this inspection data provided by the trust showed that between May 2018 and October 2018, 14 patients had been cared for in recovery overnight. This was due to the lack of beds (10), lack of nursing staff (2) and one patient staying due to clinical reasons. The length of stay ranged from 14 hours to 23 hours.

The recovery environment was not suitable for these patients to stay for more than 24 hours due to the lack of appropriate toilet facilities. Visitors would not be able to visit their relatives for the periods which suited the patients and themselves and the provision of meals was a challenge.

The trust had a dementia strategy and a dementia implementation group which met monthly.

Information was completed on a form "8 important things about me".

Information would then be used to plan care with the patient by encouraging them to do tasks and activities that were meaningful to them.

The surgical divisions used a patient passport for people with a learning disability coming into hospital. The passport included three main areas for staff to read prior to carrying out any intervention: things you must know about me, things that are important to me and things I like and dislike.

There was also information for staff about patients with dementia or living with a disability on the trusts intranet. This information included contact details for the acute liaison nurses, tools to be used such as assessment tools and communication tools and other key documents.

At the last inspection in 2016 we found there was limited staggering of arrival times in the day surgery unit for operations. These meant patients often arrived at 7:30am but did not have their operations until the afternoon.

At this inspection we found this was still the case. Data provided by the trust showed between May 2018 and October 2018 25% of patients (400 out of 1,631) arriving in the day surgery unit in the morning did not have their operation until the afternoon. Information provided by the trust showed that from November 2017 to October 2018 over 12% (7,105) of inpatients were discharged between 8.00pm and 8.00.

We saw an example of a menu available to patients, it included vegetarian and gluten free options as well as pureed food items suitable for patients requiring a soft diet. Patients were offered food when able to eat and we observed they had free access to drinks, including fresh water available next to their bed. There were also menus for patients from religious backgrounds. Patients we spoke with said they were happy with the quality and frequency of food and said they had access to snacks out of hours.

There were no arrangements for relatives to stay overnight across the surgical divisions but we saw advice was provided about local accommodation which was available close to the RFH site.

There were separate arrangements for relatives staying overnight for those private patients on the 12th level.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit treat and discharge patients were in line with good practice.

There had been recent changes in the designation of surgical assessment areas and admission areas, where medical and surgical patients were assessed in the adult assessment unit. Patients could be admitted to a ward or surgical assessment unit or day surgery unit for initial care and assessment.

Daily bed occupancies continued to be completed for the hospital which identified potential service problems, reviewed demand, capacity and workforce. Daily operational meetings with representation from SAS and TASS took place.

The operating theatre audit and review was sent out daily to all services which resulted in increased bookings of the list. Overall average bookings increased by 1.75% in the first three weeks of this being implemented.

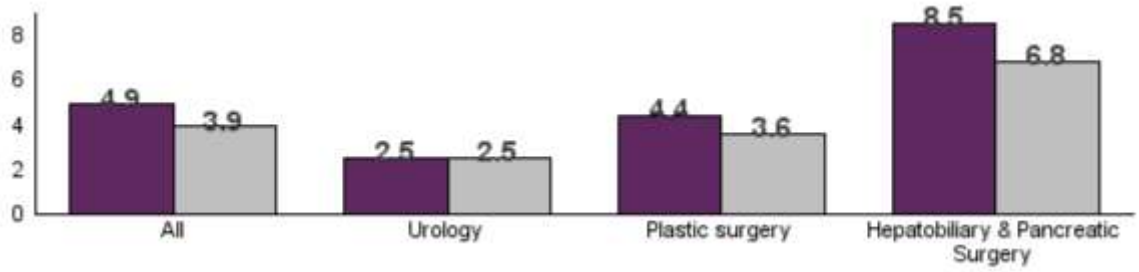
The Royal Free Hospital - elective patients

From July 2017 to June 2018 the average length of stay for all elective patients at The Royal Free Hospital was 4.9 days, which is higher when compared to the England average of 3.9 days.

Of the top three specialties by number of admissions, the average length of stay for:

- Urology elective patients at the RFH were 2.5 days, which is the same as the England average of 2.5 days.
- Plastic surgery elective patients at the RFH were 4.4 days, which is higher when compared to the England average of 3.6 days.
- Hepatobiliary & pancreatic surgery elective patients at the RFH was 8.5 days, which is higher when compared to the England average of 6.8 days

Elective Average Length of Stay - The Royal Free Hospital



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

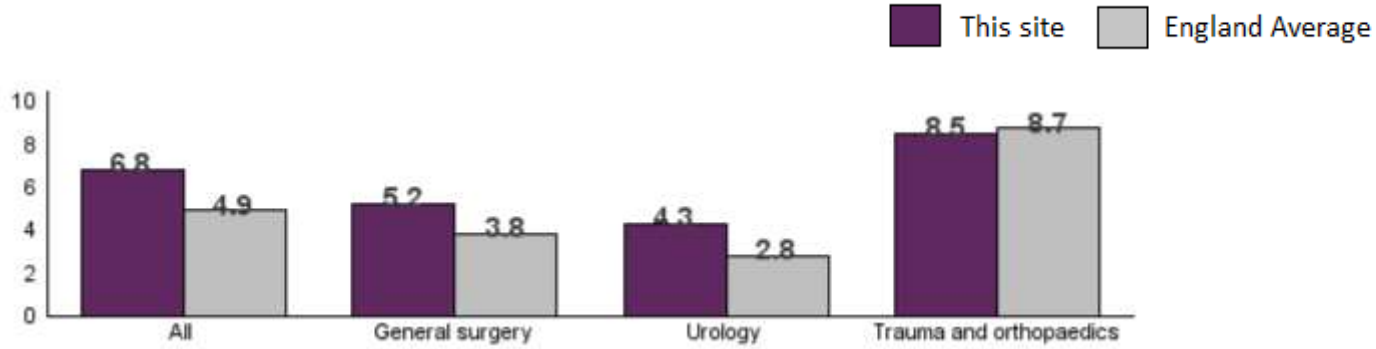
The Royal Free Hospital - non-elective patients

The average length of stay for all non-elective patients at the RFH was 6.8 days, which is higher when compared to the England average of 4.9 days.

Of the top three specialties by number of admission, the average length of stay for:

- General surgery non-elective patients at the RFH was 5.2 days, which is higher when compared to the England average of 3.8 days.
- Urology non-elective patients at the RFH was 4.3 days, which is higher when compared to the England average of 2.8 days.
- Trauma and orthopaedics non-elective patients at the RFH was 8.5 days, which is similar to the England average of 8.7 days.

Non-Elective Average Length of Stay - The Royal Free Hospital



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

(Source: Hospital Episode Statistics)

The nurse in charge on the day surgery unit documented any additional unplanned admissions to inpatient wards on a daily statistics cover sheet. The situation, background, assessment recommendations (SBAR) handover indicated a planned or unplanned overnight 23 hour stay. Daily activity meetings included if the overnight patients were planned or unplanned. Senior staff told us an audit was to be started to gain a percentage of patients requiring 23 hour or inpatient stay.
SBAR is a model used for communication between health care professionals

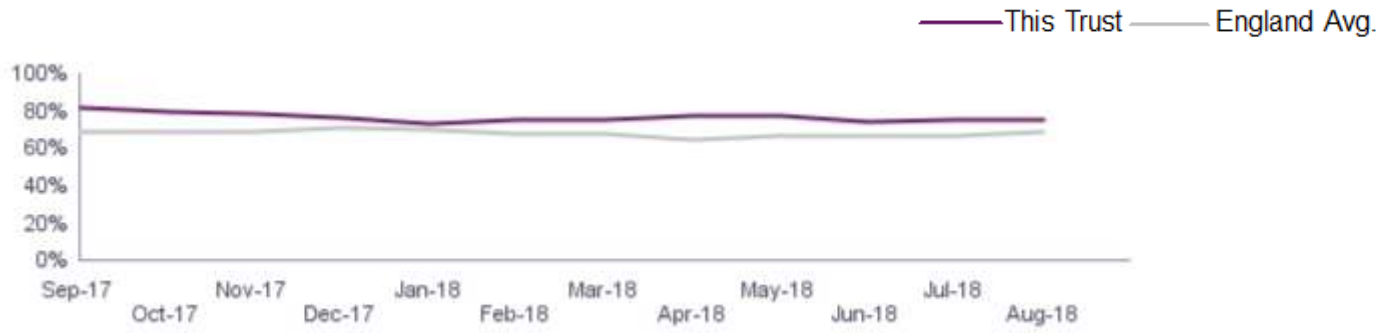
Information provided by the trust showed that between September 2018 and November 2018 there were 225 patients who stayed overnight on the DSU. There were 80 unplanned stays, 99 planned and 46 admitted as an emergency patient.

The SAS did not have any audits relating to the discharge of patients. However, senior staff told us there were weekly patient meetings with all divisions to look at all patients with a hospital stay over seven days. This would ensure all patients had a plan for their discharge and gave opportunities to unblock any possible discharge issues.

There were also weekly discharge meetings with local boroughs and clinical commissioning groups (CCGs) to discuss all patients with longer length of hospital stays and twice weekly discharge meetings with local boroughs to discuss medically optimised patients.

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was better than the England average.

In the latest month, August 2018, the trust scored 75.7% compared to the England average of 68.5%.



(Source: NHS England)

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Cardiothoracic surgery	100.0%	79.6%
Ophthalmology	92.2%	68.2%
Urology	85.3%	76.7%
General surgery	76.0%	72.6%
Oral surgery	65.1%	59.4%
ENT	64.6%	63.1%

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

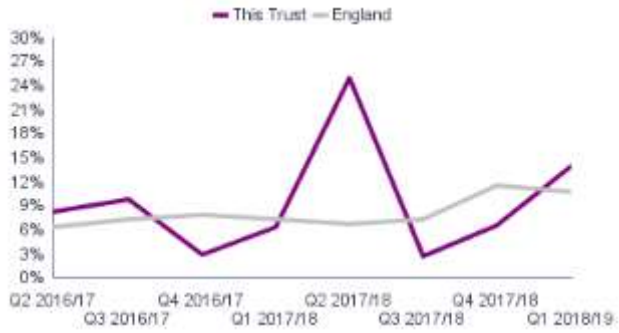
Specialty grouping	Result	England average
Plastic surgery	80.9%	81.1%
Trauma & orthopaedics	45.1%	60.0%

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

Over the two years, the percentage of cancelled operations at the trust has been similar to the England average. The only exception is in Q2 2017/18 (July 2017 – September 2017) where the trust had 25% of cancelled operations not treated within 28 days.

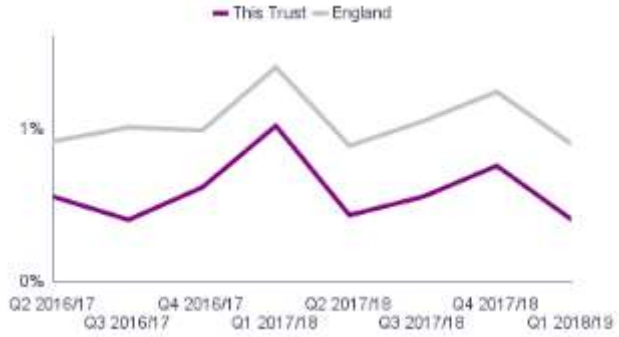
In the most recent quarter, Q1 2018/19 (April 2018 – June 2018), this trust cancelled 78 surgeries. Of the 78 cancellations 14% weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Royal Free London NHS Foundation Trust



Cancelled Operations as a percentage of elective admissions - Royal Free London NHS Foundation Trust

Over the two years, the percentage of cancelled operations at the trust was similar to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.



(Source: NHS England)

Data provided by the trust showed that between November 2017 and October 2018, 2% (285) patients on the day were cancelled on the day of surgery. The main reasons for cancellations were due to operating lists overrunning (76), lack of available intensive care/high dependency care beds (59) and emergency cases taking priority (46) and transplant surgery taking place (22).

Within the same period 30 patients were not treated within 28 days after their operation was cancelled which was more than 17 reported during the last inspection.

At our last inspection theatre utilisation for the Royal Free Hospital was 64.6%(capped) and 63.9 % (uncapped) for October 2015. Managers told us there was a project underway to improve theatre utilisation and a factor affecting theatre utilisation is availability of intensive care beds. Due

to the nature of surgery performed which may take up to 12 hours if there is no intensive care bed available the operation will be cancelled which has a negative effect on theatre utilisation.

At this inspection theatre utilisation rates for the period November 2017 to October 2018 across the main theatres varied between 70% and 80% against the trust's target of 85%. Performance had improved from our previous inspection, but further improvement remained a high priority for the service. Emergency theatres were running at 84% - 100% during 8am to 8pm.

The trust provided us with figures for delayed theatre lists for the period November 2017 to October 2018. The trust recorded that 6,540 lists (74%) started late.

The main reasons were that the patient was not ready on the ward, the order of the list and changed and needed checking and medical or nursing staff not available.

At our last inspection, the trust was not always recording the reasons for surgery being delayed. At this inspection we found the reasons for all delays were being recorded.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From September 2017 to August 2018 there were 383 complaints about surgical care. The trust took an average of 36 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 35 days however there is an option to extend the deadline if previously agreed with complainant.

The top four subjects of complaint were:

Subject	Total
All aspects of clinical treatment	217
Appointments, delay/cancellation (out-patient)	58
Communication/information to patients (written and oral)	40
Attitude of staff	39

Breakdown at the three main sites was as follows:

Site	Total
Royal Free Hospital	213
Barnet Hospital	108
Chase Farm Hospital	56

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

From September 2017 to August 2018 there were 69 compliments within the RFH surgery site.

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

An example of actions, following a complaint, included making improvements to the process around the administration of controlled drugs. A quality group was initiated with stakeholders including a senior matron, ward nurses and the pharmacy team to address the high incidence of controlled drug errors.

Information provided by the trust showed there were no recent complaints on the DSU, although generally patients stated they received insufficient written information. Staff now regularly supply written information on admission and discharge from the wards

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The SAS and TASS leadership structure consisted of a divisional director, divisional director of operations and a divisional director of nursing with a number of clinical directors reporting to them.

The local leadership team were very experienced and demonstrated a good understanding of the performance challenges and risks within the surgical services.

Staff told us members of the senior management team continued to be visible and approachable.

There were local leadership monthly multidisciplinary meetings; weekly theatre meetings which alternated between training sessions and departmental meetings.

Vision and strategy

At our last inspection in 2016 the service had a variety of developments to further

enhance the provision of surgical services in the future on the different sites.

At this inspection the service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

We saw the SAS and TASS had developed their own strategies. The SAS strategy included individual specialities which included: plastic surgery, breast surgery and breast screening, colorectal and general surgery, ophthalmology, vascular surgery, intensive care and theatre, anaesthetics and out patients. Each speciality looked at highlighted their achievements and laid out its key challenges, plans in place and future strategies.

The TASS strategy was based on the aspiration to be the best performing specialist services and academic health portfolio. To achieve this TASS set themselves the tasks of delivering its CPG's work including (workforce development, safety, patient flow, patient and staff experience, patient and staff value and engagement).

At our last inspection in 2016 staff told us they were aware of and supported the trust vision and values, and they could tell us what the strategies, meant to them, which was to provide the best care for patients and to put patients first. This was still the case at this inspection.

Longer-term plans included the continuation of research, teaching and innovation, with plans to embed quality improvement (QI) methodology into business as usual.

The trust's vision and values continued to be displayed in hospital corridors, on the

wards, in literature, on key documents and on the trust's website for patients, visitors

and staff to comment and understand.

Culture

Whilst the majority of staff felt the culture of the organisation had improved and described the leadership team as accessible and supportive, there remained a culture of bullying within the operating theatres.

Staff in the operating theatres told us there was a culture of bullying with some consultant staff shouting at nursing staff during operations.

Staff also told us there were separate coffee and dining areas for staff. Medical staff would take their breaks in a separate area to the nursing and ODP staff.

There had been an unexpected patient death in the operating theatre the week prior to our inspection. Staff told us there had been no debrief and no opportunity for staff to discuss their feelings after the event.

The operating theatres did not provide a quiet space for staff to go to when an unexpected event had occurred or when staff needed some time to sit and reflect. There was also no psychological support available for theatre staff.

Staff in the operating theatres told us that the lack of staffing, skill mix, recruitment and never events had affected staff morale.

Operating theatre staff had been appointed as speak up guardians who had started to make a difference. But there had been a recent change to the rate of pay for bank staff which staff had told us, had not been communicated until the very last minute. We were told this was another example of the lack of inclusiveness and led to staff feeling undervalued.

We saw senior staff undertook a ‘What matters to you ‘ day across a number of wards where staff had the opportunity to discuss what they would like to improve, what staff would do differently to help the improvements, what the timescales were and who was needed to support the processes.

Examples included improving team work though more social events and being more appreciative of one another by thanking them.

Governance

The trust was developing a systematic approach to continual improvement in the quality of its services and safeguarding high standards of care.

There was a clear quality governance structure in place which demonstrated how governance was discussed and reported through the quality governance managers for the SAS and TASS up to the head of quality and governance and the hospital medical director.

The trust board would receive regular reports via the divisional quality and safety board

At this inspection we reviewed the minutes of mortality and morbidity meetings, and clinical audit events. These showed complications of surgery and audit results were discussed.

We looked at copies of governance meetings, risk registers, and incident reporting practices. These showed that the management systems in place enabled learning and improved performance, and these were reviewed on an on-going basis. There were patient safety and risk feedback bulletins including incidents and learning.
We reviewed the surgery’s NEs provided by clinicians to support the completion of actions. There was limited evidence to support shared learning across the trusts on the records and there was little documentation to show how the evidence could be followed through to where learning was shared.
The new instrument, swab and needle policy had been circulated and we saw staff had read and documented that they had read the new policy.

We visited level 12 (the private wing) of the trust where patients were treated and cared for by the trusts medical, nursing and administrative staff. Information provided and conversations with the staff demonstrated a clear integrated governance framework which ran in parallel with the other trust governance systems.

Activity was reviewed and monitored by the private patient unit (PPU) integrated governance committee, the PPU management board and the trust CPPG. There was a monthly cycle of reporting and communication which included: regulatory compliance, reviews of the risk register, incidents, safeguarding reports, patient experience, policies, staff engagement and training and development.

Management of risk, issues and performance

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

We saw the SAS and TASS risk registers. The SAS risk register contained 27 open risks: one extreme risk (an imaging machine needing regular maintenance), 15 high risks (staffing, equipment and access to theatres), 10 moderate risks and one low risk. Over 13 of these risks were nine months past their review date.

The TASS had six risks on its risk register; five were high risks and one moderate risk. The majority related to capacity and staff recruitment. All had been reviewed.

Mortality and morbidity trends continued to be monitored monthly through summary hospital-level mortality indicator
(SHIMI) and hospital standardised mortality ratio (HSMR).

The RFL continued to be a positive outlier on both measures and had been maintained over several years.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The hospital was going through a transition to full electronic systems which was resulting in some confusion/duplication of information.

The trust used a patient administration system across the trust which included radiology reporting and operating theatre activity.

The trust used an electronic documents and recording management (EDRM) system for letters produced in the outpatient clinics. Hospital notes had also been scanned onto this system. However, there was a separate system for discharge letters.

Staff told us information was often missing and medical staff had to use the GP referral letter to make judgements about a patient's condition as patients notes were missing.

Changing to using a paperless system had commenced. We saw 7 west (vascular) had recently introduced an electronic prescribing/ medication system. Staff told us this system had improved

the VTE prophylaxis prescribing although the system was slow due to Wi-Fi issues. The gynaecology ward had plans in place to become paperless.

Staff told us there was currently three log ins needed into three different systems which made access difficult at times.

Engagement

At the last inspection in 2016, clinical staff described feeling that there was little communication or involvement regarding changes to services, and that they were not encouraged to speak during divisional meetings.

At this inspection senior staff told us that in 2017 the team engaged with NHS Elect to work with staff which had improved participation in all meetings.

Staff told us communication had improved and there was a variety of ways information was cascaded for example: emails, weekly and monthly meetings.

There had been an increase in the number of multidisciplinary simulation training days which had a positive impact on speaking up.

There were now speaking up champions throughout the division and a high number of staff had attended conflict resolution training.

Senior staff had engaged NHS Elect to work with band seven theatre coordinators and the theatres management team.

There were leadership development programmes in place for staff and a change of management in some areas, meetings and agendas were reviewed resulting in a wider participation.

Teams were encouraged to develop the division’s strategy that all staff signed up to.
Pre-consultation section in change management policy.

The national staff survey 2017 showed the RFH had a response rate of 47.1%, which was 5% higher than 42% in 2016.

The SAS division’s response rate was 49%. There were 1179 questionnaires sent out with 550 returned. Information provided by the trust showed the key areas of focus in improving staff experience remained. These were bullying and harassment, team working, appraisal, feedback and development, management support from immediate managers and health and wellbeing (including flexible working).

Learning, continuous improvement and innovation

Evidence provided by the trust and discussion with staff showed there was continuous learning, improvement and innovation amongst staff.

The service promoted learning and development, and research and innovation. Staff were positive about the support they received to challenge existing practice and try out new ideas.

We saw a number of examples of staff participating in international, national, regional and local research projects and recognised accreditation schemes in order to ensure patient care was evidence based.
The TASS hosted the national amyloid centre and the institute of immunity and transplantation, a centre dedicated to research and clinical care for immune related disorders.

Senior staff told us there were a number of development programmes for staff which supported continuous learning and development.

The surgical specialities run simulation training to support learning in for staff in the operating theatres and other clinical areas. There were audit days for all surgical specialities to support and develop learning, in addition to quality medical rounds and Schwartz rounds. Schwartz rounds are a multidisciplinary forum in which healthcare staff within an organisation discusses the care of their patients.

The SAS and TASS participated in the Leading for Improvement: Programme Outline and Objectives, dated April 2018. This programme included five workshop days that would take place every quarter over an 18-month period. The programme included areas such as:

- Improvement and high impact leadership fundamentals
- Measurement for improvement and building an effective learning system.
- Managing improvement
- Coaching for improvement, the psychology of change and joy in work.
- Moving from patient centred care to partnering with patients and the community

Critical care

Facts and data about this service

The Royal Free Hospital is a major tertiary referral centre for medical and surgical specialties. The critical care unit provides services to support all the in-patient specialities including hepatobiliary services (for patients with diseases of the liver, bile duct, gall bladder and pancreas), an established liver transplantation programme, haematology, complex vascular surgery, plastic surgery and renal services. The Royal Free Hospital has an active organ transplant programme for liver and kidneys. Most patients come to the unit after planned surgery but a proportion are admitted through the emergency department and from hospital wards, either due to becoming more unwell or after emergency surgery.

Up to 1700 patients are admitted to ICU each year. Of these admissions 40% are planned, some 30% of patients had diseases of the liver, gallbladder, bile duct and pancreas. 50% of patients were long stay (over two weeks). The 34 ICU beds are on the 4th floor of the hospital in three wings, known as 'pods': south, east and west, each with similar layout and storage facilities. Each pod has 24-hour consultant cover by a specialist in intensive care medicine and all care is consultant led. Each consultant is supported by a team of junior grade doctors who are at different stages of their training. A senior nurse leads each shift on each unit.

ITU East has 14 beds including one side room and a two-bedded side room

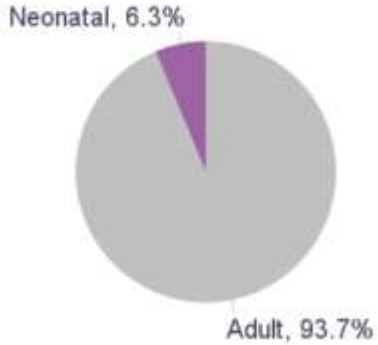
ITU South has 11 beds including eight side rooms

ITU West has nine beds including six side rooms

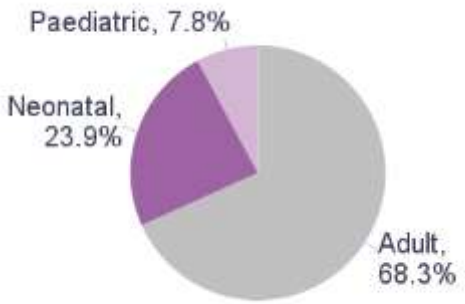
The trust as a whole, has 95 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Royal Free London NHS Foundation Trust and England.

This trust



England



The unit is part of the North East North Central London Critical Care network.

All beds can facilitate level 3 care. The unit is considered at capacity if 28 beds have level 3 patients, but this number is often exceeded. Level 3 care is for patients requiring advanced or basic respiratory support together with support for at least two organ systems. Level 2 care is for patients requiring single organ support. Level 3 patients are nursed one to one and level 2 patients were nursed 1:2 unless in a side room, where one to one care is always needed.

The critical care service uses a range of enhanced physiological monitoring systems, organ supportive therapies and complex treatments and treat all acute illnesses that necessitated a high staff to patient ratio and a highly skilled, multi-professional team.

Critical care is part of the hospital's surgical and associated services division, led locally by a clinical lead and two matrons. The team includes 15 critical care consultants. Eight teams of nurses are each led by a senior nurse (band 7). There is an education team of practice development nurses. Allied health professionals such as physiotherapists, a dietician an occupational therapist and pharmacists support the unit.

A Patient at Risk response team (PARRT) supports the ICU as well as the rest of the hospital. It is led by a Band 8a nurse supported by an establishment of 11.19 WTE Band 7 nurses.

We inspected the ICU during an announced inspection between 11 and 13 December 2018. We spoke to over 40 staff including doctors and nurses at various grades, health care assistants and allied health care professionals. We reviewed 10 patient records and 15 medication charts. We spoke with 8 patients or their relatives. We made observations of the environment, staff interactions with patients and relatives and checked items of equipment.

