Care Quality Commission

Royal Free London NHS Foundation Trust

Barnet General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Medical care (including older people's care)	Good
Surgery	Good
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

This was the first inspection of Barnet Hospital under the new methodology. We have rated the hospital as Good overall with all core services rated as Good.

Barnet Hospital is a Good Hospital providing good levels of care and treatment across all of the eight core services we inspected.

We carried out an announced inspection between 2 and 5 February 2016. We also undertook unannounced visits during the following two weeks.

We inspected eight five core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Maternity and Gynaecology, Services for Children, Critical care, End of life care and Outpatients and diagnostic services.

Our key findings were as follows:

- Staff were proactive in reporting incidents and we saw evidence of learning taking place as a result of incidents. Learning was shared with all staff via safety briefings and posters were displayed within the department.
- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice.
- The needs of people living with dementia were being met, staff showed good understanding of the condition. The environment was good for patients living with mental ill health.
- We found where patients were unable to consent to restraint, no mental capacity assessment had been undertaken and no best interest decisions had been recorded. This meant that patients had their liberty restricted without hospital staff being able to evidence that the patient did not have the capacity to agree to the treatment plan.
- The trust used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to direct the treatment they provided and policies, procedures and local guidance were being reviewed to ensure they met NICE guidance. However following the acquisition of Barnet Hospital by the Royal Free Hospitals NHS Foundation Trust staff were still able to access the policies and procedures from the Barnet and Chase Farm NHS Hospitals Trust which could lead to confusion.
- Where risks were identified such as falls and pressure area management there were action plans to resolve or manage them in a timely fashion.
- The theatre recovery area is regularly used to accommodate patients overnight.
- There was very effective multidisciplinary team working between doctors, nurses, physiotherapists and other allied health professionals. The electronic patient record allowed information to be shared proactively between staff groups to ensure good coordination of patient care.
- Staff were supported by their managers and there was a culture of openness to learn and develop services. They were also supported by managers and the education team to develop their knowledge and skills to improve the quality of care provided to patients.
- The trust met the Royal College of Paediatrics and Child Health (RCPCH) standards for paediatric consultant staffing levels and nursing levels were generally complaint to both Royal College of Nursing (2013) and British Association of Perinatal Medicine standards (2011) for staffing children's wards and neonatal units .
- There was generally good access and flow within the children's service. Patients received evidenced based care and treatment and good multi-disciplinary working existed between the children's services, external providers and the child and adolescent mental health service (CAMHS).
- The Royal Free London NHS Foundation Trust and it's staff recognised that provision of high quality, compassionate end of life care to it's patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team, end of life care guidelines and an education programme.

Summary of findings

- The palliative care team was highly thought of throughout the hospital and provided support and education to clinical staff. The team worked closely with the practice educators and link nurses at the hospital to provide education to nurses and health care assistants. Medical education was led by the medical consultants and all team members contributed to the education of the allied healthcare professionals.
- The outpatient and radiology departments followed best practise guidelines and there were regular audits taking place to maintain quality.
- The trust had consistently not met the referral to treatment time standard or England average since April 2015.
- There had been a deterioration in the 62 cancer wait times compared with the national standard.
- The hospital cancelled 35% of outpatient appointments in the last year. From October to January 34% of short notice cancellations were due to annual leave, which was not in line with trust policy.

We saw several areas of outstanding practice including:

- We observed dynamic nursing leaders who supported clinical environments are were essential in the development and achievement of best practice models.
- The neonatal unit at Barnet hospital was very well equipped and offered outstanding levels of compassionate care delivered by all grades of staff from across the whole of the multidisciplinary team .
- The neonatal unit had level 2 UNICEF accredited baby friendly status where breast feeding was actively encouraged and mothers are given every opportunity to breast feed their babies.

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

Importantly, the trust must:

- The trust must take action to ensure compliance with The National Patient Safety Agency (NPSA) alert PSA001 issued 31st January 2011.
- The trust data base of clinical guidelines and procedures hosted via “freenet” should be updated as soon as possible.
- The recovery area ambiance of theatre must be altered to protect children from witnessing upsetting sights and hearing frightening sounds.
- Theatre recovery staff must be receive PILS training.
- The trust must address the issue of the day surgery unit being used to accommodate patients overnight.
- The trust must ensure the 62 day cancer wait times are met in accordance with national standards.
- Embedding of fresh eyes for review of CTGs
- Ensure that emergency drugs such as Sodium Bicarbonate and Adrenaline are removed from the Rescusitaires.

In addition the trust should:

- The trust should ensure the swab, needle and instrument policy is ratified and new practices are embedded in all relevant departments across all sites.
- The trust should ensure a safer surgery policy is produced and ratified.
- The trust should ensure that there is an electronic system in place to flag patients who may require additional support.
- The trust should ensure fridges are replaced on Damson ward.
- The trust should ensure appropriate storage of medicines in the day surgery unit.
- The trust should introduce the use of POSSUM scoring.
- The trust should ensure the call bells in theatres are improved to be louder.
- The trust should ensure that RTT is met in accordance with national standards and England averages.
- The trust should ensure all staff interacting with children have the appropriate level of safeguarding training.
- The trust should ensure security of prescription forms is in line with NHS Protect guidance.
- Ensure emergency medication is stored safely and access to these drugs is controlled.

Summary of findings

- The hospital should ensure that all staff undertake mental capacity assessments and record best interest meetings to ensure that they can evidence that staff are working the legal framework of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training.
- Ensure that good standards hygiene practices are followed in clinical areas such as hand hygiene and bare below area.
- The trust performance in the National Safety performance improves to meet the England average.
- The trust ensures that staff mandatory training on the medicine wards meets the trust target of 95%.
- Arrangements around equipment storage should be reviewed so that shower rooms are not used.
- The ward environments for individuals living with dementia should be improved.
- Improve antenatal risk assessments.
- Undertake a maternity acuity staffing assessment to identify staffing requirements for the merged service.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	Staff were proactive in reporting incidents and we saw evidence of learning taking place as a result of incidents. Learning was shared with all staff via safety briefings and posters were displayed within the department. Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice. The trust utilised a range of policies and guidelines, which were based on national guidance. Staff were aware of these guidelines and had received appropriate induction and training to carry out their roles. There was very good evidence of multi-disciplinary working within the department and all members of the MDT worked well together. The ED provided compassionate care and staff ensured patients were treated with dignity and respect at all times. Patients spoke positively about the care they received and the attitude of motivated and considerate staff and were satisfied with the care they received. The department had a good understanding of patient flow and managed the system well to ensure most patients accessed the appropriate care pathway for their needs. The needs of people living with dementia were being met, staff showed good understanding of the condition. The environment was good for patients living with mental ill health. Operational managers and clinical staff worked together as a team to manage the capacity in the hospital and address the challenges faced by the ED on a daily basis. There was an open culture so staff could raise concerns. Staff sickness was low and there was a stable workforce within the department. There was clear leadership visibility with the department.
Medical care (including older people's care)	Good 	There was a positive culture of incident reporting. There were established processes for investigating incidents, and there was a range of forums for staff to receive feedback and learn from investigative outcomes.

Summary of findings

Staff were aware of their role in relation to safeguarding children and adults and knew how to access the safeguarding team for advice and guidance.
The hospital achieved an 'A' rating in the Sentinel Stroke National Audit Programme (SSNAP) for their performance in January to March 2015 and April 2015 to June 2015 and scored above the England average in the Myocardial Ischemia National Audit Project (MINAP), National Diabetes Inpatient Audit (NaDIA), and National Heart Failure Audit.
There was an effective multidisciplinary approach to care and treatment with good communication between the teams.
People were cared for by staff who were kind, caring and compassionate in their approach. Patients and their relatives were positive about their experiences of care and the kindness afforded them. We observed staff being friendly towards patients and treating them and visitors with understanding and patience.
Patients told us they were involved in decisions about their care and treatment and were given the right amount of information to support their decision making. Emotional support was provided by staff in their interactions with patients.
Medical specialities planned their services to meet the needs of the local population. They responded to the needs of an ageing population and were developing services to improve the experience of patients living with dementia.
There was good leadership and management within the medical directorate with strategies on how the services were to develop. Managers were visible and approachable. Staff were proud to work for the trust and enthusiastic in their work.
There was an appropriate system of clinical governance in the medical directorate that identified quality and risk issues. Trends could be readily identified and learning was disseminated to staff.
We found where patients were unable to consent to restraint, no mental capacity assessment had been undertaken and no best interest decisions had been recorded. This meant that patients had their liberty restricted without hospital staff being able to evidence that the patient did not have the capacity to agree to the treatment plan.