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills to all staff and most staff had completed it. However, medical staff did not meet the trust target for completion of annual mandatory training updates

The critical care unit had a dedicated education team consisting of 6 clinical practice facilitators, whose role including oversight of staff attendance at statutory and mandatory training. The trust set a target of 85% for completion of mandatory training.

Many of the courses were online. Nurses said they could complete these in work time but the computers were slow. They could also complete courses at home, although the software did not work on all computer platforms. Staff were frustrated that the tracking system for statutory and mandatory training did not always properly register the completion of courses.

Compliance with statutory and mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the critical care department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	146	150	97.3%	85%	Yes
Infection Control L1	144	150	96.0%	85%	Yes
Basic Radiation Safety	142	150	94.7%	85%	Yes
Resuscitation L1	142	150	94.7%	85%	Yes
Waste Management	140	150	93.3%	85%	Yes
Emergency Planning	139	150	92.7%	85%	Yes
Fraud & Security	138	150	92.0%	85%	Yes
Moving and Handling	136	150	90.7%	85%	Yes

Health & Safety Awareness	136	150	90.7%	85%	Yes
Conflict Resolution	132	150	88.0%	85%	Yes
Resuscitation L2	128	150	85.3%	85%	Yes
Equality, Diversity & Human Rights	127	150	84.7%	85%	No
Fire Safety	124	150	82.7%	85%	No
Information Governance	123	150	82.0%	85%	No
RTT L1	30	38	78.9%	85%	No
Infection Control L2	114	150	76.0%	85%	No
Blood Transfusion	112	150	74.7%	85%	No

Nursing staff exceeded the 85% target for 11 of the 17 mandatory training modules for which they were eligible. Overall compliance was 88% at that time.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Records seen during inspection showed that compliance had improved and overall compliance was 91% by November 2018. The areas below target were blood transfusion (70%), level 2 resuscitation (79%) and infection control level 2 (77%). Staff wanting to undertake advanced courses were required to have completed all their mandatory training.

The Royal Free Hospital taught 8 or 9 Advanced Life Support courses a year. ICU nurses were offered one place per course, so several ICU nurses had advanced life support training and did not therefore need intermediate life support training.

A breakdown of compliance for medical staffs' completion of mandatory training courses from April 2018 to August 2018 is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety	29	34	85.3%	85%	Yes
Basic Radiation Safety	25	34	73.5%	85%	No
Blood Transfusion	24	34	70.6%	85%	No
Emergency Planning	24	34	70.6%	85%	No
Fraud & Security	24	34	70.6%	85%	No
Health & Safety Awareness	24	34	70.6%	85%	No
Information Governance	24	34	70.6%	85%	No
Waste Management	24	34	70.6%	85%	No
BPAT	24	34	70.6%	85%	No
Moving and Handling	23	34	67.6%	85%	No
Conflict Resolution	23	34	67.6%	85%	No
Equality, Diversity & Human Rights	22	34	64.7%	85%	No
Resuscitation L1	22	34	64.7%	85%	No
Infection Control L1	21	34	61.8%	85%	No
Infection Control L2	19	34	55.9%	85%	No
RTT L1	18	34	52.9%	85%	No
Resuscitation L2	9	34	26.5%	85%	No

(Source: Routine Provider Information Request (RPIR) – Training tab)

On inspection we found the overall compliance rate had improved to 76% compliance at the time of the inspection in December 2018, although this remained below the 85% target.

The low rate for resuscitation training in the table above is misleading. All junior doctors are required to be up to date with their advanced life support (ALS) for their Annual Review of Competency Progression. Some were undertaking their ALS, other had completed it. In addition, all staff in the PARRT team had completed the ALS course.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff were aware of their responsibilities in relation to safeguarding vulnerable adults and knew what constituted a safeguarding concern and how to escalate it. However, not all medical staff had completed safeguarding training updates, and compliance rates were below the trust target.

Staff had access to the trust's adult and children's safeguarding policies and procedures through the staff intranet and knew how to access these. We saw an example of appropriate action to safeguard a vulnerable person who used the service.

Staff reported safeguarding incidents through the electronic incident reporting system to the safeguarding team. We saw this on the incident reporting record and that appropriate action was taken.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of nurse' compliance with safeguarding training courses from April 2018 to August 2018 in critical care at the Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	146	150	97.3%	85%	Yes
Safeguarding Adults L2	144	150	96.0%	85%	Yes
Safeguarding Children L1	144	150	96.0%	85%	Yes
Safeguarding Children L2	142	150	94.7%	85%	Yes

Nurses exceeded the training target for all four safeguarding training modules for which they were eligible. Records seen on inspection showed 100% compliance for nurses by November 2018.

A breakdown of medical staff's compliance for safeguarding training courses from April 2018 to August 2018 is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L1	24	34	70.6%	85%	No
Safeguarding Adults L2	24	34	70.6%	85%	No
Safeguarding Children L1	21	34	61.8%	85%	No
Safeguarding Children L2	21	34	61.8%	85%	No

The 85% target was not met for any of the four safeguarding training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

The unit very occasionally provided care to young people over 16 from another trust. In the past year one 16-year old and five 18-year olds were treated on the unit. Young people were accepted on the unit if this was their preference, and if they weighed over 40kg, so could be treated with drugs for adults. Such patients would be discharged to another hospital for ward care.

Cleanliness, infection control and hygiene

The service controlled infection risk well. All areas were visibly clean. Staff followed approved protocols to prevent the spread of infection. They had successfully reduced formerly elevated infection levels for which they had been comparative outliers.

All areas were visibly clean and tidy including all clinical areas, relatives' rooms and toilets. Patients and relatives said they were impressed with the level of cleanliness on the unit. One relative said: "It is a very hygienic environment; staff are constantly changing gloves and aprons".

Clinical equipment we checked was visibly clean. We saw daily checklists for equipment cleaning in patients' bed spaces, which included intravenous drip stands and infusion pumps. Green 'I am clean' stickers were used to show whether communally accessed equipment on the ward was clean and ready to use.

There were reliable systems to prevent and protect patients from healthcare associated infection based on the Department of Health's code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment (PPE), such as gloves and aprons, and management of the spillage of body fluids. The cleaning standard for high risk units was met on all pods, with a score of 98% for November 2018. Dedicated cleaning staff worked seven days a week within ICU. We observed these staff carrying out cleaning duties throughout our inspection. There was a regular deep cleaning programme and some parts of the unit were being deep cleaned during our visit.

There were aprons and gloves in each bed space for staff and relatives. Relatives were required to use aprons on visiting, to leave their coats outside and to clean their hands. Staff were seen to decontaminate their hands immediately before and after every episode of direct patient contact, and ICU clinicians were 'bare below the elbow' and seen to adhere to hand washing and using hand sanitisers when entering and exiting the unit and bed spaces. One consultant from another speciality was seen not to have their sleeves above the elbow. We saw staff using personal protective equipment (PPE) as required to avoid risk of cross contamination.

Every bed space had a basin for handwashing, with guidance on effective hand washing practice. There were additional basins in the corridor. Antibacterial hand sanitisers were well places so it was easy to comply with hand hygiene guidelines. Staff followed standard protocols when they carried out an invasive procedure for a patient such as inserting a chest drain (a small plastic tube inserted into the chest). This minimised the risk of hospital acquired infections

Disposable curtains between bed-spaces were changed at fixed intervals and if they became soiled or if the patient was infectious. Curtains were labelled with the date they were last changed, and all had been changed within the past month. Single rooms used privacy glass that removed the need for curtains, and minimised the risk of bacterial infection.

Where patients had a known or suspected infection, or had a weak immune system, they were nursed in single side rooms. The fourteen side rooms were pressure controlled with decontamination lobbies, in line with good practice, although we noted the pressure monitors were overdue for maintenance since October 2018. Following the discharge of the patient these rooms

was thoroughly cleaned (deep cleaned) in line with trust policy and procedures, related to the type of infection the person had. A notice on the door of such rooms highlighted the relevant cleaning process.

Waste management, including that for contaminated and hazardous waste was in line with national standards and labelled and handled appropriately. The risk of cross contamination was reduced because nurses and doctors used disposable equipment. We saw staff disposing of equipment safely in sharps bins or clinical waste containers. Sharps bins throughout the unit were stable, correctly labelled and none were filled above the maximum fill line.

Antibiotic or antimicrobial resistance now poses a significant threat to the delivery of healthcare. Microbiology staff conducted clinical rounds daily on weekdays to ensure doctors were using antimicrobials responsibly, promoting actions that balanced both the individual's need for appropriate treatment and the longer-term societal need for sustained access to effective therapy.

The service did not display infection related safety results within clinical areas. Information provided by the trust after the inspection there were four cases of acquired MSSA, no instances of acquired Clostridium difficile or MRSA and four instances of e coli and three of klebsiella in the year to 6 December 2018.

Every three months, the specialty lead submitted data to the Intensive Care National Audit and Research Centre (ICNARC). This included data regarding the number of patients who acquired an infection whilst they were an inpatient on the unit. ICNARC reports had shown that high risk admissions from wards, high risk sepsis admissions from wards, and unit-acquired infections in the blood had been outliers earlier in 2018. However, they were rated green in the April to June 2018 quarterly return.

Environment and equipment

Some equipment was not regularly maintained and some was out of date and spares were unobtainable. There was no capital replacement programme. The service had suitable premises and staff were trained to use equipment. Some medical instruments in the emergency trolleys had open packaging so there was a risk they were not sterile.

The ICU environment had been refurbished five years ago and was bright and spacious. Many areas had natural light, which is beneficial to the orientation of ICU patients. The unit was located on the floor above the theatres with dedicated lifts for patients from theatre. It was secure, with entry to each ‘pod’ through an intercom entry system for visitors. Staff had touch card access. We observed these systems be used consistently.

The unit complied with building guidelines and space standards for critical care services (Health Building Notes: HBN 04-02 Critical Care Units: Planning and Design). Each pod had access to its own utility rooms and Point of Care testing (POCT) for tests such as glucose and haemoglobin analysis, in a consistent layout. All three pods used the same colour scheme which made it difficult for newcomers to establish where they were. There was no sign to the way out within the pods themselves. This was rectified during the inspection.

Two housekeepers for the critical care service were responsible for the organisation and storage of clinical stocks such as gauze, syringes and sterile packs, but not for ordering. Staff said supplies sometimes ran out and the order system did not work well. Cleaning cupboards were not locked despite a sign saying, “Fire door keep locked”.

We reviewed the checking history records for the resuscitation and difficult airways trolleys from July to mid December 2018 and found the equipment was generally checked daily (immediately after the morning handover) and trolleys were fully stocked. After a trolley was used the nurse in

charge ensured restocking. The resuscitation trolleys used red tags to ensure the drawers were tamperproof (and these drawers were only checked weekly if the tag was unbroken), but the other emergency trolleys were not locked. Some medical instruments in the trolleys had open packaging so there was a risk they were not sterile.

The ward and single rooms had plenty of space around the bed for all necessary equipment. At the start of each shift on ICU nurses checked all bedside equipment for their allocated patient. We reviewed this aspect of the records for three patients and found that their equipment had been checked at each shift for the past two days.

There was a range of equipment available including syringe drivers, ventilators and nasal gastric feeding pumps. However, some equipment was near the end of its working life for example ventilator monitors and humidifiers regularly failed. We saw from staff meeting notes that Point of care testing equipment (POCT) was often broken and not properly calibrated. Staff said this was a problem at weekends, because service staff were not available. There was no programme for the routine replacement of capital equipment, and staff had to submit business cases for the trust for replacement. At the time of inspection none of the business cases had been approved, pending a decision on whether to buy or lease equipment. The absence of a capital replacement programme did not meet GPICS guidelines. After the inspection the trust sent us an undated rolling replacement programme that had been presented to the asset management group.

The unit had not had an equipment manager for more than a year. The role was partially covered by a bank ODP and the matrons. The risk register defined the issue as a lack of ICU technicians. This did not highlight the full implications of the issue: the maintenance backlog and obsolete equipment. Most equipment we inspected had maintenance stickers showing servicing within the last year, although we found more than one item still in use with a sticker saying, ‘do not use after 25/1/2018’. We saw several broken monitors, one of had been reported in April 2018, nine months previously

Staff labelled faulty equipment and reported it to the relevant department. Records seen after the inspection showed the unit did not comply with the GPICS requirement that all equipment must conform to the relevant safety standards and be regularly serviced. There was a backlog in the routine servicing and maintenance of medical equipment such as patient monitors and suction pumps. Records showed only 61% of equipment was up to date with planned preventative maintenance. There were 82 items of high risk equipment such as ventilators, defibrillators and haemofiltration machines recorded as an extreme risk, 211 items recorded as high risk, mainly pumps, and 220 items categorised as moderate risk. Staff told us they reported items that failed in use with a patient as an incident.

We were not shown a formal action plan to address and monitor the equipment issue. Staff told us business cases have been written and approved for replacement ventilators and monitors, but there was yet a decision whether to purchase or lease equipment. Equipment was on loan pending decisions about this and whether to institute a rolling replacement programme. Staff said the risk had been reduced due to theatre refurbishment work in four theatres closed and equipment had been reallocated to ICU. A formal agreement for maintenance checking had recently been arranged from medical physics. We were told the infusion pumps would be audited in January 2019 and a proposal in place by March 2019.

Staff told us they had received appropriate training on the use of equipment. For example, one junior nurse told us they had completed all their critical new starter competencies and had received necessary equipment training including for infusion devices, observation machines and

ventilators. The practice educators provided teaching on the use of equipment in the absence of ICU technicians.

Physiotherapists had a good range of equipment to support early rehabilitation of patients such as ambulatory ventilators, tilt tables, standing frames as well as hoists and rota stands. There were no ceiling track hoists.

Staff had access to bariatric equipment such as beds and chairs.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Records of risks were full and clear and staff shared information about changes in risk at handovers.

Nurses completed a holistic assessment for each patient to identify individual risk factors. The nursing observation sheets directed staff to implement specific management plans to reduce unsafe outcomes, for example, venous thromboembolism or falls. There were also management plans to promote healthy physiology such as bowel and bladder function, nutrition and hydration. Patient records showed the assessments and management plans were consistently completed.

Current or new patient risks were communicated to staff during handovers. For example, when a patient had a treatment escalation plan or a patient was at risk of airway difficulties. There was a group nursing handover at each shift change, followed by a detailed nurse to nurse bedside handover once nurses were allocated a patient. There was also a handover between the nurse in charge of the unit and the nurse in charge of each pod, about staffing and bed management. All staff had access to an ICU handbook setting out standards for bedside care and a clinical resource guide. Staff said that handovers were structured and comprehensive. Junior doctors confirmed that they had all relevant information communicated to them at the start of every shift, and felt confident to seek advice and support from senior staff when a patient's condition deteriorated. They reported that contact with senior doctors was always supportive.

There were systems to minimise risk of harm to patients during interventional procedures such as tracheostomy carried out on the unit. A tracheostomy is a procedure to make a hole in the throat and insert a tube, which is connected to a ventilator or 'breathing machine'. In response to the National Tracheostomy Safety Project, the critical care team implemented use of the World Health Organisation (WHO) Safety Checklists and recorded the type of tracheostomy and the specific care required in the case of an emergency. However, the use of the WHO checklist was not audited so compliance with this protocol could not be assured.

The hospital had a critical care outreach team, known in this trust as a Patient and Risk Response team (PARRT). The team supported acutely ill patients in other areas of the hospital, prior to their transfer to the ICU, all patients with a tracheostomy, and followed up patients discharged from the ICU. Following a serious incident, it was hospital policy for the PARRT team to attend cardiac arrests in patients in the ICU. The inclusion of ICU meant the team were an outlier in the National Cardiac Arrest Audit (NCAA) because the ICU had a higher number of cardiac arrests than the national average.

The trust wide policy for monitoring and responding to the deteriorating patient was available to staff on the intranet. The hospital has introduced the standardised system, NEWS2 in all wards. A NEWS2 chart is a record of patients' clinical observations on a standardised colour coded chart to determine how unwell a patient may be. When a patient's clinical observations fell outside certain parameters, they produced a higher score, shown in colour, indicating a need for more urgent clinical care than other patients. When ICU patients were approaching discharge to a ward, nurses started a NEWS2 chart at eight to 12 hours before transfer.

The critical care team did not use NEWS2 until patients were near to discharge. Instead they monitored patients closely against a wide range of nuanced parameters at a minimum of hourly. There were multiple triggers for escalation of ICU patients. Patients on the ICU were reviewed at least twice daily by a consultant (on weekdays) and patients who were cared for by the PARRT team were reviewed twice daily by them.

When discharging a patient to the ward nurses followed a standard checklist to ensure that ward staff could see what has been happening to the patient in the last 12 hours and ensure continuity of care. Staff used SBAR on handover to the ward. SBAR is an acronym for Situation, Background, Assessment, Recommendation; a technique used to facilitate prompt and appropriate communication within teams. The process met GPICS guidelines.

A critical care consultant was on call 24 hours a day, seven days a week, and a middle grade doctor within the ICU always. Nurses knew to escalate concerns to the medical team and the nurse in charge.

We observed appropriate sepsis management through reviewing patient notes and attending meetings. Staff administered antibiotics in line with guidelines. The team ensured that patients with suspected sepsis were assessed using a structured set of observations to stratify risk, high risk patients were reviewed by consultant within one hour and received antibiotics and intravenous fluids as necessary. Trainee doctors receive formal teaching on sepsis. The PARRT team had led work on sepsis across the hospital. An ICU audit was in progress reviewing patients with sepsis and their admission to the ICU.

We checked the healthcare records of ten patients on the ICU and found individual risk assessments were carried out for each. This included but was not limited to safeguarding, skin integrity and mental capacity assessments. Where risk had been identified we also saw evidence that risk management plans were developed in line with national guidance, with risks managed positively.

Senior staff could clearly describe what action they would take in the event of emergencies and major incidents in line with local procedure. This included fire evacuation plans which were seen to recently reviewed and available to staff.

Nurse staffing

The service used a substantial number of bank nurses to enable the unit to meet national standards. The bank staff employed were long term staff with specialist training and qualifications. There were 53 band 6 vacancies and 68% of these were covered by senior long term bank staff. Other vacancies were filled by agency staff.

Some junior staff told us they were sometimes allocated to critically ill patients in single rooms with inadequate support. The trust told us after the inspection that in recognition of this senior nurses and runners were checking side rooms more frequently. Feedback had been positive from staff nursing in side rooms.

Two matrons led nursing staff on the critical care units. There was a supernumerary clinical coordinator on each shift in line with the Guidelines for the Provision of Intensive Care Services (GPICS). A nurse coordinator on each pod was usually supernumerary which enabled the service to respond to patient emergencies. Some admissions to critical care were unpredictable and for this reason the unit required enough staffing to provide a prompt response for very sick patients.

The unit ensured that staff to patient ratios complied with the Guidelines for the Provision of Intensive Care services 2015 (GCIPS) recommendations for safe provision of level two and level three care. The nurse to patient ratio for level three patients was a minimum of one nurse to every

one patient. The nurse patient ratio for level two patients was a minimum of one nurse to two patients. No information was displayed on the unit comparing planned to actual staffing numbers.

The trust reported the following qualified nursing staff numbers in critical care from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	102.8	84.3	82.0%	99.8	82.3	82.5%
Royal Free Hospital	209.2	148.7	71.1%	206.2	146.9	71.2%
Total	312.1	233.0	74.7%	306.0	229.2	74.9%

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

From September 2017 to August 2018, the critical care nurse vacancy rate was 29.2%. This was higher than the trust target of 12%. *(Source: Routine Provider Information Request (RPIR) – Vacancy tab).* The vacancy rate had been as high as 35% in the previous year. There were 58 vacancies at the time of the inspection, of which 52 were at Band 6. The small number of band 6 in permanent roles was a challenge for skill mix. Band 5 nurses said it was not easy to get their competences signed off when there were few senior staff.

The trust undertook continuous recruitment to permanent ICU staff and to the bank. The unit could only meet nursing staffing standards for critical care using bank and agency staff alongside permanent staff. On inspection there were more permanent staff than bank or agency on shift, but staff told us this was untypical.

From September 2017 to August 2018, the hospital reported an average turnover rate of 18.2% in critical care. This was higher than the trust target of 13%. *(Source: Routine Provider Information Request (RPIR) – Turnover tab).* Records showed turnover had improved significantly from the past year when it had peaked at 47% at one point when 40 staff had left because of the trust decision to change shift start times and cease payment for breaks. Many of these staff now worked full time on the bank.

From September 2017 to August 2018, the hospital reported a sickness rate of 2.3% in critical care. This was lower than the trust target of 3.5%. *(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

A quality improvement (QI) project had started in June 2017, aiming to reduce nurse turnover in ICU to 25% by December 2018. The project had involved focus groups, attaching bank staff to permanent staff teams and involving bank staff in mentoring, offering opportunities for leadership training to Band 6 and improving communication through a newsletter and fortnightly coffee catch ups. This was achieved in May 2018 ahead of schedule. There had been improvement in staff satisfaction and retention, although managers were aware of the need to continually monitor staff experience.

An initiative to improve retention was the introduction of a degree of flexible working to fit in with nurses' family circumstances. We were told 45 staff had flexible working adjustments. Self-rostering had been introduced in January 2018 and had proved popular with staff and appeared to have reduced sickness. There were some rules such as all staff worked the same length shifts, and both day and night shifts. The trust hoped that some staff would return from the bank to

permanent posts with the increased flexibility now offered. Staff said they generally got breaks on their shifts. Exit interviews were carried out to identify reasons for leaving.

From September 2017 to August 2018, 27% of nurse shifts in critical care were filled by bank staff and 4% of shifts were filled by agency staff. In addition, 1% of shifts were not filled. The unit therefore used more than 20% bank and agency staff on many shifts. (*Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)* This did not meet GPICS guidelines that the number of bank/agency nursing staff must not on average exceed 20% of a shift.

ICU managers valued the bank staff and sought to integrate them into the ICU teams to ensure safe staffing. Staff said on average over half of the staff on shifts were full time bank staff, and many of the senior staff were bank staff. On the first day of inspection 10 staff cancelled bank shifts in protest at the trust's changes to bank rates of pay. The unit had taken on additional agency staff and pulled permanent staff from elsewhere such as the practice education team. Two beds were closed because of insufficient staffing on the first day of the inspection.

All staff wore green scrubs so it was not evident to patients which staff were permanent and which temporary.

There were few senior permanent staff on shifts because the vacancy rate for band 6 was so high. Junior nurses expressed concerns that the nurses who allocated staffing on any given day did not necessarily know the skills of the team. The intention was that nurses should work on the same pod for two or three months, but nurses said that in practice they were allocated to any area of ICU. They were sometimes allocated very sick patients without adequate senior support. Some staff suggested team managers needed more training in how to support and train staff.

The ICU team said they no longer had 'protected runners', which was a risk in an emergency. There were not always sufficient staff available to reposition level 3 patients, which led to more lines being pulled out, and potentially more pressure sores. Permanent staff mentioned the heavy reliance on bank and agency staff, some of whom did not feel safe to raise concerns because they might not be booked again.

One health care assistant (band two) worked on each pod supporting nurses with a range of tasks including turning patients. Low fill rates staffing for shifts meant there were not always enough HCAs.

A trainee Advanced Critical Care Nurse Practitioner (ACCNP) had been appointed within ICU and theatres and would support medical and nursing teams.

The Patient at risk response team (PARRT) was led by a nurse consultant and supported by an establishment of 11 specialist nurses. At the time of inspection there were 9.43 WTE in post. One nurse had been appointed to start in early January 2019 and one post was still being advertised. Critical care doctors were not part of this team but worked with the PARRT team as necessary on the unit. An airway trained anaesthetist acted as a 'float' registrar seeing referrals and resuscitating patients also on wards, in the catheterisation laboratory (where heart abnormalities were treated) and in the emergency service.

Two permanent ward clerks for ICU were absent on long term sickness. The unit was being supported by two bank staff who were responsible for supporting relatives in the waiting room, and for filing notes. There was a backlog of filing.

Medical staffing

There were enough consultants to meet national standards during working hours and on average enough to meet standards out of hours. There was a risk the gap would increase as the unit expanded. There were enough junior doctors.

The trust subsequently told us they had increased the establishment of allied health professionals as part of the HDU expansion.

A clinical director led the critical care service. The GPICS recommends each separate unit should have a lead consultant and this was in place.

GPICS recommends the consultant/patient ratio must not exceed a range of 1:8 to 1:15 and the ICU resident/patient ratio should not exceed 1:8. The trust met medical staffing standards for intensive care during the week when there were three consultants on ICU, which is an average of 11.3 patients per consultant when at capacity (assessed as 28 level 3 patients). Day time cover was 8am to 8pm. The GPICS standards were not met at weekends. Consultant rounds took place only once on Saturdays and Sundays. There were two consultants on site in the morning (8am to 12pm) at weekends compared to three on weekdays. This is 17 patients per consultant. In the afternoon there was one consultant on site from 12pm to 6pm A consultant in intensive care medicine was on call at night, and could attend patients within 30 minutes.

Some consultants' ward cover was in blocks that provided continuity to patients, but the rota showed that not all consultants worked this way, and some worked single days. There were no plans to phase out working patterns of single work days to provide continued care for patients although this had been highlighted in the network peer review in 2016.

From April 2017 to March 2018, the trust reported a staffing level of 94.3% for medical staff in critical care, but as the units worked independently this was not a relevant number. The fill rate at the Royal Free Hospital was 86%.

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Barnet Hospital	5.5	7.0	Over-established by 27.7%	0.0	1.0	N/A
Royal Free Hospital	36.5	32.6	89.3%	41.5	35.6	85.8%
Total	42.0	39.6	94.3%	41.5	36.6	88.2%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The 15 consultants were a mix of full time intensive medicine and joint posts with renal medicine and anaesthetics. There were 32 trainee doctors on a tiered rota. The number of trainees had increased from 24 in earlier years. There were also trust clinical fellows. There was demand for the trust posts which offered research opportunities.