Summary of findings

Rates of harm free care as monitored by the National Safety Thermometer were displayed and showed wards scoring between 76.9% and 90.7%, which was below the England average of 94%.
Adequate personal protective equipment (PPE), hand washing facilities and hand gel were available for use at the entrance to the wards / clinical areas and standards of hand washing and cleanliness were regularly audited. However we observed poor infection control and hygiene practices.
Compliance with mandatory training for the medicine directorate was 75.1% for medical staff and 85.4% for nursing which was below the trust target of 95%.
The trust used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to direct the treatment they provided and policies, procedures and local guidance were being reviewed to ensure they met NICE guidance. However following the acquisition of Barnet Hospital by the Royal Free Hospitals NHS Foundation Trust staff were still able to access the policies and procedures from the Barnet and Chase Farm NHS Hospitals Trust which could lead to confusion.

Surgery

Good

The general environment was visibly clean and a safe place to care for surgical patients.
We found that services for surgery at Barnet Hospital were caring and compassionate and were well led. There was a good approach to team work and a good team ethos to achieve the best care for patients. Senior staff were visible, available and supportive to all staff.
Staff were aware of the safeguarding policies and procedures and had received training. Most staff understood their responsibilities under the Duty of Candour and were able to provide examples.
Mandatory training was up to date and staff gave examples of specialist courses undertaken.
There was a good culture of reporting incidents and we saw evidence of changes to practice as a result of investigations, and there were robust systems in place.
Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
All patients were treated with respect and dignity, and services were responsive to patient's complex needs.

Summary of findings

Staff were competent, knowledgeable and passionate about their specialties on both the surgical wards and in the theatre department.
Wards and departments undertook frequent audits such as environmental, theatre checklist, infection control, hand hygiene, falls and pressure areas. Clinical governance teams analysed the audits and fed the results back to staff.
Where risks were identified such as falls and pressure area management there were action plans to resolve or manage them in a timely fashion.
Recovery was used regularly to accommodate patients overnight.
Barnet hospital performed badly in the national emergency audit. (NELA)
Physiological and Operative Severity Score for the enumeration of Mortality and Morbidity (POSSUM) is widely used in the UK in surgery. It measures surgical outcomes based on a standardised scoring system. It provides the patient with as much information as possible to make fully informed consent. This was not being used at Barnet Hospital.
The trust was non-compliant with The National Patient Safety Agency (NPSA) alert PSA001 issued on 31st January 2011.

Critical care

Good

Staff were proactive in reporting incidents and there was evidence that learning from investigations had taken place consistently with an effective system in place to ensure all staff were aware of updates to practice.
We found good levels of cleanliness, infection control and hygiene across critical care and rates of hospital acquired infection were low.
Staffing levels were reviewed continually using an established nursing acuity tool staff to provide care and was in line with national guidance.
Patients on the critical care unit received effective care and treatment that met their needs. Their care and treatment was planned and delivered in line with national and local guidelines.
Patients were treated with compassion, dignity and respect and staff provided emotional support to patients and relatives. All of the patients we spoke with praised the staff for the care they provided and said that they would recommend the critical care services.

Summary of findings

There was very effective multidisciplinary team working between doctors, nurses, physiotherapists and other allied health professionals. The electronic patient record allowed information to be shared proactively between staff groups to ensure good coordination of patient care. Staff were supported by their managers and there was a culture of openness to learn and develop services. They were also supported by managers and the education team to develop their knowledge and skills to improve the quality of care provided to patients.
The leadership team had oversight of the issues affecting the unit but it was unclear what plans were in place to address these.

Maternity and gynaecology

Good 

A single management team oversaw the main maternity site at Barnet Hospital and a small birthing centre at Edgware Hospital.
At Barnet Hospital wWe saw examples of safety incident reporting systems, audits concerning safe practice, and compliance with best practice in relation to care and treatment.
Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed that staff carried out care in accordance with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.
The ratio of clinical midwives to births was one midwife to 29 women which is slightly higher than the national average of one to twenty eight women. The trust provided evidence of one-to-one care during labour which is recommended by the Department of Health.
Women confirmed that they had one to one care in labour and told us they felt well informed and were able to ask staff if they were not sure about something.
Patients and their relatives spoke highly of the care they received in both the maternity and gynaecology services.
At Edgware Birth Centre we saw examples of safety incident reporting systems,audits concerning safe practice, and compliance with best practice in relation to care and treatment. Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed that staff carried out care in accordance with

Summary of findings

National Institute of Health and Care Excellence (NICE) guidelines.The trust provided evidence of one-to-one care during labour which is recommended by the Department of Health.
However, the named midwife model was not yet in place.
Care and treatment did not always reflect current evidence-based guidance.Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care. However, some of these guidelines were out of date.
The management structure was top heavy with more band seven midwives than band six midwives. Senior management and trust board members were not visible. Management had made important changes to the service without consultation.

Services for children and young people

Good

The trust met the Royal College of Paediatrics and Child Health (RCPCH) standards for paediatric consultant staffing levels. Nursing levels were generally complaint to both Royal College of Nursing (2013) and British Association of Perinatal Medicine standards (2011) for staffing children's wards and neonatal units .
There was generally good access and flow within the children's service. Patients received evidenced based care and treatment and good multi-disciplinary working existed between the children's services, external providers and the child and adolescent mental health service (CAMHS).
Training provision to staff was good with meticulous recording of mandatory training enhanced by the implementation of a new on line data base to monitor staff compliance.
Children's service were effectively supported by children's critical care and neonatal retrieval services.
Staff were caring, compassionate and respectful. Staff we spoke with were positive about working in the service and there was a culture of flexibility and commitment.
The service was well led and a clear leadership structure was in place. Individual management of the different areas providing acute children's services were well led. A governance system was in place and we saw that clinical risks identified. Feedback from staff, parents and children and young people was generally good.

Summary of findings

Although services provided evidenced based care as identified within evidenced based clinical guidelines, many of these were out of date posing potential risks to patients.
The poor post-operative recovery facilities for children exposed them to potential hostile sights and sounds and recovery nursing staff were not PILS trained.

End of life care

Good

They was a dedicated team providing holistic care for patients with palliative and end of life care (EOLC) needs in line with national guidance.
The hospital provided mandatory EOLC training for staff.
A current EOLC policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.
The Royal Free London NHS Foundation Trust and its staff recognised that provision of high quality, compassionate end of life care to it's patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team, end of life care guidelines and an education programme.
The palliative care team was highly thought of throughout the hospital and provided support and education to clinical staff. The team worked closely with the practice educators and link nurses at the hospital to provide education to nurses and health care assistants.
Medical education was led by the medical consultants and all team members contributed to the education of the allied healthcare professionals.
Medical records and care plans were completed and contained individualised end of life care plans. Most contained discussions with families and recorded cultural assessments. The 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were all completed as per national guidance. However there were inconsistencies in the documentation in the recording of Mental Capacity Act assessments.
There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. These referrals were seen and acted upon within 24 hours.

Summary of findings

The EOLC service had supportive management and visible and effective board representation. This had resulted in a well led trust wide service that had a clear vision and strategy to provide a streamlined service for EOLC patients.

Outpatients and diagnostic imaging

Good

The areas we visited were clean and tidy. Staff on the whole demonstrated good infection control practices. Staff reported incidents and there were good systems of incident feedback to staff and to governance committees.

Records management was good and over a 12 month period almost 100% of complete medical records were available for clinics.

The outpatient and radiology departments followed best practice guidelines and there were regular audits taking place to maintain quality.

Staff contributed positively to patient care and worked hard to deliver improvements in their departments.

Staff felt supported by their managers and stated their managers were visible and provided clear leadership.

The trust had consistently not met the referral to treatment time standard or England average since April 2015.

There had been a deterioration in the 62 cancer wait times compared with the national standard.

The hospital cancelled 35% of outpatient appointments in the last year. From October to January 34% of short notice cancellations were due to annual leave, which was not in line with trust policy.

Barnet General Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Barnet General Hospital

Barnet Hospital is situated in the borough of Barnet which has a population of around 370,000. The hospital has a total of 538 beds. The hospital has a full Accident & Emergency (ED) and Urgent Care Centre (UCC).