There were separate rotas for anaesthetists, for intensive care medicine and ST3+ physicians, senior clinical fellows, and a third rota for core Anaesthetic Trainees (CAT), core medical trainees and junior clinical fellows. The number of trainee doctors, and grades on each day was variable. There were always four trainees on at night.

More consultants were needed to ensure night and weekend cover and to cover the 42 patients that would potentially be in critical care when the new surgical high dependency beds on the

theatre floor were open. The intention was to open four beds in late January or early February, increasing to eight beds. Although the trust told us an increase in medical staff would be part of the HDU expansion, some consultants voiced concerns about the difficulty of recruitment. Doctors had concerns about anaesthetic cover for airway emergencies in the new HDU as there was already a shortage of anaesthetists.

From September 2017 to August 2018, the trust reported a vacancy rate of 5.1% in critical care. This was lower than the trust target of 12%. The vacancy rate at the Royal Free was 9.3%. *(Source Routine Provider Information Request (RPIR) – Vacancy tab).* However, on inspection we found the rate had increased to almost 13%.

From September 2017 to August 2018, the trust reported a turnover rate of 7.0% in critical care at Royal Free Hospital. This was lower than the trust target of 13%. *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

From September 2017 to August 2018, the trust reported a sickness rate of 0.4% in critical care both trust wide and at the Royal Free site. This was lower than the trust target of 3.5%. *(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

From September 2017 to August 2018, the trust reported that 6% of medical shifts in critical care were filled by bank staff. During that time no posts were filled by locum staff at Royal Free Hospital.

A breakdown of bank/locum usage is shown in the table below:

Site	Total hours available	Bank Usage		Locum Usage		NOT filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Royal Free	73,203	4,108	6%	0	0%	5,326	7%

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

One locum consultant was working in the unit during the inspection, who had been appointed in November.

The therapy teams were led by two part-time Band 8a staff, a lead physiotherapist and a speech and language therapist (SLT). The team included physiotherapists, SLTs, an occupational therapist and a dietitian. The establishment was 18 staff, but there were five vacancies. There was pressure on the physiotherapy team in particular because of their range of responsibilities and because of the high occupancy of the unit. The GPICS recommended ratio of physiotherapists to patients is ratio 1:4 and the ICU did not meet this at the time of the inspection. After the inspection we were told the establishment of allied health professionals had been increased to support the expansion of the unit

The current staffing level for consultants, nurses and therapists had been decided some years ago based on a 28-bed profile for the unit. Staff told us there were often 29 or 30 level 3 patients a day.

Records

Staff kept detailed records of patients' care and treatment. However, all records were on paper. A sample of records was audited daily.

The service used hand written patient healthcare records. We found records were accurate, complete, legible, and generally up-to-date. Staff copied some information from the computer to make the paper record complete, which had potential for error.

Nurses completed a large daily observation record with prompts for a holistic patient assessment and evidence-based care plans for generic needs such as prevention and management of pressure ulcers, falls, venous thromboembolism. Venous thromboembolism (VTE) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis) and travels in the circulation, lodging in the lungs (known as pulmonary embolism). Nurses recorded hourly information such as blood pressure, temperature and fluid balance.

Records made by medical staff and other members of the multidisciplinary (MDT) team were in a separate folder. The current day's medical record was kept in the nurses' and doctors' station so staff could review it without disturbing the patient.

Records were not locked away as they were in constant use by staff and monitored closely. Computer screens were locked when not in use.

Staff were aware of medium term plans to introduce an electronic patient healthcare record system for ICU however they did not know when this would start nor whether the proposed system would be more effective than the system trialled and abandoned in 2017.

Five sets of records were audited daily and there was a monthly report. In November 2018 the unit was above the hospital average in 13 questions and below average in 15. Performance for November 2018 showed high scoring for pain scores, pressure care bundles and fluid chart completion but lower scores for ensuring every paper record had patient ID, and full completion of admission records. We saw the results were discussed at ward meetings to learn from them. We noted that not all paper records seen on inspection had patient ID.

We looked at a random sample of 10 patient notes. These all included details of allergies, a daily treatment plan and record of daily consultant reviews. Staff recorded specialist assessments, including assessments for nutrition, neurology and respiratory needs. The records showed input from multidisciplinary team including physiotherapists, dietician and tissue viability team. The time and decision to admit to the ICU was recorded for those admitted for level three care with formal handover documentation in place.

We observed a critically ill patient returning safely from transfer to another part of the hospital for investigation. Staff were appropriately trained in transfer procedures, had anticipated potential problems and completed the paperwork correctly.

Medicines

The service generally followed good practice when prescribing, giving, recording and storing medicines. There had been a reduction in medicines incidents since the previous inspection. There was adequate pharmacy cover for the unit.

The ICU had a dedicated critical care pharmacist. The GPICS standard indicates there must be a critical care pharmacist for every critical care unit. In addition, there must be sufficient pharmacy technical staff to provide supporting roles. The GPICS standards recommend a minimum staffing level of 0.1 WTE pharmacy staff per Level 3 or Level 2 beds.3 ICU pharmacists. The staffing complied with GPICS core standards.

The lead pharmacist had an MSc in critical care. They attended consultant led MDT ward rounds on all three units. A band 7 chief pharmacy technician provided support to the pharmacist for ICU (0.6 WTE). The service was provided Monday to Friday. An on-call senior specialist critical care pharmacist was available if required out of hours.

Medicines, including intravenous (IV) fluids, were stored in a secure clinical room, which could be accessed by all staff with an ICU smart card. However, we found some 'mixed' storage of IV fluids in trolleys which created a risk of error. The trolleys were not locked. We checked the controlled drug cupboard and found controlled drugs were in date, all accounted for and checked daily.

We randomly checked 20 stock medicines throughout the service and found that medicines were in date and stored according to the manufacturer's recommendation. Patient's individual medicines were stored in separate trays in the clinical room.

The proportion of reported incidents concerning medicines had fallen to 21%. In the 2016 inspection the rate had been 40%. Staff involved in medicine errors had to write reflective reports

Fridges in the clean utility rooms were not locked but the rooms themselves could only be accessed by staff with an ICU touch pass. One fridge was untidy with open medicine packets. A blood fridge on the unit served all three pods.

We reviewed 15 prescription records and there were no gaps in records for patient's medicine charts. Allergies were clearly documented. Designated clinicians had carried out the required clinical assessments for patients on admission. Specialist advice from the microbiology team was available to review appropriate use of antibiotics.

Incidents

The service managed patient safety incidents effectively. Staff had a good understanding of what constituted an incident in ICU and reported them appropriately. Managers investigated incidents and staff could tell us of lessons learned.

Staff understood the escalation and reporting process and could access the incident reporting system using the computers at the patient's bed space. Most said no blame was attached to incident reporting, although junior nurses said that senior staff on occasion recorded an action they had taken as an incident without explaining to them what they had done wrong.

During the 12 months preceding our inspection 606 incidents were reported, of which three were classified as moderate harm. There were 127 medication incidents, 12 instances of broken equipment mainly pumps, and humidifiers on ventilators. Such incidents were reported when they impacted directly on patient care, but staff said other instances of broken equipment were not reported but the piece of equipment was labelled and placed in the designated location for collection and repair. The highest number of incidents related to hospital acquired pressure ulcers (105) and other skin trauma such as moisture lesions (53). The critical care team did not benchmark their incident reporting rate with any similar units..

We saw that the ICU had had problems earlier in the year with ensuring traceability from donor to recipient after blood transfusions. Some blood compatibility tags had not been returned to the blood transfusion lab. This is a legal requirement under the Blood Safety and Quality Regulations 2005. However, staff had implemented a new system which had reduced the loss of tags to about one a month.

Lessons were learnt following incidents, with action taken as a result of investigation when things went wrong. In response to an increase in reporting incidents of skin trauma staff had additional training on the SKINN care bundle and an action plan for skin care in ICU was drawn up.

Lessons were learned when patients died. Mortality and morbidity (M&M) reviews were held about every six weeks and were attended by relevant members of the consultant team. These reviews focused on individual deaths, as well as patient harm caused by delays or errors. The meetings were advertised to staff but we did not see a list of who attended meetings. Each meeting

reviewed a sample of key cases using a national standard template which included a section on “Learning and actions to improve” and also including an overall care score and to assess the likelihood of the death being avoidable on a Likert scale. The 1 to 6 Likert scale is the standard approach to rating avoidability of death. There was a section to record actions planned to improve but on the five M&M templates we reviewed, no improvement plans were recorded, even where suggested for improvement were mentioned.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. All staff had a good understanding of the duty of candour and could describe when it would be used. We saw evidence of where duty of candour had been applied which related to a pressure ulcer acquired during a patient’s admission to ICU.

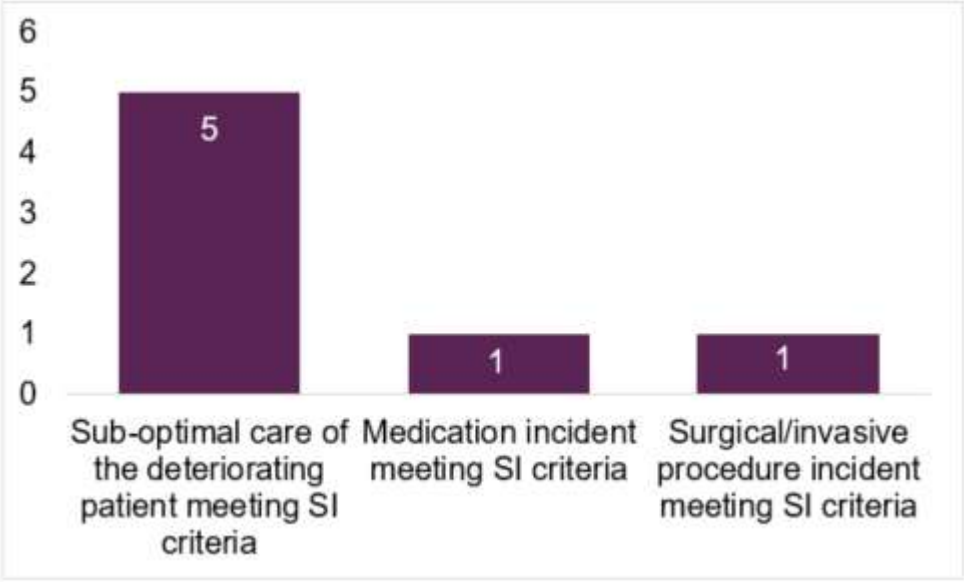
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From September 2017 to August 2018, the trust reported no incidents classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from September 2017 to August 2018, of which four were in critical care at the Royal Free hospital.

These incidents were for:

- Sub-optimal care of the deteriorating patient meeting SI criteria with five SIs.
- Medication incident meeting SI criteria with one SI.
- Surgical/invasive procedure incident meeting SI criteria with one SI.



(Source: Strategic Executive Information System (STEIS)

Learning from serious incidents was shared with staff in a variety of ways. There was a Chief Executives Bulletin and monthly staff briefings, posted on the trusts intranet, as well as

discussions at serious incident review panels and clinical performance and patient safety committees. We saw the recent incidents in ICU displayed on a noticeboard as Safety needs and incident learning (SNAIL) blog. There was also a safety lesson of the week (SLOW).

Staff gave an example of learning from a dislodged tracheostomy, which led to the production of new guidelines simulation training. New ultrasound machines had also been purchased for use before, during and after percutaneous tracheostomy to improve management of this process.

Safety thermometer

The service collected safety monitoring results but did not display the safety thermometer results to staff or patients and families.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

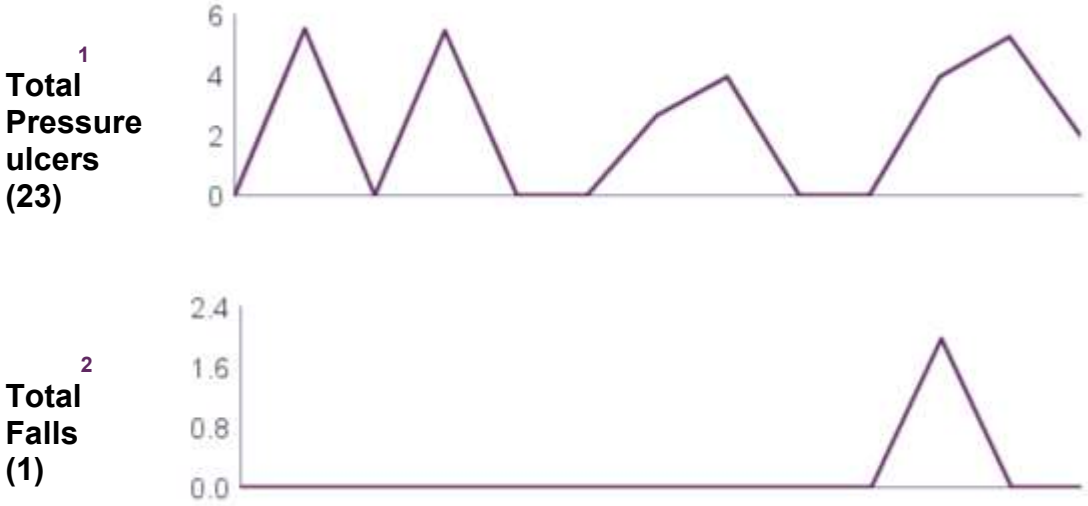
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 23 new pressure ulcers, one fall with harm and four new catheter urinary tract infections from September 2017 to September 2018. (figures for Royal Free). We reviewed data for one ITU pod (East) for October and November 2018. One patient had a new pressure ulcer, and five patients had old pressure ulcers, one of which was Category 4). There were no falls and VTE assessment compliance.

The matron said there may have been some over reporting of pressure ulcers. Most of those reported in ICU were mucosal and device related. In addition, ICU medication that constricted blood vessels increase the likelihood of ulcers.

Safety thermometer data for the unit was not on display to relatives or patients.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Royal Free London NHS Foundation Trust



Total CUTIs (4)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service had not updated all its guidelines so the most up to date information was not always readily accessible to staff. Guidelines were in a variety of different formats, many had not been through the trust approval process and were not all up to date. Progress had been slow since the concern had been identified in 2016. Only six guidelines had been revised and approved.

At our inspection in 2016 the risk register showed as a high risk that guidelines for critical care were not harmonised across the trust and most had not been recently reviewed. However, progress since this concern was identified in 2016 had been slow. Six guidelines had been reviewed at the time of the inspection, focusing on standardising the most common patient pathways. Staff said that in these key areas they were confident that best practice was followed. An example of a guideline in date was the ventilator-associated pneumonia (VAP) reduction care bundle, a grouping of five evidence-based, high-impact interventions to reduce pneumonia which is a leading cause of death among hospital-acquired infections. ICU patients were especially vulnerable to pneumonia because of immunocompromise from critical illness and mechanical compromise of normal airway protection from the ventilator.

Many of the guidelines and protocols on the shared drive had not been subject to the usual trust governance process for approving guidelines, through the Drugs and Therapeutic Committee, Clinical Practice Committee or the Clinical Audit and Effectiveness Committee. In some cases, staff used network guidelines when there was no Royal Free policy or guideline available. We found there was no trust or network guideline for admission criteria to critical care. Staff were using the North-West London Network admission criteria policy. Unapproved and out of date guidelines were still available to staff on the shared drive. The trust was aware of this and a review process had been started but was not complete at the time of the inspection

We were told a complete overhaul of all medical guidelines on ICU had started, to ensure guidelines were in line with best practice, including National Institute for Health and Care Excellence (NICE), Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS) recommendations. This was important for the safe operation of the unit.

We saw the unit used standard screening and monitoring processes. For example, staff used the Richmond Agitation-Sedation scale (RASS) to describe patients' alertness or agitation to avoid over and under-sedation. It is the first step in administering the Confusion Assessment Method in

the ICU (CAM-ICU), a tool to detect delirium in intensive care unit patients. Delirium in critically ill patients has long-term impacts on mortality, cognitive and functional status and quality of life.

An audit in 2017 which had measured the impact of education on the use of CAM-ICU showed that while training had increased the use of the screening, staff were using it for fewer than 50% of relevant patients. On this inspection staff told us they sometimes used the CAM ICU to assess delirium, but the pharmacist and occupational therapists also often worked together on managing delirium. This was in response to evidence of the value of minimising the use of drugs with the potential to trigger delirium and using orientation techniques, sensory stimulation and involving relatives. An occupational therapist was involved.

Some 90% of patients were deemed able to tolerate physiotherapy for rehabilitation and had access to this. Rehabilitation was provided four days a week by a team of physiotherapist, occupational therapist and physiotherapy assistant for 45 minutes. On the fifth day this was carried out by a therapy assistant. This was in line with NICE guidance and FICM standards. Physiotherapists also led the weaning of tracheostomy patients, as cited in the critical care guidelines, although staffing had not been increased to reflect this role. The service sought to provide all aspects of care mandated in NICE QS158: Rehabilitation after Critical illness in Adults. In 2015 rehabilitation had been audited against NICE Clinical Guideline CG83: Rehabilitation After Critical Illness and the audit concluded that more staff were needed. No more recent audit had been carried out, although the 2016 peer review report also mentioned the need for more physiotherapists.

We reviewed 10 patient records and found that expected treatment and monitoring was in place.

The critical care team followed good practice in the use of sedation in accordance with the recommendations of FICM. There was daily assessment of each sedated patient using a recognised scoring tool. Sedation was adjusted to achieve optimal levels for each patient, thereby reducing the potential for negative side effects. Patients who were assessed to be at risk of venous thromboembolism (VTE) had been prescribed and administered with VTE prophylaxis in accordance with NICE guidance. The management of critical care patients with sepsis complied with NICE QS161: ‘Sepsis’.

The unit participated in local and national benchmarking. Local benchmarking occurred through participation in the “North East and North Central London Adult Critical Care Network”. Peer review within the network service had reviewed performance against the London Quality Standards in 2016 which were mainly met. The main areas of non-compliance or partial compliance related to discharges. Patient flow was on the risk register. Not all recommended staffing levels were attained.

A local audit programme was based on the needs of the unit, on learning from incidents and results of national audits. Audit plans included audits of infection control to prevent ventilator acquired pneumonia, end of life care to improve the environment and experience of patients in end of life care, and ensure there were two senior opinions in decisions to withdraw treatment. We saw two examples of policies in response to serious incidents: a chest drains policy awareness and compliance audit and the use of defibrillators. There was evidence that changes to practice had been made after audit of NICE Guideline CG65, Prevention of hypothermia in the peri-operative phase in adult, which led to training in the use of fluid warmers.

The unit also contributed to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units across the UK.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. All patients unable to take food or drink orally were given enteral or parenteral nutritional support from the day of admission.

Patients basic nutrition and hydration needs were identified, monitored and met. We saw that nurses completed a holistic assessment of patient's needs. Staff competent in assessing patient's fluid and electrolyte needs, prescribed and administered intravenous fluids and monitored the patient experience in compliance with NICE Quality Standard 66. We observed fluid monitoring in place for patients, which demonstrated daily fluid input and output totals.

All patients unable to take food or drink orally were given enteral or parenteral nutritional support from the day of admission, as recommended in the Guidelines for the Provision of Intensive Care Services. Nutrition can be provided either through a feeding tube (enteral nutrition) or, when the digestive tract cannot be used, through an intravenous tube called a catheter that is inserted directly into the veins (parenteral nutrition). Staff confirmed they had access to dietitians on weekdays. A dietitian saw both enteral and oral feed patients within three days as recommended in the Guidelines for the Provision of Intensive Care services. Where patients needed supported nutrition naso-enteric feeding was started by the nursing and medical team as needed to ensure adequate nutrition to facilitate rehabilitation.

Regular meals, drinks and snacks were provided for patients who were able to eat and drink.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. All patients had an individualised analgesic plan appropriate to their clinical condition, in accordance with the Core Standards for Pain Management Services in the UK.

The critical care team could refer to the acute pain service when required. Out of hours, anaesthetists were available for specialist pain advice and treatment.

Staff used a standardised tool to assess patient's pain. They used, the Critical Care Pain Observation Tool (CPOT) to scale the pain of patients who were unable to report it themselves. We saw pain assessments completed regularly.

A patient we spoke with said they had pain relief when they asked for it, and nurses check on their level of pain.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared their results with those of similar services to learn from them.

At the inspection in 2016 CQC had imposed a requirement for the unit to submit data consistently to the Intensive Care National Audit and Research Centre case mix programme (ICNARC), and benchmark with other centres. This was also a GPICS requirement. The service now submitted data quarterly. The outcomes data showed that the intended outcomes for patients were achieved and were broadly in line with similar services. Consultants were aware of the results and had been responsive in investigating when results were outside the expected range. However, we did not see the service using this data as part of routine monthly review of performance.

The risk of patients dying was lower (better) than average. Hospitals submit data to compare the actual number of patient deaths with the expected number of patient deaths, based on risks that are predicted at the time of admission. This calculates a score known as the risk adjusted acute hospital mortality ratio. At the Royal Free Hospital, the risk adjusted hospital mortality ratio was 1.0 in 2016/17 and 0.8 in 2017/8 (quarterly report). This was within expected range.

(Source: Intensive Care National Audit Research Centre (ICNARC)

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
1,663 admissions	Risk-adjusted hospital mortality ratio (all patients)	1.0	1.0	1.0	none	Within expected range

The quarterly quality ICNARC report (April 2017 to March 2018) showed most patient outcomes were similar comparable units.

The risk of 'low risk' patients dying was very slightly above average. The risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.1. The quarterly report for 1 April to 30 June 2018 showed an improving trend against this measure since 2014-15.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
1,230 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	0.9	1.1	1.0	none	Within expected limits

(Source: Intensive Care National Audit Research Centre (ICNARC))

The number of patients who were readmitted to critical care within 48 hours of being discharged was lower (better) than average. These were known as 'unplanned readmissions within 48 hours' and are an indicator of ineffective care. Unplanned readmissions to critical care (1.0%) (2018/9 Q1) within 48 hours of discharge were within the expected range for the unit. Early re-admission is a national quality indicator of critical care services. Lower rates are associated with better outcomes.

Patients tended to stay longer in the ICU at the Royal Free than similar units, including those patients who did not ultimately survive. However, patients had been in hospital a similar length of time before admission and remained in hospital a similar length of time after discharge to similar units.

The unit had used electronic audit tools for documentation checks since July 2018. The audit captures data from whether patients have enough to drink through to more complex indicators such as sepsis management and care bundle compliance. These, which were used throughout the hospital, produced ward rankings

Competent staff

The service made sure staff were competent for their roles. Staff had access to specialist training and development, including simulation training and senior staff appraised staff performance.

No newly qualified nurses were accepted on the unit as the trust considered nurses needed ward experience first. Nurses who had completed a preceptorship were accepted. New nurses had an induction period and orientation. The trust ran corporate inductions weekly and the unit ran an ICU induction every month which junior nurses said was comprehensive. All nurses appointed to critical care were allocated a period of six weeks supernumerary practice until they completed a competency based assessment in critical care. This was in with the GPICS recommendations.

GPICS recommends that each unit has a dedicated clinical nurse educator responsible for coordinating the education, training and continuing professional development framework for critical care nursing staff. A Clinical Practice Education Team coordinated the education, training and continuing professional development (CPD) framework for ICU nursing staff and a doctor did this for medical staff. Training logs, in line with GPICS requirements, were held to demonstrate that staff were adequately trained and familiar with the use of equipment.

The two nurse coordinators were supported by 3 WTE band 6 nurses. Staff spoke highly of improvements the post holder had made in staff development and education. Nurses who joined the critical care team were required to complete the National Competency Framework for registered nurses in Adult Critical Care. Each competency required sign off by a senior nurse. The Introduction to Critical Care module was accredited with the University of Greenwich. This was mandatory but almost staff progressed to the Intensive Care course after eighteen months to a year. The unit had good pass rates for the training module exams – the last cohort had a 100% pass rate, and it averaged around 95%.

The GPICS recommended a minimum of 50% of registered nursing staff should hold a post registration award in critical care nursing. At the time of our inspection, 83% of nursing staff had an introduction to critical care course or an intensive care course, 7% were undertaking one of these qualifications and 9% had places on a course in January 2019. 49% of the 150 permanent nurses had taken the intensive care course.

There were in-house band 6 development courses and offer opportunities to advance interest in specialist areas, including leadership courses. Within the band 6 programme all staff undertook Immediate Life Support (ILS) with an aim to prepare them to undertake ALS once they had completed the programme. Any staff who had previously completed an ALS could recertify without undertaking ILS.

Additional courses and study days were available, for example on continuous renal replacement therapies (CRRT) which are dialysis treatments provided as a continuous 24 hour a day therapy, non-invasive ventilation, nasogastric tube insertion and respiratory failure and oxygen therapy. There was considerable emphasis on training for insertion of nasogastric tubes following an incident.

Bank and agency staff were also inducted to the unit. Agency staff were only employed if they passed a competency assessment including a drug competency assessment. A health care assistant we spoke to confirmed they had received appropriate training for tasks they were allocated. They confirmed they received support from nurses and other senior staff when required. Regular bank staff attended cluster education days along with permanent staff and were also offered training and education to ensure they were compliant with mandatory training.

Staff confirmed they had received adequate training to carry out their role including training in the use of equipment.

Medical staff received an orientation and induction programme following their employment. Doctors confirmed they were well inducted and had the opportunity to meet key people at that time. They had allocated time for training and felt cared for by senior staff. They were enthusiastic about the training programme on site which was recognised by intercollegiate board for all levels of training. There was learning through ward rounds with bedside teaching; opportunities to manage patients after complex surgery as well as consultant led teaching and a journal club. They said they had “Incredible support” from some consultants, and felt “Really valued and well looked after”.

From April to September 2018 critical care nursing staff at the Royal Free hospital had a 71.5% completion rate for appraisals and medical staff had a 91.7% completion rate.