Our inspection team

Our inspection team was led by

Chair: Janelle Holmes, Director of Operations and Performance, Salford Royal Foundation Trust

Team Leader: Nicola Wise Head of Hospital Inspection Care Quality Commission

The trust was visited by a team of CQC inspectors and assistant inspectors, analysts and a variety of specialists.

There were consultants in emergency medicine, medical care, surgery, paediatrics, cardiology and palliative care medicine and junior doctors. The team also included midwives, as well as nurses with backgrounds in surgery, medicine, paediatrics, neonatal, critical care and palliative care, community services experience and board-level experience, student nurse and three experts by experience.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people

Detailed findings

- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, Monitor, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospitals and community services, including doctors, nurses, allied health professionals, administration, senior managers, and other staff. We also interviewed senior members of staff at the trust.

Facts and data about Barnet General Hospital

The hospital provides a full range of adult, elderly and children's services across medical and surgical specialties. The hospital provides dedicated specialist wards for older people, a cardiology service (including a coronary care unit), a dialysis unit and a level 2 neonatal intensive care unit.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Urgent and emergency services

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

Information about the service

The Royal Free Hospital NHS Foundation Trust has Emergency Departments (ED) on two sites; one at the Royal Free Hospital and another at Barnet Hospital. Both sites provide a 24-hour, seven days a week service. 208,949 patients attended the ED department on both sites during 2014-2015. About 22.1% of ED attendances resulted in admission during March 2014 - April 2015.

A clinical director, an operational manager and two matrons led the department. This was a separate leadership team from Royal Free hospital and feed into the trust divisional structure.

Barnet ED was extensively redeveloped in 2013 in terms of size and quality of the building estate as part of the Barnet, Enfield and Haringey (BEH) clinical strategy due to the closure of the Chase Farm Hospital ED. The Royal Free NHS Foundation Trust acquire the Barnet and Chase Farm Hospitals in July 2014.

The ED at Barnet Hospital saw about 138,328 adult patients during 2015 compared with 79,412 in 2014 and 41,319 paediatric patients in 2015 compared with 22,398 in 2014.

There were different areas in ED depending on the severity of condition of patients. There was a six bedded resuscitation unit, commonly known as 'resus', for patients with immediately life threatening illnesses and injuries, this included one dedicated area for paediatric patients.

The 'majors' area, for patients with acute illnesses had eighteen cubicles and two side rooms, could be used to isolate patients or provide privacy. There was also one psychiatric assessment room.

The area for treating low risk patients whose condition was not life threatening, often called 'minors', had nine treatment areas including a minor room, GP room, a triage room and a plaster room. This area also included the Urgent Care Centre (UCC) for GP services

There was a separate children's ED with its own waiting area. The waiting area was also the play area and toys were available. It had five assessment rooms and a separate breast-feeding room. There was also a paediatric assessment unit run by the paediatric department.

The department also managed the Adult Assessment Area (AAU). The AAU had seven bays for male patients and six bays for female patients; it also had two side rooms and four chairs.

All 'Walk-in' patients registered with staff at reception. There were 42 chairs in the waiting area. A nurse triaged adult patients to the appropriate area. All children were triaged by a children's nurse in the children's ED.

Patients who arrived by ambulance were taken through a separate entrance. Seriously ill patients were taken to resus and those less seriously ill were assessed in a three bedded rapid assessment area and after assessment were transferred to the main ED.

Urgent and emergency services

We inspected the hospital in one day and visited unannounced on the same evening. During our inspection, we spoke with 57 members of staff and 22 patients and relatives. We examined 10 sets of medical notes for patients treated in the department.

Summary of findings

Overall we rated the Barnet Hospital Emergency Department as Good because;

Staff were proactive in reporting incidents and we saw evidence that learning had taken place as a result of incidents. Learning was shared with all staff via safety briefings and posters were displayed within the department.

Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice.

The trust utilised a range of policies and guidelines, which were based on national guidance. Staff were aware of these guidelines and had received appropriate induction and training to carry out their roles.

There was very good evidence of multi-disciplinary working within the department and all members of the MDT worked well together.

The ED provided compassionate care and staff ensured patients were treated with dignity and respect at all times. Patients spoke positively about the care they received and the attitude of motivated and considerate staff and were satisfied with the care they received.

The department had a good understanding of patient flow and managed the system well to ensure most patients accessed the appropriate care pathway for their needs.

The needs of people living with dementia were being met, staff showed good understanding of the condition. The environment was good for patients living with mental ill health.

The trust has been above the England average for percentage of patients seen within four hours since February 2015.

Operational managers and clinical staff worked together as a team to manage the capacity in the hospital and address the challenges faced by the ED on a daily basis.

Urgent and emergency services

There was an open culture so staff could raise concerns. Staff sickness was low and there was a stable workforce within the department. There was clear leadership visibility with the department.

However;

Staff did not felt part of the overall trust vision and there was no long term plan for Barnet ED service since the takeover by Royal Free NHS foundation trust

Are urgent and emergency services safe?

Good

We rated safety in the Emergency Department as Good because;

- We observed staff washed their hands between seeing patients and all equipment was cleaned properly.
- Medicines were stored appropriately, with a separate locked cupboard for controlled drugs. Fridge temperatures were checked daily, however these were not recorded in accordance with recommended guidelines.
- There was formal scoring or an early warning system to identify deteriorating patients in the department.
- Staff were proactive in reporting incidents and we saw evidence that learning had taken place as a result of incidents. Learning was shared with all staff via safety briefings and posters were displayed within the department.
- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice.

However;

- Patients arriving via ambulance did not consistently receive an assessment within 15 minutes of arrival, which was not in line with Royal College of Emergency Medicine (RCEM) guidance.
- The nurse to patient ratio in the resuscitation area was not in line with the Royal College of Nursing staffing recommendation.
- Staff in the ED had not met the trust target of 95% for mandatory training. However, there was an action plan to achieve this target.

Incidents

- The ED departments for the trust reported 615 incidents to national reporting and learning system (NRLS) during January 2015 – December 2015, accounting for 6.6% of all incidents reported by the trust. 77% of those

incidents reported by ED had resulted in no harm. The top three categories of incidents reported were access, admission, transfer and discharge, implementation of care and on-going monitoring and clinical assessment.

- The Barnet ED reported twenty-five serious incidents (SIs) between November 2014 and October 2015. Out of 25 serious incidents, two incidents resulted in death of patient. We reviewed the serious incident investigation reports and a panel including divisional directors, clinical director, matron and clinical governance leads reviewed these incidents in particular to identify any learning or changes to policy or process that were required within the department. Unexpected deaths in department were discussed at the monthly departmental board meetings and at the quarterly departmental clinical governance committee meetings.
- Out of 25 serious incidents, 20 incidents were related to ambulance delays. We reviewed the data submitted to us, which stated that patients were kept safe and observed until there was capacity available in the department. Patients were kept updated in terms of waiting times and the reasons behind it.
- There was one 'Never Event' reported for the period November 2014 to October 2015, which was related to wrong route of medication and which met the serious incident criteria. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The trust advised us that this had been fully investigated. Senior staff told us that intermediate actions have already been taken place and extra support was also provided to the staff member involved. Learning from this never event was also shared with staff and across Royal Free hospital as well via clinical governance meetings.
- There were no recorded instances of pressure ulcers, falls or catheter related urinary tract infections in the department between September 2014 and September 2015.
- Staff reported incidents using an electronic reporting system. Staff were aware of the incident reporting procedures and how to raise any concerns, staff said they were encouraged to report incidents and received direct feedback from their line manager, clinical leads and in teaching sessions. They gave us examples of incidents they had reported. Junior doctors and nursing staff showed us how they reported incidents on an electronic incident reporting system. We saw examples of incidents reported and action plans for delay in CT scan review and for a pressure ulcer case.
- We saw examples of root cause analysis (RCA) completed as part of the investigation of incidents. Lessons learned from incidents were shared across teams and duty of candour was applied.

Duty of Candour

- All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice. 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 told us that they receive training on duty of candour at induction. We saw a list of training dates for staff. Staff working in the resuscitation area showed good understanding of their roles and responsibilities in relation to the duty of candour.

Cleanliness, infection control and hygiene

- The trust had policies and procedures for hand hygiene and infection prevention and control.
- There were no cases of MRSA, C.Diff, and E coli reported for the ED during the period of April 2015 to October 2015.
- The trust audited hand hygiene in the ED on a weekly basis. Between May 2015 and November 2015, average compliance was 90%. Hand hygiene audit results were displayed on notice boards within the department.
- There were dispensers with hand sanitising gel situated around the ED walls including the main waiting area and reception. Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected.
- We observed staff consistently complied with hand hygiene practice. All staff regularly cleaned their hands as they moved around the ED from one area to another, or when leaving or entering the department. We observed all staff adhering to the infection control policy.
- The 'bare below the elbows' policy was adhered to and personal protective equipment (PPE) such as

disposable gloves and aprons were readily available in all areas. Most staff wore gloves and aprons when they treated patients. We saw regular infection prevention and control audits took place in order to ensure all staff were compliant with the trust's policies such as hand hygiene and the use of PPE.

- Most of the equipment we examined such as vital sign monitors, wheelchairs, toilet rising seats were visibly clean. We observed green 'I am clean' labels were in use to indicate when equipment had been cleaned. We also observed staff cleaning equipment with sterile wipes after use and beds being cleaned.
- There was 24-hours cover for domestic staff. We observed domestic staff cleaning the department throughout the day. We saw cleaning schedules displayed on the back of toilet doors and toilets were all clean. Disposable curtains around the cubicles were clean and stain free with a clear date of first use indicated on them. We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely. We noticed posters and information cards explaining waste segregation procedures and waste segregation instructions.
- The Barnet ED department's main entrance and surrounding pathways were clean and uncluttered. The room used by patients who were awaiting a mental health assessment was clean.

Environment and equipment

- The department was exceptionally clean throughout including storage rooms. The department was well spaced out with the exception of the minor's treatment area which seemed a little cramped on space. All areas within the department were brightly lit. Staff told us that they enjoy working in such clean environment.
- Documents submitted by the trust indicated the majority of equipment was in service, and the rest had a job reference number assigned with a service date. We randomly checked equipment in the adult and children ED and all equipment was in working order, with clinical engineering checks completed. All medical vital signs equipment were checked by the medical electronics department, signed and dated ID labels were applied to all machines.
- The resuscitation trolleys were correctly stocked and daily logbook was usually maintained. However, the resuscitation trolley in majors area had daily checks missed in five out of thirty days in January 2016 and two days out of four in February 2016.
- The secure room for mental health patients met the standards set out by the Psychiatric Liaison Accreditation Network. The furniture was clean and had no rips, there were two exits to the room and anti-ligature fittings.
- During the time of the inspection, the electronic door used by ambulance staff was broken and held permanently open. Efforts were being made to reduce the cold draft by putting up a marquee. Discussions with the contracts manager confirmed a contract was out to tender to have the two entrance doors to ED replaced.
- The environment of children's ED was child-friendly, the waiting room was bright with plenty of light and plenty of clean toys and books for children. There was a toilet with nappy changing facilities and a water dispenser.

Medicines

- Medicine was stored appropriately and controlled drugs in the resuscitation area were in a locked cupboard. We checked the logbook of the last three months and observed checks were carried out daily. Controlled drugs were checked by two registered nurses each night.
- Staffs were able to contact the main pharmacy department with clinical queries relating to medicines. There were pre-filled syringes for emergency medicines (adrenaline, atropine etc.) stored on trolleys, which allowed the nurses to access them quickly. These were stored in drawers on the trolley out of reach of patients and their relatives.
- There was piped oxygen available at each bed space.
- Fridges were locked to ensure safety and security of medicines. Staff checked and recorded current fridge temperature, but there was no evidence that the fridge was reset daily, and no records were kept of the minimum and maximum temperatures.
- Patient records contained appropriate documentation of medicines prescription and administration.

- Medicines errors were reported via the incident reporting electronic system. The incidents were reviewed by the medicines safety committee and learning was shared across staff via quarterly newsletter such as medicines safety bulletins.
- Medicines policies were available on the trust intranet and easily accessible to all staff.

Records

- There was a system for managing patients medical records adequately to ensure these were accessible and accurate. Reception staff generated a paper record, containing basic patient details, name and address when patients registered. When the patient was discharged this was returned to reception for filing. The reception staff would scan the paper documents including treatment records, into the patient's computer record. Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- We looked at eleven sets of patients' records to check that timely care was given to the patients and the department routinely carried out risk assessments such as for pressure ulcers. We found that all patients had vital observations done within 15 minutes of arrival. Patients were seen by the ED doctor within one hour in five out of eleven cases (45%). Where applicable, appropriate antibiotics were prescribed and administered in all cases. In three cases, patients were referred for input from other specialisms and in all those cases patients were seen within 1 hour of referral and met the departmental escalation policy. We saw well documented assessments of falls, pressure areas, and nutritional status in patient's notes.

Safeguarding

- The department had a positive focus on child safeguarding. All children who attended were checked to identify if they were 'at risk' within their home environment. We observed the input of patient details on the ED electronic patients recording system, staff showed us examples of the flagging system used to identify children deemed 'at risk.'
- Both clinical and nonclinical staff were aware of their respective responsibilities in relation to safeguarding and showed good understanding of safeguarding for adults and children**.** However, some staff had a more robust level of knowledge on the Mental Capacity Act than others, but others were able to confirm how they would access better information in addition to asking their own colleagues for advice and support. Information on how to report a concern was available and displayed on boards in the department.
- The paediatric ED had effective working relationships with the main paediatric in-patient department via the paediatric assessment unit and in the community.
- Staff in the paediatric department had up-to-date training and exhibited a good level of knowledge about safeguarding children. Overall staff were 94% compliant with safeguarding children level one training, 91% with level two and 80% with level three, 85% with safeguarding adult level one and 85% with level two training . Staff told us that there was a training programme to train groups of ED staff and to increase compliance with safeguarding level three training and we saw evidence that this training session happened twice in 2015.

Mandatory training

- Staff had relevant, up-to-date training in life support and advanced life support and paediatric life support. All consultants were competent in advance trauma life support (ATLS), advance paediatric life support (APLS) and advance life support (ALS).
- We looked at the e-Learning system reception staff used to complete their mandatory training, which included level one and two safeguarding training, information governance, infection control, non-clinical waste management, equality and diversity, and major incident planning.
- Although the department staff were not meeting the trust target of 95% for mandatory training, overall staff compliance with relevant areas was good. 80% were compliant with conflict resolution, 82% with equality and diversity, 87% with mental capacity act and deprivation of liberty (DoLS) training, 87% with waste management and 90% with infection control level one training. However, there was an action plan put in place by practice development nurse to increase compliance.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority ("blue light") were transferred immediately to the resuscitation area.

The ED knew of the patient's arrival in advance and an appropriate team prepared for their arrival. There was a fully equipped bed area for children in the resuscitation area.

- Rapid assessment and treatment (RAT) was nurse led with assigned consultant in the majors area, there was also an administration assistant to register patients quickly. A nurse assessed lower priority patients arriving by ambulance after receiving a handover from the ambulance crew. There were three beds with a vital signs monitor and ECG machines in the rapid assessment area; the room was well designed with easy access to resus area in case of an emergency and access to the UCC and majors area.
- The target for ambulance handover was 15 minutes. We observed four ambulance handovers, however on only two occasions the department met the target of handover within 15 minutes of ambulance arrival.
- Data submitted to us prior to inspection showed that in 95% of cases, the ambulance turnaround time for Barnet Hospital during December 2014 – November 2015, was more than 15 minutes.
- Ambulance median time to initial assessment for the trust was lower than the England average until March 2015. From March 2015 onwards, the trust performed above the England average. This data was published nationally at trust level only and the median time to initial assessment ranged from 2 minutes to 11 minutes.
- Ambulance turnaround time did not meet the national target of handover. There had been 126 'black breaches' (ambulances waiting over 60 minutes to hand over a patient) between November 2014 and October 2015. Barnet hospital had a high level of black breaches between December 2014 and March 2015 with the highest number recorded in January 2015 with 59 breaches.
- Staff told us the department received ambulances from two different trusts and there were issues with information not being shared between the two trusts' systems. This caused too many ambulances to arrive within minutes of each other. They confirmed that all these breaches happened when ambulances arrived in batches within a short period of time on those days when the department was very busy and there were exit blocks with bed availability, putting extra pressure on ED.
- We reviewed the data submitted to us, all these breaches were a combination of several issues including winter pressures on the department, high ambulance and patient flow capacity issues and no available bed in the main hospital, all of which caused blockages and resulted in breaches.
- Walk in patients registered with a receptionist. There were two GP streaming and two nurses allocated to the initial assessment area, who made initial observations and directed patients to the appropriate waiting area. We observed during the evening that the department was very busy and patients were standing in the waiting area as there were not enough seats.
- Nurses working in the initial assessment room confirmed they were certified as competent to triage patients and that agreed clinical protocols for triage, aligned to the universal triage tool were followed.
- After being booked at main reception, children were immediately directed to a separate children's waiting area. Child triage included a pain score. If a doctor had a concern about child safeguarding they contacted social services while the child was in department.
- There was formal scoring systems to identify deteriorating patients. Staff told us they used 'Patient at Risk' (PAR) scoring system for observations and vital signs of adult patients and Paediatric Early Warning Signs (PEWS) for children. We observed five cases where PAR scoring was completed appropriately.
- We observed a suspected case of sepsis, which was adequately investigated and relevant treatment, including antibiotics were given within the one hour target time frame.
- Staff raised concerns regarding patients waiting too long in the ED as no suitable beds were available within the hospital. They told us there were long waits to transfer patients living with mental illness to a more suitable location.