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/No
Medical	12	11	85%	91.7%	Yes
Nursing Registered	130	93	85%	71.5%	No
Healthcare Assistants	11	4	85%	36.4%	No
Total	153	108	85%	70.6%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

On inspection we found the appraisal rate had improved to 91% for nursing staff. Staff told us that learning needs were identified during appraisals and gave us examples where they were

Medical and nursing staff we spoke with across all levels told us that additional training opportunities were good. There was simulation training for pathways for major haemorrhage, syringe drivers, tracheostomy, CPAP continuous positive airway pressure and BIPAP Bilevel Positive Airway Pressure.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other professionals such as physiotherapists, dietitians and occupational therapists all contributed to patient care.

On admission to the Intensive Care unit, all patients had a treatment plan that was discussed with the consultant in intensive care medicine, as recommended in the GIPCS 2015. Early in the patient’s stay, the team assessed the patient’s risk of developing physical and non-physical morbidity, as recommended in NICE CG158: Rehabilitation after Critical Illness in adults (2017).

The team worked with specialist renal, liver and vascular consultants. Where made they made appropriate referrals to other teams such as the palliative care team.

The team worked collaboratively with the specialist nurse for organ donation who was employed by NHS Blood and Transplant. Wherever possible, the critical care team referred patients to the organ donation team one day prior to treatment withdrawal to allow notice for the specialist nurse to prepare. A donor had to be matched within 24 hours. Consultations were taking place which could result in a significant increase in liver and kidney transplants at the hospital potentially doubling the number of kidney transplants. This would have implications for theatres and ICU.

Staff reported good working relationships with other teams and we observed good rapport. Consultant led ward rounds had daily input from a multidisciplinary team in line with GPICS

recommendations. A member of the therapy team attended morning handover Monday to Friday to relay respiratory and rehabilitation plans to the medical team. Therapists were co-located so could share information when a therapist could not attend a round. The unit had daily microbiology input from Monday to Friday, and telephone support was available at the weekend. Pharmacists worked closely with nursing and medical staff and reviewed each patient's medication daily to ensure they were suitable and within prescribing guidelines.

Our review of patient records showed input from physiotherapist, pharmacists, dieticians and speech and language therapist (SALT) staff. Nurses said consultants and doctors on their ward rounds asked their views about their concerns about their patient that day. We observed a systematic approach to ward rounds.

A multidisciplinary team of nurses, physiotherapists and SALT staff were also involved in the weaning plan for patients.

The service was part of the North East and North Central Adult Critical Care Network which provided opportunities to share practice and learning with other hospitals.

The GPICS standard recommends a minimum dietetic staffing level of 0.05 WTE per level 2 and 3 beds. Dietetic cover consisted of 1.5 WTE dietitian which met the standard.

The GPICS standard recommends there should be an identifiable lead occupational therapist with appropriate experience, who will be accountable for the service provision and development. The standard recommends a ratio of 0.22 WTE occupational therapists per critical care bed. There was one occupational therapist.

There were weekly multidisciplinary review meetings for long stay patients (over 14 days).

The ICU attended a planning meeting with the HPB and vascular team to review planned surgical cases where there was likely to be a need for critical care.

Patients with a tracheostomy had a swallow and communication needs assessment once tracheotomised.

There was a dedicated senior physiotherapist for ICU. GPICS Guidelines stipulate a physiotherapist with weaning skills for ICU physiotherapy teams. Weaning was considered for all patients at day 3 of tracheostomy formation and less than PSV16 ventilation support. A formal MDT round was undertaken twice a week, with ad hoc reviews as required. There was a weekly ventilator and tracheostomy weaning round.

There was no dedicated psychological support service for the ICU. The National Institute of Health and Clinical Excellence (NICE) state that depression is approximately two to three times more common in patients with a chronic physical health problem, and treating depression in people with a chronic physical health problem has the potential to increase their quality of life and life expectancy (NICE, Clinical Guideline 91: Depression in adults with a chronical physical health problem). Staff told us they could access a psychologist for patients needing this support from the main care teams, for example liver and renal teams.

Seven-day services

There was consultant level cover on site or on call at all times, although the ratio of consultant to patient did not meet national standards out of hours and at weekends. Most services were available seven days a week and out of hours

Most services were delivered seven days a week as mandated in NHS Services Seven Days a Week Clinical Standards. However, there were some areas of reduced capacity.

Medical and nursing staff provided cover 24 hours a day, seven days a week. Consultant cover was available seven days a week, including on call outside normal working hours. A consultant was on call specifically for this service could attend within 30 minutes

The PAART team was available 24-hours a day, seven days a week.

The pharmacy team provided cover from 9am to 5.30pm Monday to Friday. The hospital pharmacy was open from 9.20am-6.30pm. On weekends the pharmacy provided inpatient supply 10am-5.00pm and bank holidays from 10am to 1pm. An on-call service was available out of hours.

Other members of the multidisciplinary team were available with reduced level of service. For example, physiotherapy was available for respiratory patients only, not for rehabilitation.

The team could access psychiatric support for relevant patients.

Speech and language therapists provided cover during the week from Monday to Friday. If a patient was not swallowing properly at the weekend staff would keep them 'nil by mouth' and provide enteral feeding.

A consultant confirmed there was seven-day access to diagnostic services such as x-ray and computerised tomography (CT). Consultant-directed diagnostic tests and completed reporting was also available seven days a week.

Health promotion

Although staff told patients about organisations that could support them and help them to manage their own health and wellbeing, there was little written information to support patient and relatives

Health promotion is the process of enabling people to increase control over, and to improve, their health (World Health Organisation, 2018). Physiotherapy staff assisted with patient rehabilitation. and sought to ensure health promotion was embedded into patient care from admission and beyond discharge from the ICU, particularly about mobility.

We had noted at the inspection in 2016 that there was limited written information for patients and relatives. This was still the case.

Staff told us they encouraged patients to bring their relatives or those close to them to unit, as the service focused on the patient and family, and such relatives support was fundamental in terms of health improvement and stopping people coming back into hospital. However, doctors said health promotion had not been high on the agenda, as was evident from the lack of a follow up clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent and documented this.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Training records showed 100% of nursing staff and 90% of medical staff had completed training on the MCA and consent.

The sample of patient records we reviewed demonstrated consent for treatment was completed. Patients told us staff explained treatment and care and sought their consent before proceeding. Patients gave their consent whenever possible. Staff acted in the best interests of patients who were not able to make their own decisions due to a lack of mental capacity at that time. We saw that staff recorded best interest decisions in the patients' medical notes. The mental capacity of patients on the unit frequently varied from shift to shift dependent upon their health status.

We found restraint forms and “Do Not Attempt Cardiopulmonary Resuscitation” (DNA CPR) forms were appropriately completed where required.

We reviewed the healthcare records of ten patients admitted to ICU during our inspection. We found that these staff had had completed mental capacity assessments for these patients where their capacity was in doubt.

Staff understood the requirement for deprivation of liberty safeguards (DOLS). One long stay patent was subject to DOLS.

The trust reported that from April 2018 to August 2018 Mental Capacity Act (MCA) training and deprivation of liberty (DOLS) training was completed by 94% of nurses in critical care and 77% of doctors compared to the trust target of 85%. (Source: *Routine Provider Information Request (RPIR) – Training tab)*

Is the service caring?

Compassionate care

Staff cared for patients with compassion. All the observations of care we made were positive. Staff were welcoming and showed kind and compassionate care. They were courteous and professional towards patients and their friends and families.

Staff protected the privacy and dignity of patients. We saw that consultants checked before entering patients bed spaces when curtains were drawn. Staff ensured that curtains were drawn before completing care tasks. Nurses switched glass to opaque in side rooms when personal care or clinical review took place. Staff voices were kept low during ward rounds.

Patients and those close to them told us that staff were caring. One relative of a patient told us “The care is first class, amazing”. Another patient told us, “The staff are brilliant here.” A relative of a patient who had been in the unit several times said, “Each time they have good care”

Some other relatives would have liked more continuity of care for their family member “Had five different nurses in three days”.

At the inspection in 2016 we had noted there was limited effort to seek feedback from patients and families. On this inspection we saw an example of a Friends and Family survey on ICU, dated 20 November 2018. This appeared to be a new initiative started by one of the consultants. Paper forms were in the relatives’ rooms and waiting room and we were told nurses could complete results on the computers at the bedside. There were 35 responses although no indication of the response rate. 63% of comments were from relatives and the remainder from patients. 63% of respondents thought doctors responded to all their concerns and 88% thought nurses did this. 97% of respondents rated the care excellent. There were some very positive comments “Responsiveness, information and friendliness are fantastic”, “Care and support is excellent”, but some respondents said they would like clearer communication, for example about the effect of drugs and one respondent mentioned the night team not having sufficient handover information.

Although the results of this survey were on display to staff, one staff member told us that staff did not routinely collect information from ITU patients. The survey results were not on display to relatives.

Staff understood and respected people’s personal, cultural, social and religious needs and took these into account when planning and delivering care. We saw this in initial assessments where these issues were considered.

Emotional support

Staff provided emotional support to patients to minimise their distress. Patients and relatives felt supported by the team. They told us that doctors and nurses had listened to their worries and understood the anxiety patients and their families experienced in critical care.

We saw a consultant helped a relative to feel more at ease with a difficult decision by sensitively explaining the options available.

We saw that when patients or their carers were told bad news, and sought to give reassurance and comfort. There was a quiet room to share bad news with relatives. However, one relative mention the lack of private places for grieving relatives and had witnessed “Very distressed relatives in the waiting room after the death of a patient”.

Staff understood the impact that experience in critical care had on patients ‘wellbeing and on those close to them. They encouraged families to visit and where possible support their relatives. We saw evidence that patients’ emotional needs were discussed in multidisciplinary meetings and plans for appropriate management and treatment plans were actioned. However, the unit did not have its own psychology input.

A Chaplaincy-Spiritual Care Team offered support to all patients, staff, families, friends/carers, visitors and volunteers of any faith, belief or philosophy of life. We encourage compassionate, non-judgemental care, respectful of diversity. They offered one to one spiritual and religious support in response to an individual’s needs. The team included an Imam, female Muslim chaplain, Rabbi, Roman Catholic priest, Anglican priest and several volunteers from other faith/belief backgrounds. (Humanist, Buddhist, Sikh). They offered end of life care and support and were regularly called to dying patients. They also provided space for people to practice their faith in hospital. (Chapel, Muslim Prayer Room, Shabbat Room). There was weekly programme of mindfulness, meditation, Holy Communion, Jummah prayers and a space for quiet and reflection

The hospital had a dedicated Bereavement Service to facilitate the administrative management of all in-patient deaths and provide bereavement support. We were told a new Bereavement booklet was in the final draft stage to support families and friends as well as staff. ICU had their own Medical Certificate of Cause of Death book (with visual guide) and Bereavement wallets for families and friends so that certificates could be swiftly completed to expedite services for families when needed.

The team did not have enough staff to offer critical care follow up clinics, nor was there dedicated psychology input to the unit. This meant service did not comply with GICPS guidelines in relation to providing. assessment of patient’s needs (including psychological needs) a few months after discharge or ongoing support. While many patients make a good recovery following critical illness, a number experience ongoing problem, both physical and psychological which can affect employment and return to work, school or study, finance and income, personal relationships and social interactions. In a few cases, patients (and their relatives) can have extreme symptoms of stress after ICU treatment. This is known as post-traumatic stress disorder (PTSD). Staff said they met with families and patients after discharge, at their request. The absence of this service had been raised at the network peer review in 2016 but no action had been taken to progress this.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. The critical care team kept patients and relatives informed about the treatment plans. They told us that staff communicated well with them to ensure they understood care, treatment and condition.

We heard doctors describing and explaining the risks of treatment to relatives using plain English. Doctors answered questions with sensitivity. Nurses helped patients to understand their condition in an empathetic way.

We heard nurses helping patients to understand what had happened to them, orientating patients to their surroundings, reassuring them they were being cared for and their loved ones were safe. A relative said “the nurses are very nice, kind and attentive, and explain everything very well’.

Staff told us that the service did not routinely use patient diaries for level three patients. Patient diaries provide a daily record of each day’s event whilst a patient is in intensive care. Diaries can support patients with a better understanding of what has happened to them in critical care, help them set realistic goals for recovery and minimise the risk of adverse long-term problems (National Institute of Clinical Excellence (2009) Rehabilitation after Critical Illness).

We saw evidence that the MDT carefully considered the needs of family members when discussing the limitations of available treatment for individual patients. For example, the team ensured that care was continued to allow time for family members to come to terms with the news.

The team followed best practice and involved the specialist nurse for organ donation when they approached families about organ donation when treatment was being withdrawn. These nurses would support families when their relative had been identified as dying and suitable for organ donation. The unit had achieved the Gold standard in the Potential Donor Audit (PDA).

Is the service responsive?

Service delivery to meet the needs of local people

Some of the facilities for patient’s relatives were not welcoming. There was limited written information about hospital services, ICU performance or about issues such as sedation and delirium. There were no follow up clinics for patients after they were discharged, even though many patients spent longer than average in ICU. The lack of written information had been a concern at the previous inspection.

There were some local patients but many others were referred to the hospital as a tertiary centre for patients with liver or kidney disease or vascular problems. These patients often required critical care. All the critical care beds had the same equipment so could be ‘flexed’ so that patients received the correct type and level of care.

At the inspection in 2016 we had mentioned the paucity of information for relatives. On this inspection we saw a generic booklet (by ICU Steps) about critical care which was useful but lengthy and only in English. We saw a draft of a shorter information leaflet specifically about this unit with information about travel to the hospital, shops within the hospital, support from the chaplaincy and critical care team, visiting, infection control and some aspects of care. However, this was not in use at the time of the inspection. There was no information about support groups that patients and their relatives might want to use, such as the stroke association. The leaflets were not readily available in large font and did not meet the Accessible Information Standard. However, the complaints procedure leaflet could be requested in other formats.

In the very bare relatives’ waiting room there was a wall mounted interactive touch screen for relatives to find out information about the unit. We did not see anyone use this and, and some relatives might not be confident in using a touch screen, or doing so in front of other relatives. On the third day of inspection it was out of order. There was little other information on notice boards in the waiting area.

There was no accommodation for relatives but there were discounted rates at local hotels. In extreme circumstances, there were some reclining chairs in a communal relatives' room where a relative could sleep. This also had other different types of seating, and facilities to make hot drinks and microwave meals, and a dining table. During our inspection, at mid-morning a relative was sleeping in the room which meant the other seven people using the room were sitting in a rather dark space and clearly felt in inhibited from speaking to avoid waking the person. This was not a good experience for family members. At the same time, the dining table was blocked by a maintenance ladder, so relatives could not sit round a table. Relatives told us that this room was not a suitable environment when a person was emotional or distressed.

When the waiting room reception was not staffed, before 9.30am and after 5pm and at weekends, there were instructions for relatives on the entrance to critical care on how to telephone the unit. The wording on how to do this was not clear and would be hard for a non-English speaker to follow. The handset drew attention to emergency numbers such as 2222 and we felt there was a risk that a visitor might ring this number in error.

Patients who could eat and drink could choose their meals from a selection of menus. These included vegan, gluten-free, kosher and halal choices. Different textured food was also available

Visiting hours for the ICU were between 12pm to 8.00pm, seven days a week however; staff told us that these hours were flexible dependent on people's needs. If a patient was very sick then visiting hours would be "open". We saw a relative be allowed in to the unit outside of these hours due to personal circumstances. Several relatives mentioned the slowness of the lifts to reach the fourth floor.

Although there were facilities within the hospital where relatives could purchase food and drink, there were limited facilities within ICU, and no information in the waiting room about where in the hospital to purchase food.

There were two accessible toilets for visitors.

Interview rooms, used to have discussions with patients' families including giving bad news were very basic with no windows and no pictures. There were no tables for people to have a drink, or write notes, and some of the paint was peeling (south interview room).

Meeting people's individual needs

The service took account of patients' individual needs. Many patients had complex needs and staff were experienced in managing these needs and had a range of techniques to do this. Staff had access to communication aids and translators when needed, giving patient the opportunity to make decision about their care, and day to day tasks.

We were told that staff were accustomed to working with patients with mental health issues, learning disability or cognitive impairment. They would work with the appropriate team on this, taking extra care to meet the needs of these patients.

Translation services were available for patients whose first language was not English, both by telephone and face to face. The team were sometimes able to match patients with nurses who could speak their language. We did not see notices advertising translation services in public areas, nor did we see information about how to obtain Next Steps in other languages. This guide for patients and relatives is produced by a charity, and is available in 15 languages. Copies in English were on the unit. Nor did we see notices informing people about advocacy service available to patients and those close to them.

Staff used augmentative and alternative communication aids with tracheostomy and ventilator patients, ranging from "low tech" Alphabet charts to “high tech” means, using the blink of an eye from the patient or swallowing and speaking valves or above cuff vocalisation. The trust also offered British Sign Language interpreters, lip speakers and touch sign interpreters. 96% of all interpretation and translation requests were met in the last financial year.

The hospital did not meet the standard for requiring consultant-led communication to be supplemented with written information for patients.

There were no mixed sex breaches on the ICU. A mixed sex breach occurs when level one patients are placed on an open ward area with a member of the opposite sex. Mixed sex breaches should occur infrequently on critical care units, as patients are stepped down to a ward once they reach level one dependency. Staff told us there were no patients on ventilators in wards.

Patients who could eat were provided with menus with a range of options including allergy free, vegetarian, gluten free, softer choices and kosher. Yoghurts and other snacks were also available.

Access and flow

Most people could access the service when they needed it although a few patients awaiting surgery had their operations delayed, to ensure a critical care bed was available post operatively. There had been improvements in the number of patients who had to wait more than four hours for discharge to a hospital bed or who were discharged out of hours when compared to the previous inspection.

About four admissions a day were from planned surgery. There was a weekly planning meeting with ITU, Anaesthesia, Operations managers, and clinicians to agree priority order for all booked patients for the following week.to review the anticipated critical care needs of these patients to enable bed planning. There were some emergency admissions each day. The policy was to ensure one empty ICU bed 95% of the time. There was a flow chart for staff to follow when a bed for a critically ill patient was required. The hospital policy of acceptance of all liver failure cases impacted on other planned surgery and pressure on the finite ICU resources.

Patients should be admitted within four hours of the decision to admit being made. Data provided by the trust from an audit of referral, acceptance and admission showed not all patients were admitted within four hours of referral, although 83% were admitted in less than four hours after acceptance by ICU clinicians.

Managers told us that the recovery area in main theatres was available and staffed as necessary, for critical care patients if ICU capacity was reached. Patients could be cared for by an anaesthetist and recovery nurse in recovery overnight at times.

Adult critical care bed occupancy rates are shown below trust as a whole

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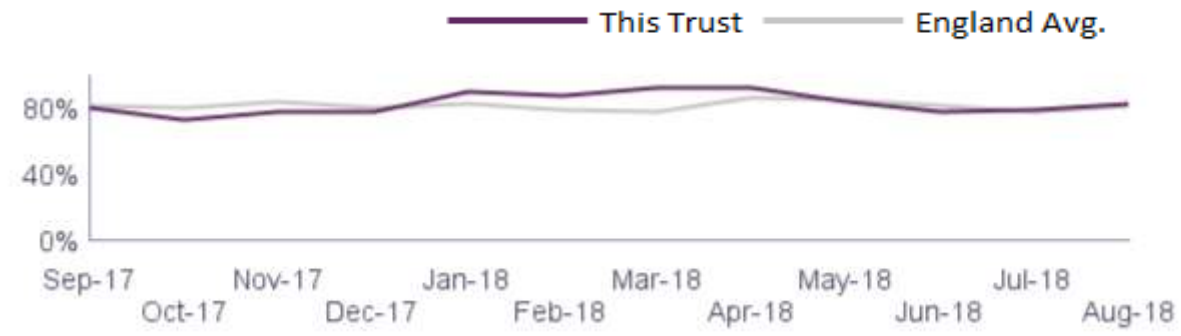


Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at

midnight on the last Thursday of each month. (over 100% in 2016).
(Source: NHS England)

Between January and 18 November 2018 49 elective operations were cancelled on the day because there were no ICU beds, including two cancellations in September 2018 because there were not enough ICU staff. Overall there were 73 cancelled operations because of the lack of ICU beds in this period. In five cases in the past year the ICU was unable to accept patients because they had been unable to discharge patients to the ward. Staff told us that the priority for beds in the hospital was to avoid 12-hour breaches for emergency patients, which would override a discharge from ITU if there was only one bed. (worse than 2016 inspection)

The unit did not comply with GICPS standards for discharge from intensive care to a general ward, which should occur within 4 hours of the decision, nor with the requirement that discharges should occur between 07:00hrs and 21:59 hours. There was a four-hour discharge CQUIN, but staff said they were unlikely to meet this. The reason for the time objective was because out of hours discharge of patients who were fit to be discharged earlier in the day, was shown to increase hospital mortality. Staff told us there were difficulties discharging patients from the critical care unit due to a lack of bed availability in the rest of the hospital.

Sometimes patients had to wait longer than expected to be discharged from the unit. These were known as ‘delayed discharges’ and were counted in ‘bed days’. At the Royal Free Hospital, there were 12,410 available ICU bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 3.2%. This compares to the national average of 4.9% for all units. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 2.3%. 226 delayed patients in 12 months to December 2018. This was considerably better than in the 2016 inspection when there were 411.

Actions had been taken to improve discharge including recording the time of decision that a patient was ready to leave. The nurse then had to complete all essential tasks before the patient was ready to transfer. Staff said there was a lot to complete before transfer to the ward and the need for MDT involvement could cause delays, as could porter availability.

Bed management meetings took place daily to identify potential capacity issues in the hospital and facilitate patient flow across the hospital. From September 2018 to August 2018, Royal Free London NHS Foundation Trust had adult bed occupancy about the same as the England average.

Doctors told us discharge delays were a result of the hospital operating at full capacity, as well as the complexities of some discharges for social reasons and because comorbidities. There were not enough ward beds. The team had identified that most of delayed discharges were short stay surgical patients and therefore included creating a surgical HDU in their strategy.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
12,410 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	2.3%	3.2%	4.9%	0%	Not in the worst 5% of units

(Source: Intensive Care National Audit Research Centre (ICNARC))

Sometimes patients were transferred to another unit and the reason was not related to the treatment they needed. These transfers were known as 'non-clinical transfers to another unit'. Of the 1,787 admissions, 0.5% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 0.9%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
1,787 admissions	Crude non-clinical transfers	0.9%	0.5%	0.4%	0%	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

Sometimes patients were discharged to the ward outside of normal working hours, between 10:00pm and 6:59am, and the reason was not due to a delay in the discharge process. These are known as non-delayed out-of-hours discharges to the ward. 2.3% of admissions were non-delayed, out-of-hours discharges to the ward which was within expected range. The figure in the 2015/16 annual report was 1.8%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
1,462 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	1.8%	2.3%	1.9%	0%	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

The service would be opening a new HDU at the Royal Free site early in 2019, initially four beds but ultimately eight beds.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, although complaints were not always completed within the recommended time.

Relatives we spoke with were aware of how to raise concerns. Staff told us they tried to resolve complaints before they became formalised.

From September 2017 to August 2018, there were seven complaints about critical care. The trust took an average of 40 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 35 working days. On inspection we found that the average response time for the last two cases was 49 working days (43 and 56) against a trust target of 35 working days which showed a decline in performance. As

there were few written complaints received it is not clear why even complex cases such as the two most recent cases we reviewed should receive a timely response

From September 2017 to August 2018 there were 10 compliments within critical care. Seven compliments were about Royal Free Hospital.

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

We were told that complaints and compliments were discussed at monthly meetings, although we did not see minutes where complaints were discussed.

Is the service well-led?

Leadership

Staff said the matrons and consultants in the unit were visible and approachable. However, there were nursing vacancies at band 6 and band 7 and some junior staff told us not all nurse coordinators were supportive leaders and that leaders in the wider division were not visible to many ICU staff. Bank nurses felt unsupported by the wider trust.

The critical care service had been part of the hospital surgical and associated division (SAS) since July 2017. The leadership team had been in post for just over a year. The division was headed by a divisional clinical director, a divisional director of operations and director of nursing, covering five groups of services. A clinical director maintained oversight of anaesthetics, theatres and critical care.

The ICU had a clinical and operational lead for the ICU. Within the ICU an allocated consultant led each pod during the day. Trainee doctors and clinical fellows told us they received good leadership and support from consultants.

A divisional director of nursing oversaw nursing care. Two matrons shared responsibility for the nursing elements of the ICU. A nurse in charge was on duty 24 hours a day, who was generally supernumerary, as recommended in the Guidelines for the Provision of Intensive Care services (GPICS) 2015.

The matrons were visible on the unit, and tried to work clinically every other Friday morning. Staff told us they respected the matrons and felt supported by them. However junior nurses reported that they did not get enough support in caring for very sick patients from some of the unit coordinators which left them feeling vulnerable.

Staff in the wider critical care team said they saw little of the divisional director of surgery and associated services or trust-wide executive leaders. There was a feeling that decisions that impacted on ICU were made outside the division.

Some ITU staff said trust leadership seemed distant and did not always appreciate clinical needs or the need to adhere to the Faculty of Intensive Care Medicine Core Standards.

Vision and strategy

The ICU had a written plan for one year and for three years, but in speaking with senior staff about strategy we found a range of views about priorities. There was no funded plan to achieve the changes.

There was no formalised vision and strategy for the critical care service trust wide as the decision had been taken that the differences between the services provided on different sites were too great for this to make sense.

There were different views among consultants about the vision and strategy for the unit. Some of the changes were driven by trust policy for developing complex elective surgery on the RFH site which was likely to include an expansion of the ICU bed base to accommodate complex surgery and transplantation. The service was developing departmental and senior staff meetings to discuss and develop future strategies and developments in ICU.