Nursing staffing

- The trust assessed staffing levels and skill mix based on the Royal College of Nursing (RCN), Emergency Care Association (ECA), and the Faculty of Emergency Nursing

(FEN) recommendations. RCN guidance recommended two registered nurses to one patient in cases of major trauma or cardiac arrest and one registered nurse to four cubicles in either major or minor trauma.

- At Barnet Hospital, the trust established nurse to patient ratio at 1:2 for resuscitation room which did not meet the RCN recommendations. For majors and minors area, the nurse to patient ratio was 1:4 and 1:7 and met the RCN recommendations.
- The nurse vacancy rate was 15%, Matron told us that a business case had been submitted to fill the remaining posts including adult and paediatric nurses. The ambulatory assessment unit was fully staffed and there were no vacancies. There were staff retention plans in place, including a in house foundation and adult emergency care courses, accredited by Middlesex University and University of Greenwich, which were transferable and would enhance recruitment and retention.
- The vacant positions were covered by agency staff and they usually had regular agency staff who were familiar with the department. Agency staff had to cover an induction check list before they were allowed to start work.
- All nurses we interviewed told us there were always enough medical and nursing staff on duty.

Medical staffing

- The adult ED department had nine whole time equivalent (WTE) consultants including one locum consultant (to cover a long-term sickness) at the time of our inspection. The department was not compliant with the recommendation of the college of emergency medicine of ten whole time equivalent consultants.
- Consultants were present on site from 8am until 10pm, weekdays and eight hours on weekends. The ED did not meet the CEM standard that consultants should provide 16 hours emergency cover seven days a week. However, consultants reported that they often stayed to midnight when department was busy.
- Doctors we interviewed told us medical cover was good with enough middle grades available at all times. Trainees told us the consultants were fully involved in care delivery and were confident there were sufficient numbers of staff available.
- Nursing staff we spoke with told us they got the support they needed from consultants and had no difficulty accessing them over night and at weekends.
- During our inspection, we observed there were sufficient medical staff to meet the demand.
- The department had low levels of sickness absence for medical staff (3%) and the medical vacancy rate was 9%.
- All consultants had obtained advance life support (ALS), advanced paediatric life support (APLS) and advanced trauma life support (ATLS) accreditation. All foundation year 2 and middle grade doctors were ALS accredited.

Major incident awareness and training

- There was a major incident plan in place, with clear allocation of responsibilities and triggers for escalation, to deal with a major external incident and with internal incidents. 89% of nurses and 91% of other staff had completed the emergency planning training by October 2015.
- All staff we spoke with were able to describe the process to follow in case of a major incident.
- The operational manager described the arrangements to deal with casualties contaminated with chemical or hazardous materials and items. We saw the equipment for major incidents was stored in a designated locked room.
- There were dedicated security guards within ED 24 hours a day seven days a week. Staff told us that they were generally very good and were trained in restraining. All security staff had their "security industry authority licence" and had training in conflict resolution and safe restraint, however they had no training in dealing with patients living with mental illness.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the ED at Barnet Hospital for effectiveness as good because;

- The trust utilised a range of policies and guidelines, which were based on national guidance. Staff were aware of these guidelines and had received appropriate induction and training to carry out their roles.

- There was very good evidence of multi-disciplinary working within the department and all members of the MDT worked well together.
- The department had dedicated staff to ensure patients were offered food and drink. Pain scores were recorded for most patients and we observed staff offering pain relief to patients within the triage and treatment areas.
- Specific groups of patients such as patients with sepsis received "sepsis six bundle" and children with wheezing had a pathway and there was useful information for parents
- The department participated in all relevant national audits in 2014-2015 and we saw the department had performed above the England average in most audits in 2013-2014 but worse in a few.
- The staff felt well supported by their seniors with good supervision an allocated time for training. Staff showed good understanding of consent and mental capacity act.

Evidence-based care and treatment

- The department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (CEM) guidelines to determine the treatment they provided and local policies were written in line with these. Evidence submitted to us showed that Barnet ED department audit programme incorporated NICE guidelines audits and were discussed at their clinical governance board meetings.
- Staff told us they used these guidelines regularly and showed us how they would access the local agreed guidelines on the trust intranet. We looked at the electronic paediatric emergency guidelines, which were up to date and in line with NICE guidance. We saw NICE guidelines displayed within the department.
- Staff used a variety of information technology within the department to enhance speed and access to patient care and treatment. This included internal electronic systems and systems used for digital imaging.
- There were specific pathways for certain conditions, for example, sepsis, acute cardiac syndrome and paediatric asthma. The department uses "sepsis six" model and staff displayed good knowledge of treatment options when treating patients who had sepsis.
- The trust scored similar to other trusts in the CQC ED survey 2014 for all three questions relating to effectiveness, including time taken to receive pain relief medication, staff doing everything to control the pain and availability of food and drink.

Pain relief

- The trust scored similar to other trusts in the ED survey 2014 related to pain relief offered to patients for example time it took to receive the pain relief, and staff help to control the pain.
- We observed patients in minors and majors area, they were asked to indicate their pain level on a scale of 1 to 10 with 10 described as very severe pain and were then offered pain relief accordingly. We saw the documents used to triage patients for adult and children and both had a dedicated space to document pain score. We observed an asthma patient in ED, receiving a pain assessment and being given pain relief appropriately, but when we checked patient's notes the pain score was not documented.
- We checked eleven sets of patient's notes, which showed staff had recorded pain scores in seven out of eleven cases and followed up appropriately.
- We saw pain leaflets available in the children's ED, which were in child friendly design, asking child to point to the face that best describes how they feel and scoring from zero (not hurt) to ten (hurts worst). There was information displayed for staff in line with RCEM standard for pain medication for children and on prescribing codeine.

Nutrition and hydration

Patient outcomes

- The department participated in relevant national audits of royal college of emergency medicine (CEM). They scored lower than the England average for three out of four indicators in the "consultant sign-off audit" in 2013. The standard states that three specific patient groups should been seen or discussed by a senior doctor or a consultant. However, the consultant saw 5% and senior doctors saw 47% of this patients group.
- The department participated in the CEM "severe sepsis and septic shock 2013- 2014" audit and had mixed results. They performed above England average for three out of twelve indicators. For example, in 100% cases serum lactate (indicator of sepsis in the blood)

measurement were obtained, antibiotic was given in 62% within one hour (standard was 50%) and special fluid to treat low blood pressure was given in 94% cases (standard was 100%). They did not do well in three indicators related to measuring and recording vital signs (51%) and administering antibiotics (87%) and performed same as England average in remaining indicators. Staff told us the actions taken as result of this included re-education of staff on the use of guidelines, clear display of guidelines and revised sepsis six criteria. We saw the "keep calm and do the sepsis six" protocol used in patient's notes.