Staff told us the emphasis on retaining nursing and medical staff would continue. Over the next three years staff planned to further develop in-house accredited post graduate nursing courses incorporating a High Dependency Course for the unit opening in 2019. They planned to develop the ANCCP role, appoint a clinical psychologist within the ICU for patient's families and staff, set up a critical care outpatient clinic to support patient's families and others who have experienced ICU, develop a more robust weaning and rehabilitation programme, and develop of clinical technicians' role. It was not clear whether funding was available to fulfil this vision.

Culture

Managers in the ICU had sought to promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The department engaged more effectively with its own staff than at the previous inspection.

At the previous inspection in July 2017 CQC found areas of persistent disagreement within the service at all levels which was not being addressed by senior management. The trust had worked with NHS Elect to deliver a listening and engagement exercise with staff groups in ICU aiming to build consensus on the aspirations, goals and ambitions for the unit. We were told progress continued to be monitored by the Royal Free Hospital Executive Committee. Conflict management training had been held for the senior team and managers maintained there was an improved working relationship between nursing and medical staff.

Staff told us that the culture of the service internally had improved since new management had taken over. The quality improvement project had led to changes that nurses appreciated such as self-rostering and flexibility for staff who had family commitments, as well as focus groups for staff, stopping recruiting newly qualified nurses, attaching regular bank staff to nursing teams, and a fortnightly coffee catch up to raise ideas for improvement. There remained challenges in retention of nurses and a shortage of Band 6 staff and consultants.

The trust had produced a set of values for staff. Staff were familiar with these: positively welcoming, actively respectful, clearly communicating, visibly reassuring which were displayed on notices throughout the service. ICU staff demonstrated these values in their interaction with patients.

Several staff members praised the practice development nurse (PDN) for significant improvements made to learning and development in the past year, although the number of new nurses taken on meant there was competition for developmental courses. They reported a lack of support for development from their immediate seniors. Junior nurses said teamwork with their peers was good but they lacked support from their line managers. The large number of side rooms meant many

nurses felt isolated working in these rooms and did not always get guidance and support from seniors.

Junior nurses considered teamwork with their peers was good but that they lacked support from their line managers. There was residual dissatisfaction that breaks were not paid, and that staff did not always get breaks following a trust change of policy over a year before the inspection.

Support for staff was through Schwartz rounds (a recent one was on ICU and renal care) multi-disciplinary hospital wide forum that meets once a month to discuss the impact of clinical work on those who have provided it, and through the consultant psychologist from the Health and Work Centre. There were debriefs for serious cases and staff said, “The ICU staff look after each other”.

Bank staff felt the trust did not fully realise the extent to which bank staff provided much of the experienced input to ICU, although they acknowledged support from matrons. The trust had not invited bank staff to meet CQC during the inspection, despite relying heavily on these staff to fill shifts. Trust proposals to reduce their pay had caused unrest and was likely to increase staff shortages. The matrons were seeking to ensure the quality of agency staff by reviewing their skills and testing the medicine competencies.

Staff said the entire multidisciplinary team (MDT) worked well together. Junior doctors were pleased with their training and opportunities to develop their skills. There had been a positive GMC survey.

Permanent staff we spoke with proud of the service provided on the critical care unit. Bank staff felt they provided a good service but that their experience and contribution was not recognised at trust level. They told us senior management had not invited them to focus groups related to the inspection. The trust had recently announced, with limited notice, a change to the rate of pay for bank staff at night and weekends. We noted this was having an impact on ICU staffing.

Governance

The ICU was a small part of one subdivision of the large SAS division, which was dominated by surgery and as a result did not figure much in divisional discussions. Although some senior staff said they had a voice at division and trust level, many staff spoken with did not feel part of the wider division.

Critical care was part of the surgical and associated services division and within that, part of the sub group covering anaesthetics, theatres, pre-op and critical care. We were told divisions held monthly business meetings, but meetings were mainly about surgical areas. Many patients from ICU came from the specialist surgical services of the trust, dominated by liver transplant and most transplant patients were booked for ICU. Transplant was in a different division. Many patients were medical patients, which again was a different division

Staff were not well engaged in the governance agenda and we did not see plans to increase staff engagement in the governance process There was a monthly meeting of the critical care nursing team where minutes were taken. Consultants met fortnightly and recorded key points in an email to consultants. It was unclear how the leadership team evaluated the service, reviewed the audit programme, designed standard operating procedures and considered new service developments.

A divisional board for the SAS division met monthly. We looked at the latest available minutes from the SAS divisional board meeting which recorded very brief details of discussion and did not have a detailed focus on risk management and quality of care provided. There was a quarterly quality and safety board for the division.

The lack of formalised strategy for the ICU meant we were unable to fully determine if this governance framework was effective to support the delivery of ICU objectives. The ICU seemed to be firefighting to address historic problems to do with staffing and equipment management.

Operational meetings were held by the matrons for critical care. Some other meetings did not follow a regular schedule. One consultant said although M&M meetings should be held monthly to meet GPCIS standards, meetings were often less frequent.

The service operated a local and national audit programme discussed under the effective domain in this report.

Management of risk, issues and performance

The department did not have effective systems for identifying risks or for planning to eliminate or reduce them. The risk register was not up to date and some risks had been on the register a long time. It did not include all risks staff told us about, or have comprehensive mitigation plans for the risks identified.

There was a weekly local Risk and Review Meeting for ICU usually attended by the matron, clinical lead, risk Governance Lead and a clinician (although there was no clinician at the meeting we attended.)

The ICU risk register was not up to date. GPICS requires that a risk register must be regularly updated and acted on. Six of the nine risks on the current risk register had been on the risk register since 2016 or before. Three of the risks identified in 2016 remained high risk, the lack of a clinical information system in ICU nurses, governance and maintenance of ICU guidelines and the impact on patient flow on ICU capacity. Risks added since then were the lack of ICU technicians, the difficulty recruiting specialist nurses, lack of ICU technicians, lack of continuity of management and administrative support, and changes to critical care bank rates, all of which were rated high risk. The patient flow and staffing risk were not considered to have adequate mitigations and the governance and maintenance of ICU guidelines was rated ‘uncontrolled’. The risk register did not show the projected date for resolution of the risk and mitigations were not updated regularly. The last review date for all except the risk added in October 2018 (critical care bank rates) was April 2018. We saw no formal action plan for managing each of these risks. The risk register did not appear to be addressed in the monthly divisional board meeting except for an exhortation to staff to review the 58 open risks for the division.

The system for risk identification and management in what was inherently a high-risk service was not robust. The risk of the lack of an electronic clinical information system in ITU had been on the risk register since 2012. A system had been trialled in 2016 but abandoned as being not fit for purpose. Staff at all levels were unclear about the plan for an electronic system which seemed to be outside the control of the unit.

Some of the risks of the risk register were not well articulated. More significant than ‘lack of ICU technicians’ was the delayed planned preventive maintenance of medium and high-risk equipment in the unit, slow recognition of the need to replace ventilators and monitors and the absence of a capital replacement programme. The latter was a GPICS requirement

Not all risks affecting the delivery of safe care were identified and mitigated effectively. Staff mentioned other risks which were not on the risk register. Some of these had been raised in other meetings, for example risks to the admission of patients for planned surgery because of long stays from private patients, and longer stays for some NHS patients because the priority for rehabilitation was on complex patients and on private patients. There was also the risk of

insufficient permanent staff. Staff considered all these were risks both to patients, and to the hospital's reputation as a provider of world class care.

The trust decision to cut bank rates with limited notice, shortly before winter pressures was a significant risk and staff in the ICU had the perception that they were not appropriately consulted about the probable impact. We found there had been 10 cancellations for one shift at the time of the inspection. Continuing unrest among bank staff risked undoing progress made in relation to retaining staff and integrating regular bank staff into teams. Over time it could lead to more bed closures.

The usual governance process for approving guidelines in the Trust was though the Drugs and Therapeutic Committee, Clinical Practice Committee or the Clinical Audit and Effectiveness Committee; many of the guidelines and protocols on the shared drive had not been subject to this governance process. We saw guidelines written in different formats, and without review dates. We were told there was a six-month project to review all guidelines and put them in standard format, and have a formal approval process. Six guidelines had been reviewed so far, and the trust told us after the inspection that the work was on track for completion within six months.

Information management

The trust did not use an electronic system for much of the data in ICU, and the primary records were paper-based. Staff in ICU accepted the need for greater use of IT, but did not feel involved in the trust's strategy to support an IT solution for ICU by 2020 as part of the hospital-wide digital strategy. The absence of an electronic record in ICU limited scope for data analysis.

Staff said they felt the paper records generated for each patient in ICU were comprehensive and enable safe patient care. Staff said algorithms were in clinical areas, such as on emergency trolleys. Six nurses told us the format of the observation sheet was helpful in ensuring no aspect of patient care was omitted.

The absence of a comprehensive single patient electronic record in ICU limited scope for data analysis. However, staff were clear that any new electronic system had to meet the needs of an ICU, and hoped to avoid a repeat of the past failed introduction of an electronic record.

When patients were discharged from the ICU, staff were seen to give a thorough handover to the ward with the patient's healthcare records in a format that the wards used.

Several complementary systems provided patient information, including an electronic patient record (EPR) electronic document management (EDM), a laboratory information system (LIMS), Picture Archiving Communication System (PACS), ICNARC and the Critical Care Minimum Data Set (CCMDS). Staff showed demonstrated they could access these IT systems for patient's and results as authorised. While the manual entry of data into patient records exposed the Trust to risks, as well as inefficiencies, we found no recording errors in our review of records. However, the IT department IT had to maintain a complex matrix of access controls to the various electronic systems.

We were told that most historical medical records had been scanned into the OpenText Electronic Document Record Management (EDRM) System, but all records relating to a patient's stay in ICU were paper.

Engagement

Although the department now engaged more effectively with its own staff, there was limited evidence of engagement with the public and local organisations to plan and manage the

service. The Joy of Work project had improved staff retention through enabling self-rostering, employing more clinical practice educators and introducing a newsletter and a bi -weekly coffee catch up to improve information flows.

Staff said managers shared more information than in the past, but it was also clear some clinicians felt distant from trust decision-making and somewhat disengaged as a result. The ICU voice, a newsletter started in December 2017 was a communication tool for the unit. Some information about the unit's performance was displayed on office noticeboards, including information about top risks, incidents and staff training.

Staff told us they participated in staff surveys, and in early December focus groups had been run to take a temperature check of how staff felt about working on the unit, following up focus groups run in 2017. The results were not available at the time of the inspection. The unit promoted Freedom to Speak up trust wide and the matron on the unit was a Freedom to Speak up Guardian.

Managers said staff surveys showed themes such as equitable opportunities for professional/ career development, better involvement with senior management and response to feedback, staffing levels and bullying and harassment. However, some staff alluded to tensions within the unit, lack of consultation and possible bullying behaviour.

Staff were encouraged to nominate a colleague for the learning from excellence awards, which recognised outstanding staff.

Managers gave examples of public engagement such as an ICU research doctors commenting on television, on sleep disturbance in night shift workers on the ICU. Dr Martin recently (September 2018) gave a public lecture (attended by over 700 people) about intensive care and research conducted on the Royal Free ICU. Consultants gave talks about the ICU. Patients and relatives were invited in December 2018 to discuss the results of the Cardiac output optimisation following liver transplant (COLT) trial of delivering the correct amount of intravenously administered (IV) fluids to patients at the correct time, to avoid the well-documented detrimental consequences of either inadequate or excessive IV fluids.

However as at the 2016 inspection, patient engagement on critical care was not well developed. The lack of a follow up clinic further limited opportunities for feedback. The lack of written information for families and patients had also been a concern at the inspection in 2016 and very little action appeared to have been taken. Staff could not give examples of how patient feedback was used to shape and improve the service.

There was limited interaction between the Royal Free ICU and the ICU at Barnet Hospital, aside from some shared nurse education.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. The service participated in many clinical research studies which provided some evidence base for the unit's work.

The service ran simulation training for a variety of subjects which were valued by staff.

The Joy of Work quality improvement project on staff retention in ICU had been nominated for a Nursing Times award. It had improved staff retention through enabling self-rostering, employing more clinical practice educators and introducing a newsletter and a bi weekly coffee catch up to improve information flows.

The service participated in relevant quality initiatives, such as research trials. Research was valued by the team as a way of improving patient care. Examples of research were HERALD-1: HEpatic Resection Analgesia and Length of time to Discharge which aimed to assess how best to achieve optimal pain relief for recovery after liver surgery and Timelord, a study of tissue metabolism and blood flow in critically ill patients exploring the ability of cells to take up and use oxygen to learn what determines survival in in critically ill patients. Such studies provided some evidence base for the unit’s work.

Maternity

Facts and data about this service

The Royal Free London Hospital NHS Foundation Trust provides maternity services at the Royal Free Hospital and Barnet Hospital sites. Integrated maternity care is provided in community hubs alongside community partners and at the freestanding Edgware Birth Centre.

The community midwifery service consists of 14 teams of which two provide continuity of care (CoC) for women with complex social care needs. The maternity service offers a range of specialist services including perinatal mental health, endocrine, haematology and maternal medicine clinics.

The maternity service is part of the cross-site women and children's division responsible to the Barnet business unit. In addition to the delivery suites both hospital sites offer antenatal clinics, triage, day assessment units and ante/postnatal wards. There is a fetal medicine unit at the Royal Free Hospital.

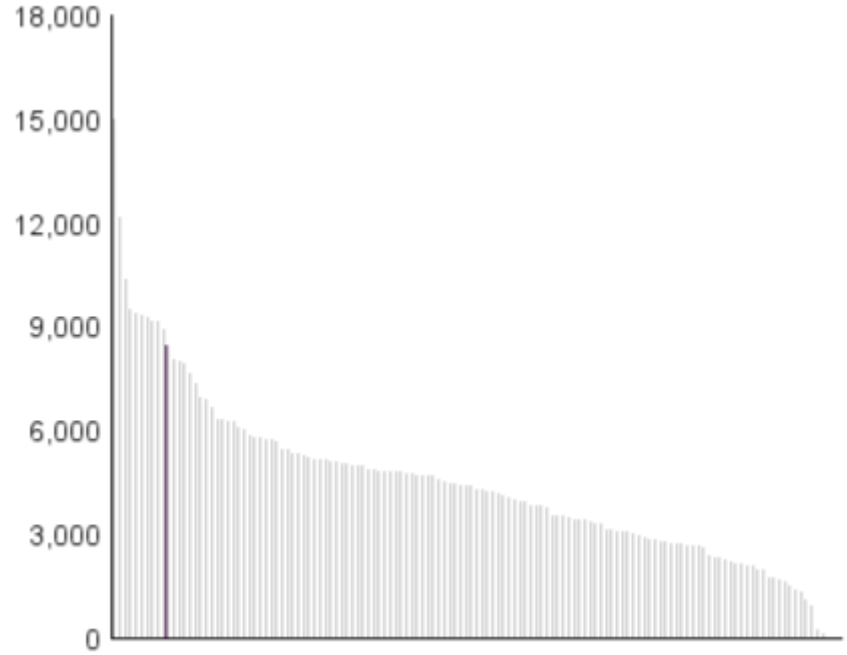
This report covers the maternity services provided at the Royal Free Hospital site in Hampstead.

(Source: Routine Provider Information Request (RPIR) – Context acute)

From April 2017 to March 2018 there were 8,405 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at Royal Free London NHS Foundation Trust – Comparison with other trusts in England



A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below:

Profile of all deliveries (April 2017 to March 2018)			
	ROYAL FREE LONDON NHS FOUNDATION TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Single or multiple births			
Single	8,304	98.9%	98.6%
Multiple	94	1.1%	1.4%
Mother's age			
Under 20	101	1.2%	3.1%
20-34	6,025	71.7%	74.9%
35-39	1,840	21.9%	18.1%
40+	432	5.1%	4.0%
Total number of deliveries			
Total	8,398		596,828

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Gestation periods (April 2017 to March 2018)			
	ROYAL FREE LONDON NHS FOUNDATION TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Gestation period			
Under 24 weeks	*	*	0.1%
Pre term 24-36 weeks	433	5.4%	7.8%
Term 37-42 weeks	7,637	94.6%	91.9%
Post Term >42 weeks	*	*	0.2%
Total number of deliveries with a valid gestation period recorded			
Total	8,077		498,704

Source: Hospital Episode Statistics, April 2017 to March 2018

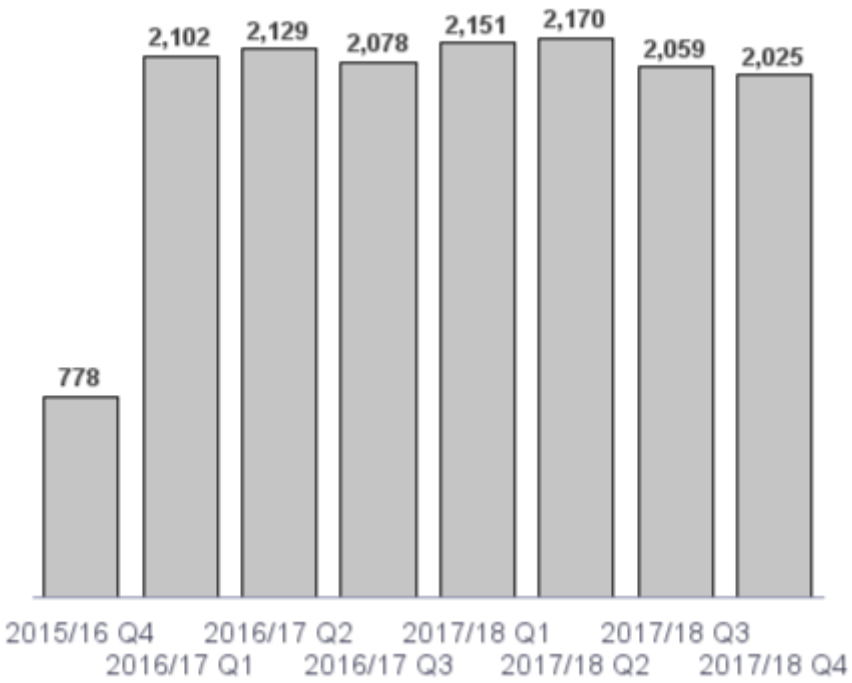
Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with "" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.*

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at Royal Free London NHS Foundation Trust by quarter



In the two years from April 2016 to March 2018, the number of deliveries per quarter remained consistent, ranging from 2,025 to 2170 deliveries per quarter

(Source: Hospital Episode Statistics - HES Deliveries (April 2016 - March 2018))

This inspection focused on the maternity core service based at the Royal Free Hospital. The inspection covered the acute side of the service and did not include the community service.

The Royal Free Hospital maternity service has an antenatal clinic which is situated on the ground floor of the main hospital building. This is a shared facility with the gynaecology outpatients clinics.

At the Royal Free Hospital, the main maternity services are on the 5th Floor of the main building. The services included an Early Pregnancy Assessment Unit (EPAU) which is shared with the gynaecology service. Within the EPAU is a triage bay where women in early stages of pregnancy are initially assessed and maternity patients are transferred to the maternity service.

The Fetal Medicine Unit is situated next to the EPAU. The fetal medicine unit (FMU) currently run services for the Royal Free Hospital (and Barnet). There is a plan to accommodate all fetal maternal assessment at the Royal Free Hospital in the future. The maternity services on occasion refer cases requiring specialist fetal medicine monitoring from Barnet, Chase Farm and the Royal Free Hospitals to tertiary units such as University College Hospital. The FMU supports women who have complications or abnormalities in their pregnancy.

On the other side of the EPAU is the antenatal and postnatal ward called 5 South comprising eight antenatal beds, 23 postnatal beds and four side rooms that are used for readmission on the ward.

The Royal Free Hospital delivery suite is situated by the main maternity reception area opposite the six lifts. The delivery suite has a consultant led labour ward with a two bed triage unit, five high risk intrapartum delivery rooms, a three bed close observation maternal assessment (CLOMA) bay which is a High Dependency Unit (HDU) and post operation recovery unit. Within

the labour ward there are two operating theatres.

Next to the labour ward is the midwife-led birth-centre, The Heath Birth Centre, with three delivery rooms, one of which is a pool room. All the rooms have en suite facilities.

During our inspection we visited all the maternity wards and units. We spoke with 16 patients and three relatives, and 47 staff, including consultant obstetricians and divisional directors, clinical leads and matrons, consultant midwives, specialist midwives and educators, senior midwives, midwives and healthcare assistants, a hospital pharmacist, trainees and other support workers.

Is the service safe?

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

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

Mandatory training

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for qualified nursing staff in the maternity department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	65	65	100%	85%	Yes
Resuscitation L1	63	65	96.9%	85%	Yes
Basic Radiation Safety	61	65	93.8%	85%	Yes
Infection Control L1	61	65	93.8%	85%	Yes
Emergency Planning	58	65	89.2%	85%	Yes
Health & Safety Awareness	56	65	86.2%	85%	Yes
Waste Management	56	65	86.2%	85%	Yes
WRAP	56	65	86.2%	85%	Yes
Fraud & Security	55	65	84.6%	85%	No
Information Governance	53	65	81.5%	85%	No
Moving and Handling	48	65	73.8%	85%	No
Equality, Diversity & Human Rights	48	65	73.8%	85%	No
Fire Safety	48	65	73.8%	85%	No
Blood Transfusion	47	65	72.3%	85%	No
Conflict Resolution	47	65	72.3%	85%	No
Infection Control L2	45	65	69.2%	85%	No
Resuscitation L2	33	65	50.8%	85%	No

At Royal Free Hospital maternity department, the 85% target was met for eight of the 17 mandatory training modules for which qualified nursing staff were eligible.

During our inspection, we were given updated data.

A breakdown of compliance for mandatory and statutory training (MAST) on 13 December 2018 for midwives and healthcare assistants in the maternity department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff [1]	Completion rate	Trust target	Met (Yes/No)
Basic Radiation Safety	129	139	93%	85%	Yes
Emergency Planning	127	139	91%	85%	Yes
Health & Safety Awareness	125	139	90%	85%	Yes
Waste Management	125	139	90%	85%	Yes
WRAP	121	139	87%	85%	Yes
Fraud & Security	119	139	85%	85%	Yes
Information Governance	120	139	86%	85%	Yes
Moving & Handling	110	139	79%	85%	No
Equality, Diversity & Human Rights	120	139	86%	85%	Yes
Fire Safety	119	139	85%	85%	Yes
Blood Transfusion	94	139	70%	85%	No
Conflict Resolution	119	139	85%	85%	Yes
Infection Control L2	119	139	85%	85%	Yes
Resuscitation L2 [2]	94	139	70%	85%	No
Mental Capacity Act & DOLS	122	139	88%	85%	Yes

[1] Excludes staff on maternity leave.

[2] Maternal resuscitation included in PROMPT drills and skills training which is 91% compliant for midwives.

A breakdown of compliance for mandatory training courses from April 2018 to August 2018 for medical staff in the maternity department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
BPAT	32	42	76.2%	85%	No
Resuscitation L1	31	42	73.8%	85%	No
Basic Radiation Safety	29	42	69.0%	85%	No
Infection Control L1	29	42	69.0%	85%	No
Conflict Resolution	28	42	66.7%	85%	No
Emergency Planning	28	42	66.7%	85%	No
Equality, Diversity & Human Rights	28	42	66.7%	85%	No
Fire Safety	28	42	66.7%	85%	No
Fraud & Security	28	42	66.7%	85%	No
Health & Safety Awareness	27	42	64.3%	85%	No
Moving and Handling	25	42	59.5%	85%	No
Blood Transfusion	25	42	59.5%	85%	No
Information Governance	25	42	59.5%	85%	No
Waste Mgt	25	42	59.5%	85%	No
WRAP	23	42	54.8%	85%	No
Infection Control L2	22	42	52.4%	85%	No

Resuscitation L2	22	42	52.4%	85%	No
RTT L1	18	42	42.9%	85%	No

At Royal Free Hospital maternity department, the 85% target was not met for any of the 18 mandatory training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

During our inspection, we were given updated data.

A breakdown of compliance for mandatory and statutory training (MAST) courses on 13 December 2018 for medical staff in the maternity department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff [1]	Completion rate	Trust target	Met (Yes/No)
sic Radiation Safety	27	29	93%	85%	Yes
nflict Resolution	26	29	89%	85%	Yes
ergency Planning	29	29	100%	85%	Yes
uality, Diversity & Human Rights	25	29	86%	85%	Yes
e Safety	23	29	79%	85%	No
aud & Security	27	29	93%	85%	Yes
alth & Safety Awareness	26	29	89%	85%	Yes
ving and Handling	25	29	86%	85%	Yes
od Transfusion	22	29	75%	85%	No
ormation Governance	25	29	86%	85%	Yes
aste Mgt	25	29	86%	85%	Yes
RAP	25	29	86%	85%	Yes
ection Control L2	22	29	76%	85%	No
suscitation L2	22	29	76%	85%	No
T L1	22	29	76%	85%	No
ental Capacity Act & DOLS	25	29	86%	85%	Yes

[1] Maternal resuscitation included in PROMPT drills and skills training, which is 90% compliant for medical staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff demonstrated a good understanding of safeguarding procedures and told us they had been well supported by the trust's safeguarding team. Staff confirmed they had received training in safeguarding adults (level 2) and children (level 2 and level 3). Staff told us the training included child sexual exploitation and female genital mutilation (FGM).

The maternity service had an integrated safeguarding team. The team consisted of a safeguarding lead for adults and two advisors on safeguarding children based at the Royal Free Hospital. There was a safeguarding named nurse who worked cross-site. Any of the team members could be contacted if the named midwife for safeguarding at the Royal Free Hospital

was not available.