- In the CEM "asthma in children 2013-2014 audit, The ED scored lower than the England average for three out of twelve indicators. These were related to initial observations within 15 minutes for blood pressure which was done in 2% and for GCS score (Glasgow coma score – tool used to assess level of consciousness) which was measured in 20% cases, and only 56% patient were treated with steroid. The department was expected to meet the standard of 100%. We reviewed the actions taken as a result of these outcomes and department had developed a paediatric wheeze pathway for children and a useful information fact sheet for parents.
- The department was similar to the England average for 'paracetamol overdose audit' in 2013-2014. In 71% of cases, patients received recommended treatment in line with the guideline and was same as the England average.
- The department scored well in CEM 'initial management of the fitting child 2014-2015 audit' and met the standard of 100% for recording clinical information in patient's notes.
- There were mixed results in the '2014-2015 mental health in the ED audit'.
- The ED scored above England average for one indicator and the same as England average for five out of six indicators in the '2014-2015 assessing for cognitive impairment in older people audit'.
- The unit contributed to the Trauma, Audit and Research Network (TARN) audits. However, the department was behind schedule to submit the data and placed this on their risk register, additional support was allocated to ensure all relevant data was submitted. From January 2012 to September 2015, the department performed within the expected range.
- We saw good sharing of results and actions from these audits displayed on governance boards in the staff rooms and in corridors.
- The un-planned re-attendance rate (number of patient re-attending within 7 days of a previous attendance at ED) for the trust was 8%, which was higher than the England average of 8% and always above the 5% target set by CEM. The trust was aware of this and informed us there were a few frequent re-attenders and staff knew the patients, they worked collaboratively within the multidisciplinary team to provide interventions.

Competent staff

- Appraisals of staff performance are to be undertaken annually. However, 74% of staff were appraised up until November 2015, which was below the trust's target of 95%. Senior staff showed us an appraisal programme for all consultants with dates booked for clinicians and told us that they will meet the target by end of financial year. Junior and middle grade doctors we spoke with had up to date appraisals.
- We observed clinical practice by both doctors and nurses was within accepted guidelines. Staff were competent and demonstrated a good level of knowledge and understanding of evidence based practice. They were aware of NICE and CEM guidelines.
- Junior doctors told us they felt well supported, had access to training and there was good clinical supervision. There was protected time allocated for teaching with weekly two hour teaching sessions and there was well-structured induction programme.
- A band 7 practice development nurse (PDN) was responsible for professional development of staff and worked jointly with emergency nurse practitioners (ENPs) at Royal Free hospital, sharing study days and courses. They had set up an accredited ED course for nurses in a partnership with the local university.
- Practice development nurse told us that staff receive email reminders from the trust and Nursing and Midwifery Council when nursing revalidation was due and there was a two hour in-house course with support from PDN for registered nurses to revalidate their nursing licence.
- Nurses involved in triaging patients received extra training. We observed five nurses triage patients, and confirmed that all were appropriately trained and their training records were maintained by the PDN.

- Nurses considered their managers were supportive of their professional development.
- The ED introduced a new induction policy for agency nurses in January 2016. Was saw evidence of completed induction checklists of several agency nurses. The checklist included relevant information about the department, important contact numbers and policies. Two agency staff who were on duty on the day of inspection had their induction completed on their first shift.
- The department manager had weekly one to one meetings with the head of nursing and they felt supported by the seniors.
- All the junior doctors we spoke with confirmed that there was a good induction programme and they had an allocated educational supervisor. They described how different cases were discussed at the weekly training sessions to allow for learning.
- Staff told us there was good support when they needed to attend external courses as part of their skill development.

Multidisciplinary working

- We observed the morning hand over huddle with two senior nurse and sister in charge. They used the mobile computer which allowed staff to briefly observe patients.
- We observed nursing handover of care during our unannounced visit in the evening. The handover focused on allocation of staff, bed capacity, number of patients within each area, number of breaches and waiting time. There was good leadership, a consultant was present and staff were clear of their roles. However, there was no safety briefing or update on any incidents or sharing of learning information.
- We observed three handovers from the ambulance service to the ED staff. These were well structured and ensured that all the relevant clinical information about the patients conveyed properly.
- We spoke with two ambulance paramedics waiting with non-priority patients to register with the receptionist in the ED. They told us that staff were good and during peak periods staff had checked patients within the ambulance to ensure patients were stable and there is no immediate harm. They told us that they preferred to bring patients here as there were better facilities and staff were caring.
- ED staff and “TREAT team” (Triage and rapid elderly assessment team) worked well to ensure prompt and effective assessment and discharge of elderly patients. Both ED and TREAT team staff members spoke highly of each other and understood the importance of joint working for these patient groups. Matron told us that the TREAT team were very proactive at reviewing patients. These good working relationships meant that staff were able to follow up and provide support within the community with a view to avoid future re-attendance.
- We observed good MDT working and positive interactions across all staff levels and specialties. Staff worked effectively with the alcohol liaison team (ALT) based within ED and ambulatory assessment unit.
- There were weekly safety net meetings between the safeguarding advisor, ALT, psychiatric liaison team, domestic violence advisor and senior nurses from ED.
- There were two acute liaison nurses (ALN's) for adults with learning disabilities across the sites, one was based at the Royal Free site the other based at Barnet and Chase Farm. The current process of being notified of admissions was that the ward, community, carers or family could contact the liaison nurse directly to inform of admission or planned appointments. All departments/wards and local community learning disability teams and care providers had trust contact details. Contact details were also on the Royal Free internet "learning disability page".
- The children’s ED linked with the children's specialist sickle cell nurse in the community trust.

Seven-day services

- The ED services for adults and children were open 24 hours a day, seven days a week.
- The on-call consultant was accessible out of hours.
- There was appropriate imaging and pharmacy support available 24 hours a day, seven days a week.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours, 7 days a week.
- MRI was available on weekdays 9:00 am -6:00 pm, ultrasound access was on on-call basis out of hour and at weekends.

Access to information

- The department IT clinical management system meet the requirements of the staff to have access to detailed information to enable them to care and treat patients in a safe and effective manner.
- However, staff told us that there was not enough training provided to staff when the new IT system was introduced in October 2015. The system was not integrated with laboratory system for blood results and it created delay in accessing timely information. There was no process for early identification of patients with dementia on the system and this could affect the care for some of these patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were available for adults with parental responsibility to consent on behalf of children
- Staff told us consent was mainly obtained verbally for procedures such as receiving medicines and minor procedures. Clinical staff we spoke with showed understanding of the mental consent and decision making requirements of legislation and guidance and they understood the requirements of the Mental Capacity Act 2005.

Are urgent and emergency services caring?

Good

We rated the ED at Barnet Hospital for caring as good because;

- Staff treated patients with respect and we saw staff interacting in a friendly and professional way with patients and their families.
- The ED provided compassionate care and staff ensured patients were treated with dignity and respect at all times. We noted staff had access to resources to assist them in offering emotional support to bereaved relatives and were able to direct relatives to external agencies for additional support.
- Patients spoke positively about the care they received and the attitude of motivated and considerate staff and were satisfied with the care they received.
- Patients and their relatives and families were kept informed of on-going plans and treatment. They told us that they felt involved in the decision making process and were given clear information about their treatment.

Compassionate care.

- We observed compassionate care delivered by nurses and doctors, particularly to children. Staff engaged in an open and positive way with patients and their relatives.
- Patient feedback was collected through the NHS Friends and Family Test. In September 2015, 85% patients surveyed would recommend the ED department to friends and family, this was lower than the England average (88%).
- The trust scored about the same as other trusts for all questions in the 2014 ED survey relating to caring. Survey covered broad spectrum of questions including staff communication with patients, information given to patients about their condition while they were in ED and patient involvement in decisions about their care.
- Our observations confirmed staff had regard to the privacy and dignity of patients. There was a system of allocating cubicles within the majors area depending on the severity of the case and dedicated cubicles for patient living with dementia. We observed that patients who arrived by ambulance waited in the corridor on wheelchairs, however those patients were with ambulance crew or a staff member and were not left alone. Women with gynaecology problems were treated in side rooms which protected their privacy and dignity.
- We saw thank you letters from patients who had been treated in ED.

Understanding and involvement of patients and those close to them

- Patients told us they felt informed about the processes in ED. They said that once treatment had started, staff dealt promptly with their needs and most felt very confident about the explanations and care they received.
- Parents accompanying their children in the children's ED were positive about the treatment their children received. They said the nurses and doctors understood them and were supportive. Parents commented positively on the knowledge of the staff treating their children.