The safeguarding team provided cover from 9am to 5 pm and there was a named doctor for children who could be bleeped and who covered maternity. There was also a manager covering maternity who could be contacted.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for qualified nursing staff in the maternity department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	65	65	100%	85%	Yes
Safeguarding Children L2	65	65	100%	85%	Yes
Safeguarding Adults L1	60	65	92.3%	85%	Yes
Safeguarding Adults L2	58	65	89.2%	85%	Yes
Safeguarding Children L3	48	65	73.8%	85%	No

At Royal Free Hospital maternity department, the 85% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

During our inspection we were given updated data.

A breakdown of compliance for safeguarding training courses on 13 December 2018 for midwives and health care assistants in the maternity department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff [1]	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L2	138	139	99%	85%	**Yes**
Safeguarding Adults	89	139	88%	85%	**Yes**
Safeguarding Children L3	116	139	86%	85%	**Yes**

[1] Excludes staff on maternity leave.

A breakdown of compliance for safeguarding training courses from April 2018 to August 2018 for medical staff in the maternity department at Royal Free Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children L1	33	42	78.6%	85%	No
Safeguarding Children L2	31	42	73.8%	85%	No
Safeguarding Children L3	23	34	67.6%	85%	No
Safeguarding Adults L1	28	42	66.7%	85%	No
Safeguarding Adults L2	25	42	59.5%	85%	No

At Royal Free Hospital maternity department, the 85% target was not met for any of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During our inspection, we were given updated data.

A breakdown of compliance for safeguarding training courses on 13 December 2018 for medical staff in the maternity department at Royal Free Hospital is shown below:

Name of course	taff trained	Eligible staff [1]	Completion rate	ust target	Met (Yes/ Nearly/ No)
feguarding Children L3	25	29	86%	85%	**Yes**

[1] Maternal resuscitation included in PROMPT drills and skills training, which is 90% compliant for medical staff.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

The maternity wards were kept clean and all the ward corridors were kept uncluttered for easy access.

Hand washing facilities and sanitising gel were available throughout the maternity department, including in corridors, by ward entrances and in clinical areas. There was prominent signage reminding people of the importance of hand washing.

Staff wore appropriate personal protective equipment when attending to women and babies in the wards. We observed staff washing their hands before attending to women and babies. Staff put on fresh aprons and gloves before giving personal care to patients and these were changed between patients. All staff we saw were ‘arms bare below the elbow’ in clinical areas, in line with national guidance.

Midwives and support nursing staff cleaned and maintained specialised clinical equipment, such as the clinical and delivery trolleys and the neonatal Resuscitaire in each delivery room and in the Heath birth centre.

We examined the results of the hand hygiene audit from August 2018 to October 2018 for 5 South ward, the Delivery Suite and the Heath Birth Centre.

5 South ward failed to meet the trust target of 95% in September 2018, when the performance was 91.6%

The Delivery Suite failed to meet the target in September 2018, when the compliance was 86.1%. This low figure was attributed mainly to items of hand jewellery. The problem was resolved by the following month.

The Heath Birth Centre failed to meet the target in September 2018, when the compliance was 86.1%. Again, this was attributed mainly to items of hand jewellery. The problem was resolved by the following month.

We examined the results of the cleaning audit from August 2018 to October 2018 for 5 South ward, the Delivery Suite and the Heath Birth Centre.

5 South ward failed to meet the trust target of 95% in October 2018, the compliance being 90.2%.

The Delivery Suite failed to meet the target in October 2018, the compliance being 91.5%.

The Heath Birth Centre failed to meet the target in October 2018, the compliance being 91.5%.

Action had been taken to address the cleaning problem. The matron reminded midwives that equipment needed to be cleaned and labelled with stickers to indicate it had been cleaned. The head of domestic services and the infection control nurse were made aware of the problem. The matron and the head of domestic services increased the frequency of their monitoring.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

On the day of the inspection, staff told us all clinical equipment was in good operating order. In the labour ward, we found the equipment in use was clean, had been appropriately checked and had been serviced regularly. The date of the service and the due date for the next service were clearly labelled on the equipment. For example, the cardiotocograph had been serviced in 2018 and was next due for service on 20th September 2019.

We noted the neonatal Resuscitaire had been checked daily. Following a delivery, all items used were replaced and the checklist was completed and signed by the midwife responsible for the use of the delivery room. We noted the checklists for September, October and November 2018 had been completed, signed and dated by a member of staff.

Support staff checked all other equipment, including monitors and infusion pumps and consumables such as saline solutions, needles, syringes and nasogastric tubes, to ensure they were in date. They also checked to ensure all consumables, including hand gels, disposable gloves and aprons, were in constant supply.

During our inspection, we found the portable appliance testing (PAT) of two electronic thermometers in the labour ward and one in the birth centre was overdue. One of the matrons checked with the medical equipment supervisor who confirmed these thermometers were tested every six months and not yearly. As a result, prompt action was taken and all the thermometers were replaced in the maternity unit. The matron confirmed all staff would be informed through staff meetings and lessons of the week's meetings.

The entrance to the maternity unit had CCTV in operation and the main entrance door was always kept locked. The unit required visitors to communicate with the receptionist at the main entrance to the labour ward before gaining entry. The receptionist ensured visitors' identity was verified before they were directed to the labour ward. All members of staff used swipe cards to gain entry.

The entrance to the antenatal and postnatal ward was operated by security swipe cards used by staff. All visitors had to use the intercom to state their identity before the staff let them into the ward.

Assessing and responding to patient risk

The maternity service used the modified early obstetric warning score (MEOWS) tool to monitor patients and detect signs of deterioration. MEOWS was designed to help midwives and other

health care professionals recognise ‘at risk’ women in labour and/or fetal distress so as to trigger early referral to the obstetrician and other medical staff. This enabled early medical intervention to prevent deterioration of the woman in labour and the baby in utero.

The service used the newborn early warning trigger and track (NEWTT) early warning tool, designed to identify babies at risk of clinical deterioration following birth. This initiated prompt investigation and intervention. From the EPR records reviewed, we saw that staff completed NEWTT appropriately in line with the trust guidance.

The maternity service developed the Keeping Mothers and Babies Together Pathway developed by the Clinical Programme Group, as part of the national project to reduce the number of babies (34/40 weeks) being admitted to the neonatal unit. The pathway used steps to improve the care of the newborn babies by using the orange hat and NEWTT observation while babies were kept close to their mothers.

Babies who were at risk in utero due to the mothers’ having complex clinical conditions such as diabetes, prolonged rupture of membranes or maternal infection and late pre-term babies (34 – 36 weeks) were kept with their mothers. These babies were identified by wearing an orange hat to indicate they were at risk babies; therefore staff had to be vigilant and carried our hourly observation for two hours after birth using the NEWTT tool appropriately while babies were kept with their mothers. Volunteers knitted the hats.

This enabled neonates to be close to their mothers for transitional care. This minimised bonding challenges between the mother and baby and reduced unnecessary admission to the neonatal unit.

Midwives were trained to recognise when a woman’s condition or the fetal cardiotocograph chart indicated signs of fetal distress. Staff understood when to follow the escalation procedure and call for medical help and assistance. Staff felt supported by senior midwives and matrons in this aspect.

There was a buddy system (fresh eyes) in place for review of CTG interpretation, with guidance for escalation where needed. Fresh eyes involved a second midwife checking a CTG recording of a baby’s heart rate to ensure it had been interpreted correctly and if necessary to take appropriate action. This was in line with national recommendations.

The maternity service followed the ‘Five Steps To Safer Surgery’ guideline of the World Health Organisation (WHO) for patients undergoing surgery. We saw that the WHO surgical safety checklist form was completed for two patients who had caesarean sections.

Staff completed and updated risk assessments for each patient. During our inspection, we met some antenatal patients, and two of them had been admitted for planned elective caesarean operations. They confirmed they had attended antenatal clinics and had been risk assessed clinically during each antenatal visit. We saw the clinical notes which included regular risk assessments and, as a result, each of them had been recommended to undergo the planned caesarean procedure to ensure their babies would be delivered safely and with good outcomes. We case-tracked one woman who had an emergency caesarean operation, with good outcomes for both the mother and the baby. The woman was extremely grateful and complimentary for the prompt action taken by the obstetric team, including the consultant, the doctors, the midwives, the anaesthetist and other theatre staff.

Routinely, women were risk assessed antenatally for venous thromboembolism (VTE). This was to determine if the patient was at risk of developing a blood clot. The EPR records reviewed

showed that staff had completed VTE assessment regularly and appropriately.

We noted there were two full time health counsellors based in the labour ward who gave help and advice to antenatal and postnatal women who needed emotional support. We met antenatal patients who were offered this service following perinatal mental health risk assessments in the antenatal clinic. The service offered had helped these women throughout their pregnancy and delivery. During our inspection we met with antenatal women who had been given counselling and they felt well supported.

We attended the morning doctors' handover in the labour ward. It was well structured with introductions by staff who stated their roles. All the patients were discussed, highlighting treatment, progress and challenges. After the handover, there was a discussion about other issues, including lessons of the week, pharmacy information, overnight Datix entries and a review of emergency caesarean sections using the Robson criteria. The Robson criteria use a number of obstetric characteristics to indicate the likelihood that a woman will need a caesarean delivery. These are parity, no of fetuses, previous caesarean section, onset of labour, gestational age and fetal presentation.

Staff used the situation, background, assessment, recommendation (SBAR) tool for handovers. We attended the early morning midwives' handover in the antenatal and postnatal ward (5 South Ward). Staff were each given a printed handover sheet with details of the women and babies in the ward. The matron and staff from the morning shift attended. A junior doctor and a ward physician/doctors' assistant was also present. The handover was given by the night staff/midwife who had looked after the women and babies allocated to them. We observed day staff were allocated antenatal and postnatal patients that staff had looked after in previous shifts. This had ensured continuity of care.

The fetal medicine unit (FMU) currently ran services for the Royal Free Hospital (and Barnet). There was a plan to accommodate all fetal maternal assessment at the Royal Free Hospital in the future. The maternity services on occasion refer cases requiring specialist fetal medicine monitoring from Barnet, Chase Farm and the Royal Free Hospitals to tertiary units such as University College Hospital. The FMU supported women who had complications or abnormalities in their pregnancy. Staff asked women about their baby's movements at each antenatal visit to reduce the risk of stillbirth. This was in line with the Better Birth programme. Women were encouraged to contact the maternity day assessment unit (MDAU) which was situated within the FMU or the maternity triage unit if they had concerns about their baby's movements.

We attended a daily cross site safety huddle. This occurred every morning at 11am between the staff at the Royal Free and Barnet hospitals. The safety huddle meetings achieved improved cross-site MDT communication to identify patient flow and patient safety issues. This in turn helped improve clinical practice to achieve good outcomes for women and their babies.

Nurse and midwifery staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Overall staffing rates

The trust has reported the following qualified nursing and midwifery staff numbers in maternity at Royal Free Hospital from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Royal Free Hospital	69.8	63.2	90.6%	69.8	66.4	95.1%

From April 2017 to March 2018, the trust reported a staffing level of 90.6% for qualified nursing and midwifery staff in maternity at Royal Free Hospital. This had increased to 95.1% from April 2018 to August 2018.
(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From September 2017 to August 2018, Royal Free Hospital reported a vacancy rate of 12.0% in maternity. This was the same as the trust target of 12.0%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, Royal Free Hospital reported a turnover rate of 16.3% in maternity. This was higher than the trust target of 13%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From September 2017 to August 2018, Royal Free Hospital reported a sickness rate of 4.6% in maternity. This was higher than the trust target of 3.5%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 17% of all nursing staff shifts in maternity at Royal Free Hospital were filled by bank staff and 4% of shifts were filled by agency staff. In addition, 1% of shifts were over-filled by bank and agency staff to cover staff absence.

The breakdown of bank/agency usage is shown in the table below.

Site	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Royal Free	174,394	29,899	17%	6,202	4%	Over-filled by 2,139	Over-filled by 1%

The trust told us that the negative values are for areas where total hours plus agency and bank hours have exceeded the establishment (effectively unfunded hours).
(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

From April 2017 to March 2018, the trust had a ratio of one midwife to every 29.2 births. This was similar to the England average of one midwife to every 25.7 births.
(Source: Electronic Staff Records – EST Data Warehouse)

The maternity units displayed the staffing levels for the day on a notice board. We were told there was a daily assessment of safe staffing on a shift by shift basis. A designated matron checked the staffing level every morning and reported this during the cross-site team huddle meeting at 11 am.

There was a matron covering the antenatal clinic and antenatal and postnatal ward, a matron covering labour ward and MDAU and a matron covering the Heath Birth Centre (and two other birth centres in the trust). One of the matrons was the maternity bleep holder for the Royal Free site daily by rotation. At the weekend, there was a band 7 care co-ordinator who held the bleep.

There were three consultant midwives for the trust. They had cross-site remits. One consultant midwife (band 8c) was mainly based at the Royal Free Hospital and was the lead educator, covering education and training of midwives and support staff; one consultant midwife (band 8c) was mainly based at Barnet Hospital and the third led the better birth strategy and spent approximately 50% of the time on each site.

The labour ward staffing level for each shift comprised a labour ward co-ordinator (band 7 midwife), one other band 7 midwife, two experienced staff midwives (band 6s) and one other midwife (one year experience).

The night staff for the labour ward consisted of a labour ward co-ordinator (band 7 midwife), one other band 7 midwife and three experienced midwives. They covered five high risk intrapartum rooms for women in labour and a three-bed close observation maternal assessment bay (CLOMA).

There were two obstetric theatres within labour ward. The anaesthetist's assistant and a scrub nurse from the main theatre gave support during surgical operations. The theatre runner was an HCA. All HCAs in the maternity department had one-week training in the main theatre.

There was a High Dependency and post operation recovery unit with three beds in labour ward. There was one HDU-trained midwife covering HDU at all times. If required, additional midwives were provided, depending on the needs of each patient. We were told that not all patients required HDU care. The unit was used for HDU patients and for patients who had caesarean sections and required observation overnight. Senior managers and senior midwives were all hands-on and they gave support to their staff. This ensured safe care was provided.

The labour ward had a triage bay with two beds. There was a band 6 midwife to cover the triage bay during the day and at night. Senior staff gave support if required and an additional midwife was deployed from the labour ward or from the other wards to assist when required. This was where women were initially assessed as they came into the labour ward before being transferred to the appropriate labour room, birth centre or to the antenatal ward.

The Heath Birth Centre next to the main labour ward was managed by a birth centre lead (band 7 midwife) who worked from Monday to Friday. There was an experienced band 6 midwife who worked a 12-hour shift. In addition, there was an on-call midwife (band 6 or band 7) covering every day and night. There was a band 6 midwife on night shift. The matron worked two days a week at the Royal Free site and was available by telephone when off-site. If escalation was needed, the bleep holder was notified. The labour ward staff also gave support in an emergency.

There was a bereavement room within the birth centre. It was situated in a quiet corner of the birth centre, away from the busy labour ward and nurses station. We were told the room was due for redecoration. Staff and women (ex-patients) from the local community had been invited to suggest a name for the room. There was a full time bereavement specialist midwife (band 7) who supported women going through bereavement.

There were 31 beds in total in 5 South for antenatal and postnatal patients. We were told each midwife was allocated eight mothers and babies per shift if the ward was full. There was usually a midwife allocated to look after the antenatal patients, depending on the number on the day and the operation list. On the day of our inspection, 5 South had three antenatal patients and 18 postnatal women and their babies. A number of women and babies were expected to be discharged on the day.

The antenatal and postnatal ward, 5 South, had a matron who was also the matron for the

antenatal clinic. The staffing level for 5 South comprised one midwife (band 7) in charge, four staff midwives (band 6s) and two healthcare assistants (HCA). Staff told us this was the planned and actual number. Staff said the number of staff and the skill mix was adequate. The midwives were supported by two healthcare assistants (HCAs) per shift. In addition, there was a physician assistant and a housekeeper on early shift within 5 South. The matron and two women health counsellors were also present in the ward on the day of our inspection.

The fetal medicine unit had its own midwives and support staff. There was a band 8 specialist midwife who was the clinical lead for the unit. There was a band 7 specialist midwife covering infectious diseases.

The maternity day assessment unit (MDAU) was within the fetal medicine unit which comprised two bays with three beds in each of the bays. MDAU was staffed by two experienced band 6 midwives.

There was an early pregnancy unit which covered maternity as well as gynaecology. Within this unit, there was a triage bay where patients were initially assessed and from which maternity patients were transferred to the maternity unit.

We were told bank and agency staff were used to cover sick leave and these workers were usually booked 72 hours in advance if needed. The manager responsible for hiring ensured that all agency and bank staff received a structured local induction to enable them to carry out their duties safely and adequately, before commencing an engagement in accordance with the trust's Temporary Workers Policy and Procedures (June 2017). The trust has service level agreements with approved agencies who ensure their agency workers have demonstrated compliance with minimum mandatory training requirements and the six standard NHS pre-employment checks.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust has reported the following medical staff numbers in maternity at Royal Free Hospital from April 2017 to March 2018 and for April 2018 to August 2018:

Site	April 2017 - March 2018			April 2018 - August 2018		
	Planned WTE staff	tual WTE staff	Fill rate	Planned WTE staff	tual WTE staff	ll rate
val Free	39.3	41.7	Over-established by 6.1%	39.3	38.7	98.5%

From April 2017 to March 2018, the trust reported an over-established staffing level of 6.1% for medical staff in maternity at Royal Free Hospital. This had decreased to 98.5% from April 2018 to August 2018.
(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From September 2017 to August 2018, Royal Free Hospital reported an over-established vacancy rate of 4.3% in maternity. This was lower than the trust target of 12%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From September 2017 to August 2018, Royal Free Hospital reported a turnover rate of 0% in maternity. This was lower than the trust target of 13%.
(Source: Routine Provider Information Request (RPIR) - Turnover tab)

From September 2017 to August 2018, Royal Free Hospital reported a sickness rate of 1.8% in maternity. This was lower than the trust target of 3.5%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From September 2017 to August 2018, the trust reported that 2% of medical shifts in maternity at Royal Free Hospital were filled by bank staff and no shifts were filled by locum staff.

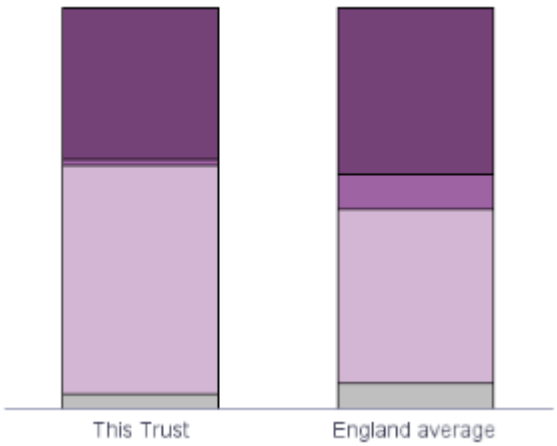
A breakdown by bank/locum usage is shown in the table below:

Site	Total hours available	Bank Usage		Locum Usage		NOT filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Royal Free	76,808	1,821	2%	258	0%	Over-filled by 1,772	Over-filled by 2%

The trust told us that the negative values are for areas where total hours plus agency and bank hours have exceeded the establishment (effectively unfunded hours).
(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

In July 2018, the proportion of consultant staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust were both about the same as the England averages.

Staffing skill mix for the 82.6 whole time equivalent staff working in maternity at Royal Free London NHS Foundation Trust.



	This Trust	England average
Consultant	38%	41%
Middle career^	2%	9%
Registrar group~	57%	43%
Junior*	4%	6%

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

Medical Staffing

The maternity service had 11 consultant obstetricians who provided maternity cover from 8am to 8pm. There was a consultant on call from home out of hours from 8pm to 8am. The consultants were supported by 16 junior doctors.

Each obstetric team comprised a consultant, a registrar and a first on-call (senior house officer equivalent). At night there was one team of two middle grade doctors and a consultant on call.

Trainee doctors we spoke with felt supported by consultants. They said they had regular consultant supervision.

In the labour ward there were two teams of medical staff. There was one team which comprised a consultant obstetrician, an anaesthetist and junior doctors (middle grades) for elective caesarean sections. There was an on-call team which consisted of a consultant obstetrician and junior doctors (middle grades) for emergencies. There was one scrub team from the main theatre serving the two.

We were told elective caesarean sections were often postponed from the morning to the afternoon when there were emergency caesarean sections. They were then performed by the on-call team.

There was a medical handover every morning in the labour ward, with the consultant obstetrician and the team of junior doctors present. Throughout the day there were regular ward rounds by consultants and their team of junior doctors.

Consultants had a weekly consultants' meeting to discuss matters arising and other relevant topics.

During our inspection, we observed the medical staff were present in the labour ward throughout the day.

The Fetal Medicine Unit had its own consultants who were specialists in fetal medicine. There were three consultants and three clinical fellows.

The consultants held FMU clinics three days a week (Monday, Wednesday and Friday mornings). There was a flexible arrangement to see patients outside these clinic sessions.

There were sonographers who carried out ultrasound screening. The number of sonographers assisting ranged from three to seven, depending on the workload. The sonographers sometimes worked with the clinical fellows and managed the Nuchal Translucency clinics which screened for fetal abnormality.

FMU worked collaboratively with the emergency gynaecology unit.

Records

Staff kept detailed records of patients' care and treatment. However, patients' consent forms were not always filled in and completed correctly.

We were shown the electronic records that had been recently introduced in the maternity service. One consultant midwife walked us through a patient record from booking to post delivery. We saw that risk assessments were done on antenatal patients and the required action taken was documented in the EPR. We were shown the observation details that included the MEOWS and the timeline of these observations and the escalation process and outcomes for the mother and baby. They were detailed and had been appropriately maintained.

We were told there had been problems when the new EPR system was introduced three weeks (17-19 November 2018) before our inspection and record keeping had been difficult while staff were learning to use the EPR system. However, staff seemed confident at the time of our inspection and there were ample EPR support staff to assist them.

Patients said they had their own notes which they brought with them every time they visited the hospital for their appointment and when they were admitted. With the patient's permission, we saw the clinical notes that were kept by the patient and they had been appropriately maintained. We saw that the consent form had been signed and dated before an elective caesarean section took place.

We checked five sets of clinical notes, two of patients who had had emergency caesarean sections and three of patients who had had elective caesarean sections. We found that in one patient's notes, a consent form was signed but not dated and there was no job title of the author. In another consent form, the signed consent form was not dated by the surgeon. In three other sets of notes we found the consent forms were duly signed and dated, with the two copies retained in the patient's notes. There was no indication as to whether patients were offered their copy or not.

Medicines

The service had not always followed best practice when prescribing, giving, recording and storing medicines. The trust medication policy and procedures had not always been followed.

During our inspection, we found evidence to suggest that staff had not always followed the trust policy and procedures in the safe storage of medicines and safe disposal of expired medicines.

In 5 South we found a sealed pack of IV lorazepam (5 vials of 4mg/ml) that had expired in May 2017 in a drug fridge. The medicine had not been discarded promptly and efficiently. However, we noted the matron had responded appropriately when the issue was pointed out to them. They immediately contacted the hospital pharmacy and safely disposed of the medication.

We were told 5 South had no drug disposal containers and there was no designated storage cabinet for drugs awaiting disposal.

In 5 South, we found individual patients' dispensed drugs in the medicine trolley in the storage room. These dispensed drugs belonged to three patients who had recently been discharged. We found three bottles containing loose tablets in a drug trolley located in the drug storage room. These were labelled for individual patients who had been discharged. The bottles contained the following medicines:

- Mercaptopurine 50mg tablets dispensed on 1 November 2018.
- Progesterone pessaries 400mg dispensed on 19 May 2018.
- Cyanocobalamin 50mcg dispensed on 2 August 2018.

Staff had not followed the correct procedures when making entries and cancellations in the controlled drug register. In the labour ward, when we checked the controlled drug (CD) register we saw an entry made on 3 December 2018 for Fentanyl infusion had been scribbled out. Whilst the matron recognised the error and provided correct information on what should have been done, there was no evidence that this had been addressed.

In 5 South, when we checked the controlled drug (CD) register, we saw an entry made for a Pethidine injection (100mg/2ml) had been scribbled out and was illegible. Staff had not followed the correct procedure in cancelling a written error in a CD register. There was no documentation to suggest this matter had been addressed.

We found the temperature of the drug refrigerators in labour ward and 5 South had been consistently too high since 1 December 2018. In the labour ward, the temperature was over 14°C. In 5 South, the temperature was above 8°C. The safe temperature is between 2°C and 8°C.

Staff had not taken any action to report or remedy this problem. This meant the medicines could be suboptimal and therefore patient treatment could be affected.

A senior staff was not able to tell us when the last medicine audit had been done and we were told the ward did not keep copies of previous pharmacy audits.

The trust confirmed later on that the issue appeared to be that staff were not familiar with how to read and reset the fridge thermometer. However, this meant there was no assurance that medicines had been stored in the correct temperature range. Therefore patients were at risk of being given suboptimal medicines.

During our inspection, we checked three adult resuscitation trolleys, one in the labour ward corridor, one in the HDU (Labour Ward) and one in the 5 South corridor. We found that they were all maintained in accordance with trust policy. The trust had followed the guidance of the Resuscitation Council UK. We spoke with the hospital pharmacist who told us they carried out morning visits to 5 South daily from Monday to Friday and they were contactable by telephone if needed. There was an out of hours pharmacist on call daily.

The pharmacist prioritised dispensing for patients who were waiting to be discharged and who needed their medicines without delay. The pharmacist was supported by a pharmacy technician who dispensed the prescribed medicines to take away (TTA medicines). The pharmacist checked that the dispensed medicines were correct before they were given to the patients.

We were told the usual practice was to dispense the TTAs the day before patients were discharged. The medicines were checked and stored in the TTAs medicine cupboard in the drug storage room. This avoided delay in discharging patients from the ward and eased bed occupancy issues.

The TTAs pharmacist’s storage cupboard and the pharmacist’s drug trolley were only accessible by the pharmacist’s team.