Emotional support

Urgent and emergency services

- The ED staff had a protocol on how to deal with relatives who experienced bereavement. They demonstrated compassion when talking about this area. There is a separate room where the doctor or nurse would talk to the family if a relative died. Families could stay in viewing room for as long as needed.
- There was a 'bereavement box' with lots of useful information for staff and leaflets to give to relatives to inform them of where to obtain emotional support and information about organ donation.
- Staff told us patients and families were informed of how to obtain a counselling service if they wanted to. There was a link with child bereavement UK and a bereavement consultant would visit the family within a week to support them.
- Staff told us that after each untoward incident they had organised a short debriefing session to discuss learning and how it affected individual members of staff. There was counselling available for staff.
- Patient told us that staff introduced themselves and were friendly and polite
- They told us they felt safe in the department.
- The department had its own well-equipped kitchen to provide food and drink to patients. During daytime there were two hostesses responsible for ensuring that patients were offered hot or cold drinks and sandwiches. There were dedicated mealtimes for breakfast, lunch and dinner. Patients in adult assessment units were offered a hot meal at dinnertime. During evening and weekends, there were no ward hostess and food and drink was offered by nursing staff.
- There was a water cooler and vending machines in the main waiting room for relatives to use. There was water cooler in children's waiting area as well.
- All patients we spoke with, told us they were offered food or drink while they had been there.
- We observed patients being offered hot and cold drinks within the majors area. However, one relative with an elderly patient living with dementia told us that the patient had not been offered any drink, although they reached the majors area 15 minutes ago, they had been in the hospital for over an hour. We raised this with the staff at that time, they informed that patients were allowed fluids only after doctor had seen them. Soon after, the clinical team reviewed the patient and they were allowed to drink

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

Good

We rated the ED at Barnet Hospital for responsive as Good because;

- The department had a good understanding of patient flow and managed the system well to ensure most patients accessed the appropriate care pathway for their needs.
- The needs of people living with dementia were being met, staff showed good understanding of the condition.
- The environment was good for patients living with mental ill health.
- Staff showed good understanding of trust complaints procedure and were able to provide examples of complaints or concerns that resulted in change of practice.
- The trust has been above the England average for percentage of patients seen within four hours since February 2015.

However;

- There was no flagging system within the department to identify patients living with dementia.

Service planning and delivery to meet the needs of local people

- The Barnet, Enfield and Haringey (BEH) clinical strategy was implemented in December 2013. This transformational change included the closure of the ED at Chase Farm Hospital and the upgrade of Barnet Hospital's ED in terms of capacity and infrastructure. The intention was to amalgamate services and realise efficiencies in terms of delivery, pathways and protocols.
- The original modelling of attendances for ED Barnet was approximately 90,000 patients with a 10% increase of ambulance case. However, the influx of patients had increased beyond the BEH modelling and the department was seeing approximately 320-360 patients over 24 hours on average with numbers rising to 400 on busy days.

- Clinical lead told us that further work was done and a business case was submitted in October 2015 to meet the increasing demands on the department. We noted that Barnet hospital emergency flow was one of the priorities on the trust 2014-2017 strategic plan.

Meeting people's individual needs

- The trust provided a dedicated 7 day week children's emergency service and children were triaged in ED. Suitably qualified children's nurses cared for all children. The environment of children's ED was child-friendly, the waiting room was bright with plenty of light with plenty of clean toys and books for children.
- The environment was good for patients living with mental ill health. The secure room meet the standards set out by the psychiatric liaison accreditation network, there were two doors to enter and exit. However, staff told us that there was a need for a safe room within the children's ED as teenagers living with mental ill health are kept in a regular treatment room as there is no dedicated space.
- There were high number of patients attending the ED with mental health needs, both because they had been brought by the police under section 136 of the Mental Health Act, and for other reasons. There was a dedicated mental health team, with two mental health nurses to assess patients, a mental health doctor was based at Edgware community hospital and would visit the hospital if needed. The mental health team worked with ED staff to provide specialist mental health, safeguarding and capacity assessments, and supported with referrals to relevant teams. However, prolonged waiting times for a suitable bed in a mental health hospital meant patients frequently stayed over 12 hours in ED.
- Staff told us that if a child and parent both with mental ill health attended for the first time, they would admit the child and the mental health team would assess both parent and child.
- We found the needs of people living with dementia were being met. There were three dedicated bays within majors area that were dementia friendly. There were dementia friendly clocks within the department. All staff showed good understanding of the condition. The department used an electronic system for patient records, but there was no process to flag patients with learning disability or dementia but staff would take relevant history of the patient. In adult assessment unit (AAU) we saw "forget me not" stickers used for patient living with dementia.
- We looked at the relatives' room where people waited while their seriously ill relatives were being cared for, or where people were informed that a relative has passed away. We found the room clean with suitable furniture. There was a separate viewing area/room where people could see their deceased relative within the ED.
- There was an alcohol liaison team (ALT) based within ED. 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 the hospital. Staff offered patients who came to ED a referral to the nurse who organised a detoxification programme in the community. ALT also gave advice on external support agencies for both alcohol and drugs.
- Staff confirmed they had 24-hour access to a telephone interpreting service. Information leaflets were available in English language only. Matron showed us a draft information booklet, which they intended to be printed in six languages to reflect the local community they serve. However, there no definite date was given to us of when it would be available.
- There was support from bereavement services and links with local Priest and Mosque Imam.

Access and flow

- Nationally agreed emergency department quality indicators state that 95% of patients should be seen, treated, discharged or admitted within four hours. An overview of the compliance report of the four-hour performance against this target between January 2015 to December 2015, indicated the Barnet hospital achieved 94%, which was below the national target but above England average.
- The trust scored the same as other trusts, for all questions in the 2014 ED survey relating to responsiveness. For example, questions related to privacy when discussing their condition or when being examined or treated and waiting time in ED.
- There was a higher proportion of emergency admissions via ED (Royal Free and Barnet hospital combined) waiting 4-12 hours from the decision to admit until

being admitted, particularly in January 2015. During September 2014 and August 2015, there were 5,437 people waiting 4-12 hours but zero people waiting over twelve hours from decision to admit to admission.

- The trust performed above the England average for total time spent in ED between January 2013 and September 2015. The figures started to decline from March 2015.
- Around 3% of ED (Royal free and Barnet hospital combined) attendees left without being seen, which is just above the England average of 2.7%.
- We observed flow of patients through minors and streaming, which was handled in a timely and methodical way. The two receptionists at the public entrance to the ED saw patients who walked into the department or who were brought by friends or family. The receptionists we spoke with said they spoke to the nurse when they thought the patient needed prioritising. They directed adult patients to the waiting area. Nurses assessed adult patients promptly and decided on the next step. Patients needing urgent and more intensive intervention were transferred through to the resuscitation or majors part of the ED.
- However, during busy period, the initial assessment and triage took as long as 30 minutes. During our unannounced visit in the evening, the waiting area was very busy with relatives standing, as there were no spare chairs. Staff told us the waiting time after initial triage was three and a half hours.
- We observed the bed management meeting in the morning and afternoon. There were nine breaches of the four-hour target on the day of our visit and there were six patients waiting more than ten hours to be admitted. There were four daily bed management meetings within the hospital and every two-hour escalation review within the department to monitor bed status. Staff told us this was mainly due to no appropriate beds being available for the type of care required as in-patient. We saw one patient waiting for more than six hours for a respiratory bed once decision was made to admit the patient. However, some staff were not clear about the escalation process for the trust to open more beds.
- As part of the BEH clinical strategy, in 2013 adult assessment unit (AAU) was designed to be a 12 hour clinical decision unit and contained 15 trolley spaces and 4 reclining chairs. However, staff told us that there were exit blocks due to insufficient ward capacity on the Barnet site, the unit was used by all specialities (but predominantly medicine) as a holding point before ward allocation. Additionally, we were told that on occasion, the unit had a number of psychiatric inpatients awaiting inpatient mental health beds, sometimes for days, who required significant amounts staff resources in order to maintain safety.
- We spoke with ambulance staff waiting with non-priority patients to register with the receptionist in the majors area of ED. They confirmed that there had been problems in the past with long waits when several ambulances had arrived within a short period. However, even under pressure the staff were professional and the process for handover was efficient and no patient came to any harm.
- The rapid assessment and treatment (RAT) area was set up to assess and treat patients with a range of conditions promptly. For example, nursing staff were able to provide a patient with an ECG (electro-cardiogram), or to carry out other observations. The area was led by a senior nurse/ emergency nurse practitioner (ENP) with allocated consultant to oversee.