The medicine storage room in 5 South was locked when not in use and was accessible by staff using the swipe card security system.

All controlled drugs that were in date were appropriately stored in the controlled drug cupboard. The controlled drug facility was adequate for the amount of stock held. The hospital pharmacist confirmed the controlled drugs were checked daily and the number matched the recorded number in the controlled drug register. Access was restricted to appropriately trained qualified members of staff.

The medicine drug trolleys used in all the wards were kept locked when not in use and were stored within the drug storage room.

Midwives had induction training and regular updates on medicines management.

Midwives had been trained to scan patients' wrist bands before giving medicines to ensure the correct medicines were given.

All trained staff had access to the standard operating procedures for medicines management.

Staff had access to an up to date British National Formulary (BNF).

We checked two Electronic Prescription Service (EPS) medicines charts in each ward. We found they were signed by the prescriber and records of administration had been kept correctly. The principles of antimicrobial stewardship had been implemented. Appropriate therapeutic drug monitoring was in place and had been recorded in the drug charts examined; midwives had good awareness of this.

The pharmacist confirmed the Electronic Patient Records (EPR) team were working to resolve drug prescription issues such as deep vein thrombosis (DVT) compression stockings, which were currently prescribed on the drug chart.

Doctors were given a quick reference guide regarding using the EPR system and there were pharmacists and floor walkers available to assist staff who needed support with the EPR.

Incidents

The service managed patient safety incidents well.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported one incident which was classified as a never event for maternity. This was at Barnet Hospital and was for a retained foreign object post procedure.

(Source: Strategic Executive Information System (STEIS))

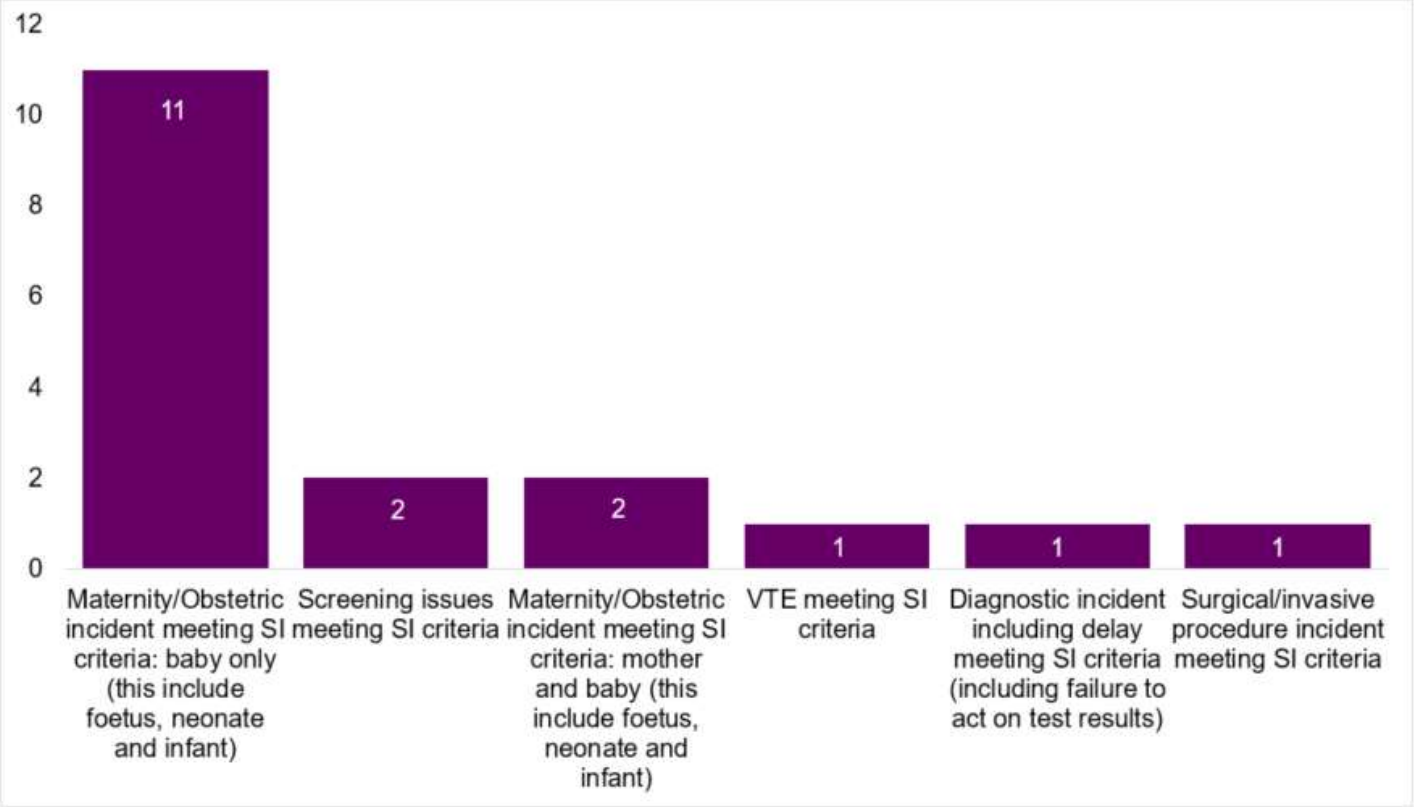
The Royal Free Hospital maternity service has had no never events since 2016. Staff confirmed they were kept informed of any never event, including the most recent never event at Barnet Hospital. and that lessons learnt following root cause analysis had been cascaded to all doctors, midwives and nursing staff.

In accordance with the Serious Incident Framework 2015, the trust reported 18 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from October 2017 to September 2018.

Of these, the most common types of incidents reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with 11 (61.1% of total incidents).
- Screening issues meeting SI criteria with two (11.1% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with two (11.1% of total incidents).
- VTE meeting SI criteria with one (5.6% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on results) with one (5.6% of total incidents).

- Surgical/invasive procedure incident meeting SI criteria with one (5.6% of total incidents).



A breakdown by site is shown below:

Royal Free Hospital: Three (16.7% of total incidents)
Cross site: One (5.6% of total incidents)
(Source: Strategic Executive Information System (STEIS))

We reviewed three root cause analysis and investigation reports in 2018 and found comprehensive detailed accounts, including lessons learned and actions taken to improve clinical practice and aiming to reduce the likelihood of a similar incident happening again. For example, in one case, staff were retrained in CTG interpretation and appropriate use of the escalation process.

We saw evidence showing staff had followed the duty of candour policy and procedure. We saw that staff had informed the patient and their relative and offered support and an apology when things had gone wrong. The patient and their relatives had been kept informed during an investigation and had explained to them the outcome of the investigation.

During our inspection, we discussed the root cause analysis of four serious incidents that had taken place since January 2018. Out of the four investigated, two had been closed and two have yet to be completed. The risk and safety manager explained that action plans were being completed on two serious incidents, one of which was about SBAR handover notes that had been left in the hospital lift. We saw the completed reports and found the root cause analysis and investigations were in accordance with NHS England guidelines. An external body was involved in one serious incident investigation.

The risk and safety manager confirmed the trust had referred its first case, a recent serious incident in the community to the Healthcare Safety Investigation Branch (HSIB).

The starting date for HSIB operation was 12 November 2018. HSIB will investigate cases that meet one or more of their criteria, including:

1. direct or indirect maternal death in the perinatal period;
2. intrapartum stillbirth;
3. early neonatal death;
4. severe brain injury diagnosed in the first seven days of life, when the baby:
    a. was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
    b. was therapeutically cooled (active cooling only); or
    c. had decreased central tone and was comatose and had seizures of any kind.

The risk and safety manager explained that HSIB is unable to take on all cases at the moment and all serious incident investigations into maternity events that meet the specified criteria must be investigated as normal by the host organization.

Staff confirmed they had been informed of lessons learnt from serious incidents investigated. Matrons organised Lesson of the Week meetings to ensure all staff received the correct information and discussed the lessons that were learnt and the changes made to protocols and procedures.

Safety thermometer

The service used safety monitoring results well.

The trust followed national guidelines in providing specific data which was fed into the NHS Maternity Thermometer tool.

The latter records key indicators or metrics relevant to the safety of a maternity department. These metrics are collated and compared nationally every month, so that any outlier departments regarding safety are discovered.

We reviewed the Maternity Safety Thermometer data for the Royal Free Hospital from August 2018 to October 2018. We took averages over three months of the data. The England Average data was taken from the NHS Maternity Safety Thermometer website, averaging the same three months.

Four clinical metrics were significantly better than the England average, as follows:

The percentage of women having a maternal infection was 2.4%, compared with 6.38% England average.

Number of women experienced a 3rd or 4th degree perineal trauma over the period reviewed, was 0% compared with the England average of 1.65%.

The percentage of women having primary postpartum haemorrhage of more than 1000 ml was 2.4%, compared with the England average of 9.95%.

The percentage of term babies with an Apgar score less than 7 at 5 min was 2.4% compared with the England average of 3.37%.

The patients' perception of the care was significantly worse than the England average on two metrics, as follows:

The percentage of women who said they had been left alone during labour at a time that had worried them was 7.9%, compared with the England average of 2.50%.

The percentage of women who had concerns about safety during labour and delivery that they

felt were not treated seriously was 11.1%, compared with the England average of 6.86%.

We looked at the figures for patients experiencing physical harm.

10.3% of women had an episiotomy.

15.1% of babies required unexpected transfer or admission to SCBU, NNU or NICU.

A further 4.8% had expected transfer or admission to SCBU, NNU or NICU.

(SCBU is the Special Care Baby Unit; NNU is the Neonatal Unit; and NICU is the Neonatal Intensive Care Unit.)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

The maternity service ensured staff followed national guidelines, including guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG).

All policies, protocols and clinical pathways were reviewed regularly and reflected national guidance and legislation. Staff were able to access all these documents on the trust intranet.

The Maternity service had taken steps to implement the National maternal and neonatal health safety collaborative projects in seven areas, which are described below.

1. Saving Babies Lives

In March 2016, NHS England introduced the Saving Babies' Lives care bundle aimed at reducing perinatal infant mortality. The trust had implemented this care bundle. It involves 4 interventions:

1. Reducing smoking in pregnancy.
2. Risk assessment and surveillance for fetal growth.
3. Raising awareness of reduced fetal movement.
4. Effective fetal monitoring during labour.

Women were screened for smoking at their antenatal booking appointment by carrying out a carbon monoxide (CO) test to identify smokers or those exposed to tobacco smoke. If the test was positive, the woman was referred to the stop smoking service/specialist as the appropriate intervention.

There was risk assessment and surveillance of pregnancies for fetal growth restriction. For women at high risk of fetal growth restriction, fetal growth was assessed using serial ultrasound scans with estimated fetal weight derived from ultrasound measurements recorded on a chart.

For low risk women, fetal growth was assessed using antenatal symphysis fundal height charts by clinicians trained in their use.

The trust had produced an information and advice leaflet to raise awareness among women of the risk of reduced fetal movement, so if it occurred, they would report it to their doctor. The trust

had a checklist to manage the care of women with reduced fetal movement.

The trust had ensured that all staff who cared for women in labour undertook annual training and underwent a competency assessment on cardiotocograph interpretation and the use of auscultation.

2. Maternity Safety Huddles

The maternity service had implemented cross-site maternal safety huddles to increase situational awareness and improve patient flow. The aim was to achieve the trust's aim of delivering world class care at the right time in the right place by the right team.

Previously, in-utero transfers had required ad hoc conversations between the delivery suite coordinator, obstetrician and neonatal teams on each site and had involved hours of delay. There had been little situational awareness between sites.

Safety Huddles meetings each morning involved short sharp qualitative feedback at the end of each huddle. It was attended by doctors and midwives from both sites.

The implementation of Safety Huddles had a very positive impact on patient safety and high quality care for at risk mothers and their babies. The maternity service had achieved improved cross-site MDT communication to identify patient flow and patient safety issues because of daily safety huddles meetings.

This had ensured the needs of both mother and baby were carefully considered when deciding the place of delivery. The trust had a Neonatal Unit (Level 2) based at Barnet Hospital and a Special Care Baby Unit (Level 1) at the RFH. Also at the RFH there was a highly specialised adult service, including regional haemophilia services and robotic surgery.

3. The Perinatal Mental Health Service (PMHS)

There was a perinatal mental health service team within the trust. This was a community-based mental health team serving the needs of pregnant women and postnatal women with moderate to severe mental health needs working in partnership with the RFH Unity team of midwives (and Barnet Hospital Acacia team).

The PMHS team comprised a perinatal psychiatrist, clinical nurse specialists, a clinical psychologist and administrators, obstetricians and midwives.

The aim of the PMHS was to improve the health and wellbeing of women who have, or are at risk of, mental health problems and to improve outcomes for women, their infants, partners and their families.

The PMHS followed the NICE guidelines on antenatal and postnatal mental health.

The PMHS team assessed and treated women (over 18 years of age) who were planning a pregnancy who had mental health problems and who needed advice, women who were currently pregnant and women who had had a baby in the past six months (with follow-up for up to 12 months).

At the Royal Free Hospital, 24 women had been referred to the perinatal mental health service from January to June 2018.

4. Keeping Mothers and Babies Together CPG Pathway (Royal Free London NHSFT)

The aim of this project was to introduce service improvements to reduce the number of babies born at or after 34 weeks gestation being admitted to neonatal units. Nationally there has been a decrease in the birth rate but an increase in term admissions to neonatal units.

The project commenced in 2017 cross-site and involved keeping 88 babies (34/40 weeks at birth) with their mothers and monitoring this group of babies. The result was a reduction in the overall admission rate of 34/40 weeks babies by 20 % (from 7.3% of births to 5.8%) cross-site.

The RFH data demonstrated a shift in admissions from 8.5% to 5.1% (40% reduction) for these babies.

5. 'Your Feedback on your Maternity Care'
The trust maternity service user experience strategy for 2018-2020

Feedback was taken from at least 15 different sources, including NHS choices, national surveys, inspections, complaints and compliments, external bodies, GPs, HealthWatch, social media, patient surveys and the Friends and Family Test.

The maternity service formed a Maternity Voices group where parents and parents to be could share their views and experiences of maternity care with midwives and doctors from the local maternity services, and with the clinical commissioning groups, who pay for and monitor maternity care. The project team analysed the topics which were important to parents and made recommendations on how maternity care could be improved.

6. Designing and implementing highly reliable and effective pathway of care for fetal monitoring during labour: CTG sticker (Royal Free London NHSFT)

This project was undertaken following the NHS Litigation resolution publication "Five Years of cerebral palsy claims" (September 2017) which highlighted the need to improve staff confidence in interpreting cardiotocographs and in escalating concerns in a timely manner.

The project spanned the staff confidence survey, a review of serious incidents citing CTG issues and admissions to the neonatal unit citing CTG issues.

There had been challenges and lessons had been learnt and actions had been taken to improve. Staff were positive about the clinical management section but confused regarding classification of a suspicious CTG. The team revised, among other areas, the classification of suspicious CTGs to match the International Federation of Gynaecology and Obstetrics (FIGO) classification table.

The trust aimed to reduce the number of unexpected term admissions citing CTG issues by 50% by 2020 by devising and implementing a clear pathway for risk assessment, fetal heart monitoring and escalation of concerns; to reduce by 50% the number of cases of avoidable harm relating to deterioration of the unborn from a mean of two per year to one per year.

7. Cervical ripening Balloon – Looking to the Future. (Royal Free London NHSFT)

This project was undertaken as research indicated that balloon and prostaglandin resulted in similar cervical ripening rates. The benefit of using balloon was a reduction in the risk of hyperstimulation, without affecting the number of women not delivering within 24 hours. There

was also more maternal satisfaction with outpatient induction.

The aim was to use the cervical ripening balloon (CRB) as the first induction method for all women.

The project meant a reduction in the time from arrival to first agent inserted, an increase in Outpatient induction of labour and a review of the indication for induction of labour (IOL) and if appropriate it could be rescheduled. It involved multidisciplinary CRB insertion competency training for doctors and midwives.

User feedback showed clients liked having a set time to arrive. Positive comments were received on the information provided. Outpatient IOL clients were happy to go home with the balloon inserted and clients were happy regarding not having to wait too long until induction started.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Patients said they were offered snacks and sandwiches in between mealtimes. Women in early labour were offered light refreshments, such as sandwiches, and a light meal after delivery or caesarean section.

We observed lunch being served from a hot food trolley in 5 South Ward. There was a selection of hot meals and desserts. Staff told us patients were given a menu to choose from and that patients had a choice of hot dishes at mealtimes. However, one person said there was only one choice for breakfast.

There was a selection of hot drinks and juices throughout the day in the wards. Patients in the antenatal clinic could access the water dispenser.

We saw that patients were offered cultural dishes and there was provision for patients with special dietary needs, who were referred to a hospital dietician for assessment to ensure their dietary needs were being met appropriately.

Women were supported by the midwife lead for infant feeding soon after birth. Women whose baby had tongue tie (which affects their feeding) were assisted by the midwife lead for infant feeding and the baby was referred to the paediatrician for assessment and clinical advice.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

We spoke with five postnatal patients about pain relief in labour. They all felt that the labour ward midwives were very supportive and they had good experience of childbirth with effective pain relief. The women said staff discussed and offered them a choice such as Entonox and epidural.

We saw postnatal patients the day after a caesarean section operation, and they appeared comfortable. One patient who had epidural said she remained comfortable after transfer from the labour ward as the epidural was still effective.

Patients in the postnatal ward said they were given their pain medicine on time and when they needed it. There was one occasion where a midwife apologised for not giving the analgesia on time because they had read the wrong time on the new electronic patient record. This was soon

resolved when the patient's relative asked again within the hour.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.
The maternity service participated in national audit programmes and local audits to ensure quality standards were maintained.

Quality Improvement CTG audit

The trust had organised a programme of staff retraining to improve performance in Intermediate auscultation and cardiotocography. The trust hopes to reduce the occurrence of avoidable harm to neonates attributed to poor intermediate auscultation and cardiotocography by 50% from the current mean rate of 2 per year to 1 per year by 2020.

In the 2017 National Neonatal Audit Royal Free Hospital's performance in the two measures relevant to maternity services was as follows:

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 37 eligible cases identified for inclusion, 90.3% of mothers were given a complete or incomplete course of antenatal steroids.

This was as expected when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit's recommended standard of 85% for this measure.

For the metric, "Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?", this data was supressed due to low numbers (three).

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

From April 2017 to March 2018, the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections was as expected and rates for emergency sections was higher than expected.

Standardised caesarean section rate (April 2017 to March 2018)

Type of caesarean	England	ROYAL FREE LONDON NHS FOUNDATION TRUST			
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardised Ratio	RAG
Elective caesareans	12.4%	1,028	12.2%	92.9 (z=-0.7)	Similar to expected
Emergency caesareans	15.9%	1,733	20.6%	128.2 (z=2.1)	Higher than expected
Total caesareans	28.3%	2,761	32.9%	112.3 (z=1.7)	Similar to expected

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from April 2017 to March 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

Proportions of deliveries by recorded delivery method (April 2017 to March 2018)			
Delivery method	ROYAL FREE LONDON NHS FOUNDATION TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Total caesarean sections[1]	2,761	32.9%	28.3%
Instrumental deliveries[2]	1,017	12.1%	12.4%
Non-interventional deliveries[3]	4,620	55.0%	59.3%
Total deliveries	8,398	100%	100% (n=596,828)

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

[1]*Includes elective and emergency caesareans*

[2]*Includes forceps and ventouse (vacuum) deliveries*

[3]*Includes breech and normal (non-assisted) deliveries*

The proportion of deliveries by recorded delivery method were all similar to the England averages.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As at September 2018, the trust reported one active maternity outlier. This is for an emergency caesarean section (October 2017). Actions are being followed up by the inspection team.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

At the time of our inspection, we were given updated data on rates of caesarean sections.

We examined the total rate of caesarean sections from April 2018 to September 2018 for the Royal Free Hospital site alone. The England average rate is 29.6%. The average rate over this whole period was 31.4%, triggering an amber alert. Over this 6-month period, April was red (36.7%), 3 months were amber and 2 months were green.

We examined the rates of emergency caesareans from April 2018 to September 2018 for the Royal Free Hospital site alone. (This had been an outlier for the trust as a whole.) The England average is 18.1%. The average for this site was 16.4%, which was comfortably in the green. For the first month of this period, April 2018, the rate was 18.6%, which was therefore in the amber. All the other months were green ie better than or equal to the England average.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.87.

This is up to 10% lower than the average for the comparator group rate of 4.95. Performance was better than expected for the stabilised and risk-adjusted perinatal mortality rate. There is currently no national aspirational standard for this audit.

(Source: MBRRACE UK)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

From April 2018 to September 2018, 79.6% of staff within maternity at Royal Free Hospital received an appraisal compared to a trust target of 85%. Nursing and midwifery staff had a 79.2% completion rate and medical/dental staff had an 80% completion rate.

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Trust target	Completion rate	Target met Yes/ No
Administrative and Clerical	1	1	85%	100%	Yes
Estates and Ancillary	1	1	85%	100%	Yes
Healthcare Assistants	12	10	85%	83.3%	No
Medical and Dental	25	20	85%	80.0%	No
Nursing and Midwifery Registered	53	42	85%	79.2%	No
Additional Clinical Services	1	0	85%	0.0%	No
Total	**93**	**74**	**85%**	**79.6%**	**No**

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

During our inspection we were given an updated appraisal rate for midwives and healthcare assistants. As on 13 December 2018, the number of staff that had completed their appraisals was 101 out of 115 and the rate was 88%.

The maternity service had a rotational system of placement of midwives. This ensured midwives maintained their skills, practices and competencies.

Midwives were provided with additional clinical training to ensure their competencies were being maintained. Midwives were given training on interpreting cardiotocograph traces to help detect fetal distress during labour so that appropriate escalation procedures could be taken to seek medical assistance so as to ensure a good outcome for the baby. Midwives were given training on obstetric and sphincter injuries (OASIS) to avoid 3rd/4th degree tear during spontaneous delivery of a baby.

The maternity service had an educator lead (band 8c consultant midwife) and a clinical practice facilitator (CPF). There was a CPF assistant called a clinical support teacher (Band 7 midwife) who was funded by Middlesex University. The support teacher also worked as a part time midwife in the labour ward.

The education team reviewed staff training programmes, staff competencies, guidelines and care pathways, organised equipment and arranged clinical and mandatory training for staff. This ensured staff maintained their competencies in clinical practice. They followed the Practical Obstetric Multi-Professional Training (PROMPT) scheme, using the training manual from the Royal College of Obstetrics and Gynaecology (RCOG)

The CPF managed student midwives. There were 46 students in total with four on the 18 months training programmes and 42 on a three-year training programme. CPF also supported the practice development midwives (specialist midwives).

Midwives received support through the professional midwifery advocates (PMAs) who replaced the supervisors of midwives. There were 13 PMAs and they were band 7 and 8 midwives and some of them had been supervisors of midwives. PMAs report to the Head of Midwifery. PMAs had training provided by Health Education England London region.

Multidisciplinary working

Doctors, midwives and other healthcare professionals supported each other to provide good care.

We found there was good internal MDT working between the maternity service, the neonatal unit, the theatre team, the community team, the pharmacists and other professionals.

There was good external multidisciplinary team working with other trust hospitals, the commissioners, the social services safeguarding team and others. For example, the safeguarding midwife from Unity attended the monthly social services meetings.

There was a weekly antenatal referral meeting where the perinatal mental health nurse specialist attended together with the consultant psychiatrist and the consultant psychologist.

The maternity service worked closely with the North Central London Maternity and Newborn Network to share practice information and peer support.

Seven-day services

The maternity service provided seven-day 24 hour services. There were 11 consultants who provided maternity cover from 8am to 8pm. There was a consultant on call from home out of hours from 8pm. There was a bleep rota for out of hours cover by the doctors.

The maternity unit had a midwife manager/matron on call from 5pm to 9am and there were two other staff on call out of hours 7 days a week. At weekends, the midwifery on-call team commenced from Friday 5pm to Monday 9am on a rotational basis. The Head of Midwifery arranged the on-call rota following the submission of preferences by individuals on the on-call list.

Health promotion

The midwife lead for infant feeding was involved with promoting breast feeding, if this was the option a woman chose. The maternity service was involved with the UNICEF Baby Friendly Initiative. It meant the trust was committed to supporting mothers to initiate breastfeeding and encouraged them to exclusively breastfeed for the first six months, while at the same time also supporting parents who chose to bottle-feed. The service had achieved the United Nations Children's Fund (UNICEF) Baby Friendly Stage Three.

Pregnant women were screened for perinatal mental health using the Wooley guidance tool.

Women were offered influenza vaccination and pertussis vaccination

Women were screened for Clostridium difficile and Methicillin-Resistant Staphylococcus Aureus (MRSA). The labour ward quality and safety notice board show information on infection control which stated there had been no cases of C. diff for 101 days since the last infected case. There had been no MRSA infection for 187 days since the last infected case.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

The trust reported that from April 2018 to August 2018, Mental Capacity Act (MCA) training was completed by 78.9% of staff in maternity at Royal Free Hospital, compared to the trust target of 85%.

A breakdown of completion rate by staffing group at Royal Free Hospital is below:

- Nursing and midwifery staff: 86.2%%
- Medical/dental staff: 66.7%
- All staff: 78.9%

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

We saw that appropriate consent was obtained before treatment began and this was recorded in the patient's records. In the antenatal ward, we saw the consent forms that had been signed and dated by the consultant obstetrician and the patient prior to elective caesarean operations for two women.

Staff confirmed they had had training on the Mental Capacity Act and the Deprivation of Liberty Safeguards. On the 13 December 2018, 88% of midwives and HCAs had received training in the Mental Capacity Act (MCA), which was above the trust target of 85%.

Staff told us there were no patients receiving treatment that were subject to the Mental Capacity Act 2005. Staff knew the correct procedure to follow if a DoLs application was required.

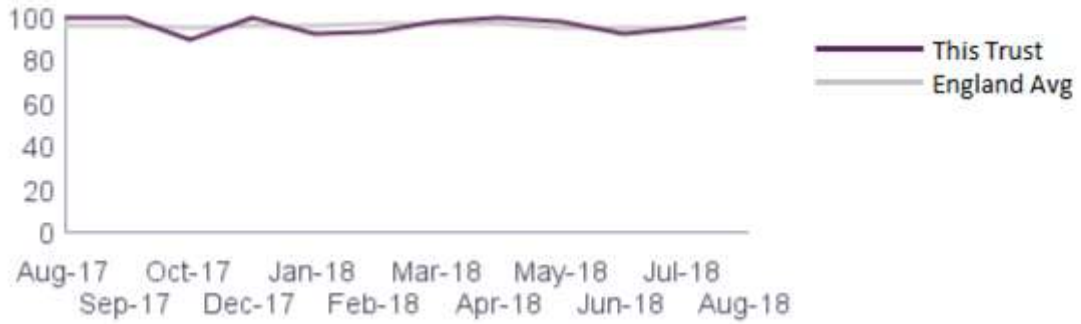
There were no patients sectioned under the Mental Health Act (MHA). The Unity team was involved in the care of people with a history of mental health conditions.

Is the service caring?

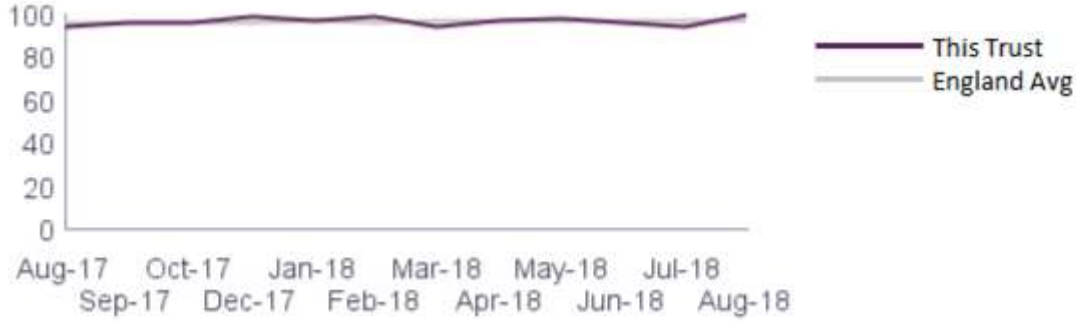
Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

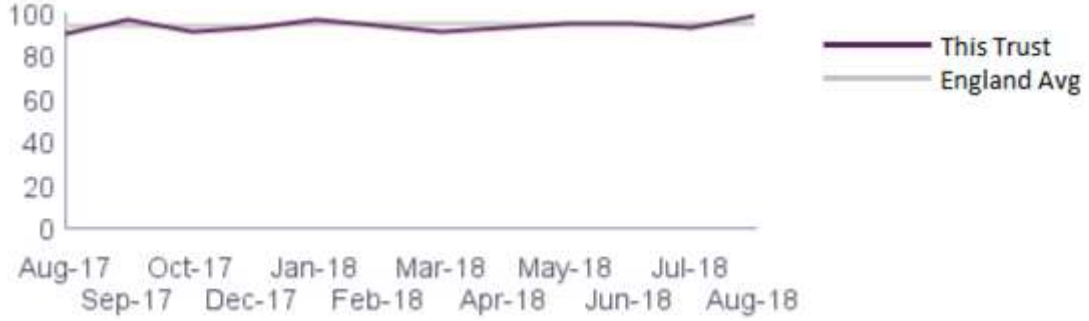
From August 2017 to August 2018, the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was similar to the England average. In the latest period, August 2018 performance for antenatal was 100%, compared to 95% England average.



From August 2017 to August 2018, the trust's maternity Friends and Family Test (birth) performance (% recommended) was similar to the England average. In the latest period, August 2018, performance for birth was 100%, compared to the England average of 97%.



From August 2017 to August 2018, the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was similar to the England average. In the latest period, August 2018, performance for postnatal wards was 99%, compared to the England average of 95%.



From August 2017 to August 2018, the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was similar to the England average. In the latest period, August 2018, performance for postnatal community was 100%, compared to the England average of 98%.

(Source: NHS England Friends and Family Test)

The trust performed about the same as other trusts for 11 out of 16 questions in the CQC maternity survey 2017 and was among the worst performing trusts for the remaining five questions.

Area	Question	Score	RAG
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.73	About the same
	During your labour, were you able to move around and choose the position that made you most comfortable?	7.55	About the same
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.66	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	9.11	About the same
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	8.84	Worst performing trusts
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	6.80	Worst performing trusts
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	7.31	Worst performing trusts
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.56	About the same
	If you used the call button how long did it usually take before you got the help you needed?	8.15	Worst performing trusts
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	8.24	About the same
	Thinking about your care during labour and birth, were you treated with respect and dignity?	8.94	Worst performing trusts
	Did you have confidence and trust in the staff caring for you during your labour and birth?	8.70	About the same
Care in hospital after the birth	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	7.24	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	8.18	About the same
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	8.41	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.53	About the same
	Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?	N/A	N/A

(Source: CQC Survey of Women's Experiences of Maternity Services 2017)

Patients and their relatives we spoke with were complimentary about the service provided. They commented that all the staff, doctors, midwives and support workers were caring, respectful and supportive.

One patient commented they were very happy with the care provided and complimented all the staff, including doctors, midwives and nursing staff.

Three patients in the postnatal ward told us they were happy with the care they had received in the antenatal clinic, the postnatal ward and during labour.

Another patient said they had had a good experience previously at the Royal Free Hospital and were happy to return to have their baby there. The patient added they were happy with the doctors and other staff throughout.

One patient said they had had a very positive experience. They said the ward appeared visibly clean and privacy was upheld throughout; that the staff were very kind and explained things clearly; that staff were very caring and they felt valued and listened to.

Emotional support

Staff provided emotional support to patients to minimise their distress.

The Unity team helped women who were asylum seekers and refugees, who were homeless, who abused drugs, who were going through domestic abuse or who had a history of mental illness. These women had access to the perinatal mental health team, which included a consultant psychiatrist and a consultant psychologist. They could also be helped by the staff of charitable organisations such as Solace Women's Aid and other independent advisors on domestic and sexual abuse. The acute liaison nurse co-ordinated these sessions.

The maternity service supported women with a history of trauma, including previous childbirth trauma. and for women who suffered from tokophobia (fear of childbirth). We met patients who were being supported due to other emotional trauma and they commented how pleased they were with the service offered so early in their pregnancy when they were initially assessed in the antenatal clinic.

A patient in the postnatal ward commented that the midwives were good and came often and when called. They said staff checked their baby regularly and they felt supported with feeding their baby. The same patient said the care was good and midwives had been calm and reassuring during the birth of their baby.

Another patient said all the staff were "marvellous." The same person commented the nursing team who assisted with feeding were helpful and very supportive.

Five patients we spoke with told us the call bells were answered straight away most of the time. One patient added that on one occasion, the member of staff answered straight away and said they would return shortly but the staff had forgotten so the patient rang the call bell again and the problem was resolved. Another patient said when they were admitted, the member of staff had forgotten to show them where the call bell was but the person had managed to reach for the bell, which was answered quite quickly.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Four patients told us they were well informed by the doctors and midwives before a procedure. For example, the consultant obstetrician and the anaesthetist explained the surgical procedure before the caesarean operation took place. In the antenatal ward, patients waiting for induction of labour had the procedure explained to them before the consent form was signed.

An antenatal patient said they could ask questions at any time and as many times as they wished. They said the consultant and other doctors and midwives were very reassuring.

A patient said they were involved in all decisions about their care and had been given options, as well as written and verbal information about choices, e.g. regarding pain relief.

A patient's relative gave us feedback on behalf of the patient. They said when they needed help, the midwives came quickly to assist them. They said they had good help with feeding their baby. Doctors explained things to them about their antenatal care. The relative added the midwives in the postnatal ward explained what they were about to do before they gave postnatal care.

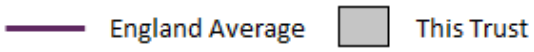
Is the service responsive?

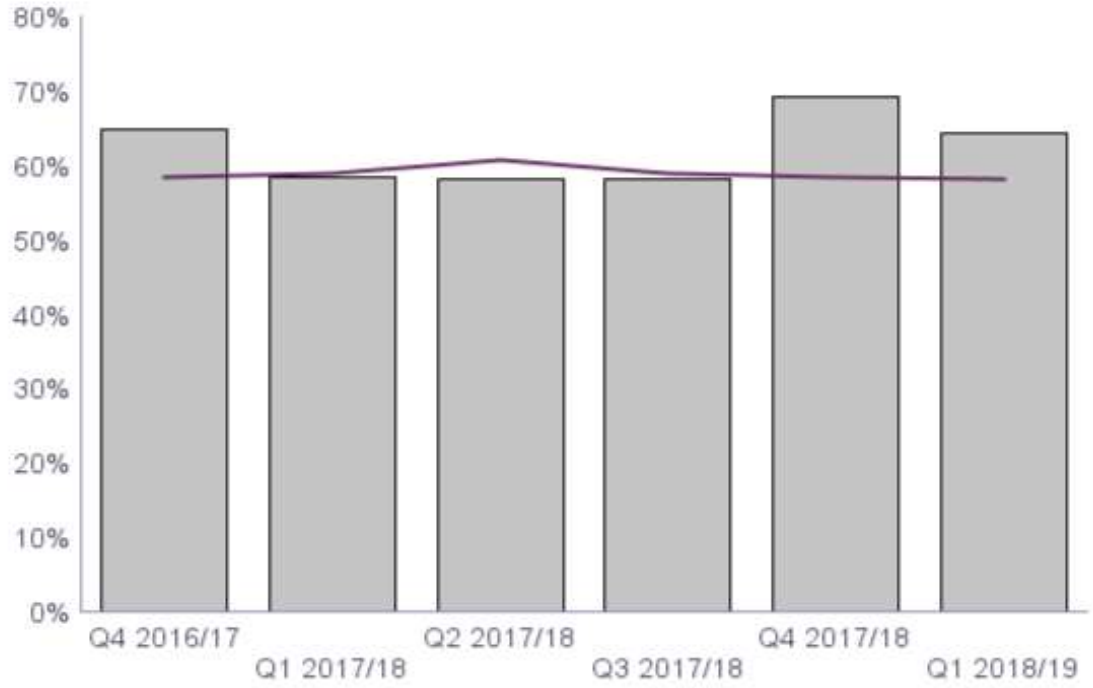
Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

From April 2017 to December 2017 the bed occupancy levels for maternity were similar to the England average. However, from January 2017 to March 2017 and from January 2018 to June 2018 levels were higher than the England average with the trust having 64.2% occupancy from April 2018 to June 2018, compared to the England average of 58.1%.

The chart below shows the occupancy levels compared to the England average over the period.





(Source: NHS England)

The Royal Free maternity service served the needs of the local population. It offered women choices and continuity of care.

The maternity service had a consultant-led midwifery service based at the hospital. This catered for pregnant women with obstetric complications who required medical team support. This service was also for women who simply preferred a consultant-led service and hospital in-patient care following delivery. There was a named midwife for each woman in labour.

Pregnant women were introduced to the local community midwife at booking and were offered a choice of models of care if their pregnancy was uncomplicated. Women who chose to use the pool for childbirth or an alternative form of relaxation in managing labour pain were supported by a named midwife throughout their labour in the birth centre. The birth centre was also used for women booked for continuity of care provided by the local community midwife.

The Heath Birth Centre with three delivery rooms was a midwife-led service. It was situated next to the labour ward which meant accessibility to the medical team and labour ward staff if emergency assistance was required.

Within the birth centre was a bereavement room and there was a bereavement specialist midwife who supported women going through bereavement.

The main maternity services and facilities were all on the 5th floor of the hospital building and accessible by lifts and stairs. The labour ward facilities included a two-bed triage unit where women were seen and assessed before being transferred to the appropriate delivery room or the antenatal ward. There were five high risk intrapartum rooms for women in labour. Within the labour ward there was a three bed HDU for women who required high dependency care. It was also used to observe women following caesarean sections.

The antenatal clinic was on the ground floor near the main entrance and this provided easy access for pregnant women who had to attend antenatal checks regularly. Both the women and their families had easy access to the toilet facilities and local cafes on the same floor nearby.

Staff were trained and they were sensitive to women with learning disability and other disabilities

such as autism. For women who had a learning disability, additional support was given by the trust learning disability team of trained nurses. The service offered included advocacy. There were information leaflets in pictorial format for people with a learning disability.

On the day of our inspection, there were two women with a learning disability in labour. They were looked after by midwives who had had training on how to assist them. This ensured continuity of care. Follow up support was provided when they were discharged into the community. These mothers would be provided with a hospital passport that had relevant information such as contact numbers of trained LD care professionals and individual care package details.

The maternity service employed two full time women counsellors based in 5 South to provide additional support to patients with a history of trauma, including previous childbirth trauma. and for women who suffered from tokophobia (fear of childbirth).

Women whose first language was not English were able to access the translation service through the trust website. Staff arranged interpreters for in-patients.

The maternity service at the Royal Free Hospital had a team of midwives called the Unity team who were assigned to care for a group of vulnerable women in the local area These women were booked for maternity care at the Royal Free Hospital. The named midwife for safeguarding was a member of the Unity team. The team provided 24-hour cover for these women.

The number of women booked in the hospital ranged from 10 to 30 per month. In November 2018 there were 18 women delivered at the Royal Free Hospital. On the day of our inspection, one woman from the vulnerable group was in labour and was cared for by staff from the Unity team.

The same midwives from the Unity team saw the women in the antenatal, delivery, and postnatal stages to ensure continuity of care and support.

There was a daily ward round by a member of the Unity team to check for the number of women with safeguarding risks. There had been a few safeguarding cases pending investigations.

We were told at least 70% of women from the vulnerable group had previous mental health issues, which was the most common reason for their vulnerability. The conditions ranged from moderate to severe. Other problems encountered among the group included domestic violence, substance misuse, refugees, asylum seekers and homelessness.

Some women might have previous safeguarding history where social services or children’s social services had been involved in their care. Some women were identified to be at risk during their pregnancy. The Unity team worked closely with social services and liaised with other agencies in caring for these women from the antenatal period through to postnatal care. The safeguarding midwife attended the multiagency safeguarding meetings when there were child safety issues, before handing the case over to the health visitor.

When new cases were identified they were referred to social services in accordance with the trust safeguarding policy. The safeguarding midwife worked closely with the multiagency team and the police when there were child protection issues.

The Unity team could refer individuals who wanted further assistance and support from the independent domestic and sexual violence advisors. This service was funded by a charitable organisation, Solace Women’s Aid. Women suffering from domestic abuse could only be referred with their consent.

The Unity team worked closely with a consultant obstetrician who had good knowledge of the group of vulnerable women who came through the maternity service. The consultant saw women with a history of substance abuse and concealing pregnancies or a complex medical history.

The trust computer system had a safeguarding drive with details of why these women were under the safeguarding team, and provided contact details of the agencies involved. Staff checked against this when patients were admitted. The onus was on the midwife to check for the safeguarding information. The midwife also checked for a care plan for anyone with safeguarding issues. Child protection information was part of a national system and this was also incorporated into the maternity service.

Meeting people's individual needs

The service took account of patients' individual needs.

The postnatal ward tried to ensure women and babies were looked after by the same midwife each day. This ensured continuity of care.

Women who were ready to be discharged were referred to the local community midwife for continuity of care. We saw women in the antenatal clinic who confirmed they had been introduced to their local community midwife when they booked at the antenatal clinic. Some patients had received regular checks by their community midwife.

Following delivery, women and their babies were transferred to the postnatal wards, where the lead midwife for infant feeding assisted the mother to establish a breast feeding or bottle feeding infant feeding regime, depending on the mother's choice. We saw the lead midwife and an HCA demonstrating to women in each of the bays how to prepare feeds and how to feed their newborn babies. This had ensured women were supported to feed their newborn baby appropriately.

Women who preferred breast feeding were encouraged and supported to do so by the lead midwife for infant feeding.

One mother expressed how pleased she was when a midwife noticed her baby had tongue tie while assisting with feeding the baby. The baby was immediately referred to a paediatrician. Within two days an appointment was made for the baby to be seen in the paediatric outpatient clinic for follow up assessment and possible surgery. The mother felt well supported by all the staff involved.

Access and flow

People could access the service when they needed it.

On the day of our visit to the antenatal clinic, we found the waiting room was busy with people waiting either to see a midwife or the gynaecology staff. The waiting room was shared by the two services. We observed that the three receptionists were busy throughout the day.

We observed the midwife in charge (band 7 midwife) making frequent announcements and apologies for any delay when the waiting time was extended because of unforeseen circumstances. In recent weeks staff said the delay was as a result of problems accessing the EPR system for individual antenatal records. We noted a large poster to explain possible delays due to EPR installation.

During our inspection, we asked several women the waiting time before they were seen by a member of staff. Women booked to see the midwife were generally seen within 10 to 15 minutes. If they were waiting to see a consultant, the waiting time was usually 20 to 30 minutes. Women said sometimes they were seen within a few minutes of their arrival, depending on how busy the clinic was on the day. Two women mentioned that if they booked for the morning session, they were seen quicker. They added the afternoon session was always a busy period. All the women we spoke with said they were all seen within an hour and they were happy to wait anyway. One woman said she preferred to arrive earlier than the time arranged so she could relax and be calm.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From September 2017 to August 2018, there were 98 complaints about maternity. The trust took an average of 40.2 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed and closed with 35 days.

The three most common subjects of complaints are shown in the table below:

Subject	Number of Complaints	Proportion of complaints
All aspects of clinical treatment	57	58.2%
Attitude of staff	17	17.4%
Communication/information to patients (written and oral)	12	12.3%

A breakdown by site is below:

Site	Number of Complaints	Proportion of complaints
Royal Free Hospital	43	43.9%

At Royal Free Hospital, 23 (53.5%) complaints related to all aspects of clinical treatment and 11 (25.6%) related to attitude of staff.

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

From September 2017 to August 2018, there were 29 compliments within maternity. Of these, 14 (48.3%) related to Royal Free Hospital.

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

Staff we spoke with knew about the complaints policy and procedure and were able to share this information with women who raised a concern. Staff told us most concerns raised were dealt with and de-escalated before they reached the formal complaint stage. A senior manager confirmed all complaints had been dealt with appropriately in line with the trust's policy.

Women were sign posted to the Patient Advisory and Liaison Service (PALS) where they could

seek advice if they wished to raise their concerns formally. The information was displayed on notice boards within the maternity service. Staff said they tried to address any concerns raised immediately or refer the person to a senior midwife to resolve the issues.

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The Royal Free Maternity service was part of the women and children division, which is a cross-site division managed out of the Barnet Hospital Business Unit. There was cross-site working at both the clinical and leadership levels.

The leadership team was well structured and each individual role was clearly defined. We observed good communication among the teams and team working among the leaders at all levels within the maternity department was evident.

There was a good working relationship among the unit matrons, clinical leads, consultant obstetricians and consultant midwives and with their frontline junior doctors, midwives and support staff.

Frontline staff said they were well supported by the leadership team at all levels. Staff felt involved when they were able to attend board and senior management meetings, such as the risk and governance board meetings.

Staff felt able to discuss practice issues with senior managers, who were often visible in the wards.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust's vision was to deliver world class expertise and local care. They aspired to combine globally recognised clinical expertise with local and friendly hospital care to represent the NHS at its best. The maternity service had participated in various national initiatives that aimed to improve clinical practice and to provide safe and good quality sustainable care for women and babies.

The trust's values were positively welcoming, actively respectful, clearly communicating and visibly reassuring. At local level, the maternity service had demonstrated to women using the service how welcoming and respectful the staff had been. This was reflected in the positive feedback the women gave about the service and the care they had received. The choices offered were clearly communicated to the women antenatally, and the treatment was clearly explained before it was given. Staff were visibly reassuring as they provided one to one care to women in labour and continuity of care postnatally.

The trust Strategy was:

1. Extending the role of a major acute provider.

2. Being a network and system leader, and the surgical hub.
3. Being a leader in the academic health science system.
4. Being experts in integrated care.
5. Reducing unit costs with UCL Partners.
6. Gaining new markets and income sources.

The maternity service provided integrated care combining acute hospital care with community care using staff who rotate from one ward to another every few weeks to maintain their skills and expertise in providing good quality sustainable care to women and babies. This was an aspect of the trust strategy No. 4, being experts in integrated care.

The maternity service participated in national maternal and neonatal health safety collaborative work, therefore networking with stakeholders, other trusts and external organisations to improve services, thus achieving trust strategy No.2.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The Royal Free maternity service demonstrated an open and transparent culture. We observed that frontline staff were knowledgeable and communicated without reservation and were eager to share any projects or meetings they had attended.

There was an open culture of reporting, and learning was shared with staff to make improvements.

Large posters providing innovative techniques and clinical practice were on display on the notice boards along the labour ward corridors and in the other wards.

We saw that staff had a positive attitude to their work. Patients we spoke with were all pleased with the way staff communicated with them. Patients said staff were reassuring and unhurried. A patient remarked “you could ask doctors or nurses as many questions as you like and they would listen and explain things to you again.”

Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The risk and governance board held regular meetings which were open to all staff to attend. There was also a regular general board meeting.

The maternity service maintained a monthly clinical performance and governance dashboard which reported on activities and clinical outcomes. Performance was monitored for a range of outcomes including type of deliveries (such as caesarean section and instrumental deliveries), the number of third and fourth degree perineal tears, episiotomies, major postpartum haemorrhage, neonatal death rate and stillbirth rate. For each metric, amber and red trigger levels were set, at which an alert would be generated and the trust would take action. We saw that the dashboard for the last three months was displayed on the notice board in the labour ward

among other clinical and educational information.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The senior management team for risk and governance were thorough and involved in ensuring all risk issues raised were taken seriously and resolved quickly.

Numerous meetings were held regularly by various groups of staff and members of the MDT team involved in safer care to drive improvement in the maternity service. For example, the maternity risk management meeting was held monthly and issues discussed at the November 2018 meeting included the caesarean section audit for August 2018, the quality and safety report (November 2018), the maternity risk register, the maternity dashboard and complaints. Decisions made were carried out with timescales set and actions taken.

There was a Maternity Safety Action Plan covering all aspects of safety and risks issues and the maternity service involvement in national safety projects and initiatives. We saw that the action plan was regularly updated, with timescales and completion dates, summary details of action undertaken and reasons for any delay.

Staff were involved through maternity safety huddle meetings for delivery suite, postnatal ward and neonatal teams cross-site to discuss patient flow, risks and high risk patients.

There was a weekly perinatal mental health meeting which was attended by the PMHT psychiatrist, psychologist and members from the Unity Team for vulnerable people. This ensured updated information was shared and clinical and safeguarding matters discussed and action plans reviewed going forward.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust had introduced a trust-wide electronic patient record system, and this went live in the RFH maternity department on 19 November 2018. This system will store patient records electronically. It will bring together patient record data from a number of disparate sources in a single place under a single login. This will ensure that diagnostic information is always available where it is required. This system is intended to improve considerably the care provided and the flow of patients through the department.

The trust anticipated that the changeover to the use of the new system would inevitably cause delays. The trust made clear that, during the transition, patient safety was paramount, but other tasks not impacting safety may well get delayed. Much effort has been devoted to producing posters and manuals to aid staff, and the public have been kept informed of what is going on. Additional staff have been provided to help with familiarisation with the new system.

Patients will be able to view their records, through a patient portal. This system is intended to improve considerably the care provided and the flow of patients through the department.

Staff had highlighted concerns and issues encountered when using the new EPR (Cerner) system, which went live three weeks before our inspection. For example, the inability of the EPR system to accept drug prescription entry retrospectively was reported using Datix.

There was one person who said that there had been problems with clinicians not being able to access patient records, and not being able to add notes to patient records.

Senior management explained that the EPR system was new and some teething problems were anticipated in the early days. They had identified the problem and they had created an EPR risk register. One of the solutions was the investment on WOW (workstation on the wheel) which would facilitate date entry into the EPR in a timely manner.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Senior managers ensured all staff, including doctors, midwives and support staff received updated information through emails, monthly newsletters, staff meetings and lessons of the week meetings.

Staff felt included and involved in local safety projects and care pathway reviews.

There were staff who volunteered to be Speak-up Champions.

The service engaged well with patients and relatives, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. This was clearly demonstrated in the service user projects where 15 sources were contacted to gather information and feedback from service users. Actions were taken to remedy shortfalls and to improve services in order to provide safe care for mothers and babies.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The trust maternity service was involved in a number of projects led by one of the matrons, a consultant midwife who was a clinical lead and care pathway co-ordinator. All staff participated in one way or another to achieve positive results and enhanced quality care and good outcomes for mothers and babies. The various projects resulted in good multiagency relationships and peer support, especially in the North and Central London areas.

There had been a number of innovative projects undertaken, such as the launch of the National Maternity Voices Partnership (MVP) group in 2016. RFH worked in partnership with service users, in a holistic and inclusive manner to provide high quality safe maternity care to families residing in the local geographical area as part of the NHS England Better Birth Strategy.

The Unity team for vulnerable women gave a 45 minutes presentation ‘Partnership working for vulnerable women’ at a Royal College of Midwives seminar on the integration of care pathways for women with complex psycho-social morbidity. This talk has been nominated for the RCM Slimming World Award for Partnership Working. The project involved working with a multi-

professional team involving social workers for children and family support services.

The maternity service team at the Royal Free site had been nominated for the Royal College of Midwives Award for Outstanding Partnership Working and the presentation ceremony is on 6 March 2019.