Learning from complaints and concerns

- ED (trust-wide) received 179 complaints between 1 December 2014 and 30 November 2015, which was 13% of all complaints received by the trust.
- The three most common causes for complaint were clinical treatment, communication and attitude of staff.
- There were copies of the trust's complaints procedures in the waiting room and staff told us, if a patient wishes to make a complaint they do their best to resolve it often with the ED matron's help and/or the PALS (patient advice and liaison service).
- All staff confirmed awareness of trust the complaints procedure and were able to provide examples of complaints or concerns that resulted in change of practice or demonstrate how they learnt from it. For example, staff gave told us about a complaints that resulted in improved care and facilities for people leaving with dementia. As a result of which, they purchased and placed special pictures recommended by the dementia society in the ED and adult assessment unit cubicles often used for patients with dementia, as these pictures would help them to calm down if they were distressed. The staff put together a “dementia box”

with items to help with calming and supporting these patients, for example, memory cards from different years (1950's and 1940's) and knitted items donated by the trust charity.
- The department purchased a CD player and nursing staff have donated CD's with types of music patients may like. Additional training to ensure staff were aware of the individual needs of patients with dementia was provided in ED by the dementia lead.

Are urgent and emergency services well-led?

Good

The emergency department for The Royal Free Hospital NHS Foundation Trust at the Barnet site was led by a clinical director, an operational manager and two matrons. This management structure reported to the urgent care divisional board and had joint governance meetings with the Hampstead site.

We rated the ED at Barnet Hospital for well led as Good because:

- Operational managers and clinical staff worked together as a team to manage the capacity in the hospital and address the challenges faced by the ED on a daily basis.
- There was an open culture so staff could raise concerns. Staff sickness was low and there was a stable workforce within the department.
- There was clear leadership visibility with the department. There were clear governance arrangements and we saw evidence of their meetings.
- However, staff did not felt part of the overall trust vision and there was no long term for Barnet ED service since the takeover by Royal Free NHS foundation trust.

Vision and strategy for this service

- The department had gone through two major changes within the last three years, with the closure of the ED department at Chase Farm Hospital in 2013 and a takeover by the Royal Free NHS foundation Trust in July 2014.
- There were extensive consultations over a number of years with Barnet, Enfield, and Haringey commissioning groups and a BEH clinical strategy was developed . The trust had predicted an increase in patients to the department and invested in expanding the ED area at that time. The Clinical Lead told us that more was being done and a business case was submitted in October 2015. This was about meeting the increasing demands on the department as the influx of patients had increased beyond the BEH modelling. We reviewed the documents submitted to us, which showed that Barnet hospital emergency flow was one of the priorities on the trust 2014-2017 strategic plan.
- Staff were aware of trust's values. Staff could name them and knew what they meant. However, senior staff told us that they did not feel part of the overall trust vision and that there was no long-term vision for Barnet ED service since the takeover by Royal Free NHS foundation trust.

Governance, risk management and quality measurement

- Staff were able to articulate the department governance arrangements and which individuals had key lead roles and responsibilities within ED. They were also clear of their own individual roles and responsibilities and commented on the considerable amount of governance information available in the staff seminar room.
- Clinical governance was embedded at local level with structured standard monthly meetings and monthly unit meetings. We noted from the minutes of these meetings that complaints, incidents and risk were discussed, evaluated and monitored.
- The department maintained its own risk register. Risks deemed to be the most significant were transferred to the trust's overall risk register. Matrons were aware of risks that had been escalated on this register and told us they were encouraged to identify and escalate risks. There was alignment between the recorded risks on the risk register and what staff expressed was on their 'worry list'.

Leadership of service

- A clinical director, an operational manager and two matrons led the department. This was a separate leadership team from Royal Free hospital and fed into the trust divisional structure. The nurses and doctors we spoke with were all clear as to their lines of supervision.
- Managers were aware of the areas where the hospital had challenges, the need for streamlining the

ambulance calls, working more effectively with GPs to identify appropriate non-emergency ambulance referral to specialities at Royal Free hospital and managing the growing demand for beds.
- We observed good leadership skills during handovers, consultants and senior nurses gave clear guidance and support to junior staff.
- The department was well managed on the day of the inspection and particularly the minors area when it became very busy. The staff spoke well of the excellent support they receive from medical and nursing leadership in the department. However, there were concerns from staff that the trust had not fully supported ED when any issues were raised related to access and flow or IT related concerns.
- Staff who were transferred when Chase Farm hospital ED closed down in 2013, thought the transfer was seamless and well managed. However there was limited communication during the more recent Royal Free take over.

Culture within the service

- The department appeared well managed with staff going about their work in a calm and measured way. There was a strong team spirit from top to bottom within the department.
- We observed good team working among nurses within the department. Shift leaders were very committed to patients and to supporting their staff, they feel their contribution was valued within the department.
- Junior doctors felt well supported for their training and supervision. Staff spoke highly of the ED matron.
- We saw that the medical team worked well together, with consultants being available for junior doctors to discuss patients and receive advice.
- All staff we spoke with were passionate about providing empathetic care and it was a close knit team. Several staff expressed their delight in working in the department, two members of staff describing it as an "amazing place to work in". Two student nurses said they hoped once qualified they would like to return to the department to work as the staff were very friendly and supportive.
- However, morale was lower among senior staff and they felt that their input was not valued during Royal Free NHS foundation trust takeover.

Public and staff engagement

- Feedback from patient was obtained from the NHS Friends and Family test and 82% of people survey would recommend the emergency department at Royal Free Hospital.
- We reviewed the urgent care divisional board report, which showed that FFT results were discussed and monitored at this bi monthly meeting. We did not see other ways of gathering feedback from users.
- Staff told us, they felt involved and that their contributions were valued within the Barnet hospital, however, they still did not felt as part of whole trust.

Innovation, improvement and sustainability

- In order to ensure that the current and future nursing workforce wass fit for purpose, the Emergency Departments and Urgent Care Centre across the trusts hospitals have had to look at different ways of working in order to " grow our own" senior workforce. In order to support this strategy the ED and UCC departments have developed an accredited 'foundations in emergency nursing course', accredited by the university of Middlesex. All of the courses were transferable worldwide and had the added benefit of being able to income generate from external candidates.
- To improve patient care for their elderly patients attending the ED, there was a consultant led TREAT (Triage and Rapid Elderly Assessment Team) which reached into ED to take over care of >80 years old and expedite their discharge safely.
- ED introduced ECP (Emergency Care Practitioners) within Urgent Care Centres at Barnet and Chase Farm to develop and retain their nursing staff and introduced nurse led discharges in paediatrics ED.

Medical care (including older people's care)

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

Information about the service

Barnet Hospital is an acute hospital with 235 inpatient beds providing a range of medical care services. These services include cardiology, respiratory medicine, general medicine, stroke and older person medicine.

In the period 1 January 2015 to 31 December 2015 Barnet hospital admitted 22,503 patients; of these 54% were general medicine cases and 22% gastroenterology cases.

We inspected the clinical decision unit (CDU), general medicine wards (Quince and Olive), older person's wards (Palm, Juniper, and Larch), respiratory ward (Walnut), cardiology ward (Rowan) and Coronary Care Unit (CCU), stroke ward (Spruce) and discharge lounge.

We visited the medical service at Barnet Hospital for one announced inspection day. During the inspection visit we spoke with 33 patients including their family members and carers, 56 staff members including nurses, doctors, consultants, senior managers, therapists, and support staff. We observed interactions between patients and staff, considered the environment and looked at 24 care records. We received comments from our listening event and from people who contacted us to tell us about their experiences. To support information provided by staff during the visit, we reviewed documentation and computer based information. We also requested and reviewed additional documentary evidence during and following the inspection.

Summary of findings

Overall we rated the medical care at Barnet Hospital as Good because;

There was a positive culture of incident reporting. There were established processes for investigating incidents, and there was a range of forums for staff to receive feedback and learn from investigative outcomes.

Staff were aware of their role in relation to safeguarding children and adults and knew how to access the safeguarding team for advice and guidance.

The hospital achieved an 'A' rating in the Sentinel Stroke National Audit Programme (SSNAP) for their performance in January to March 2015 and April 2015 to June 2015 and scored above the England average in the Myocardial Ischemia National Audit Project (MINAP), National Diabetes Inpatient Audit (NaDIA), and National Heart Failure Audit.

There was an effective multidisciplinary approach to care and treatment with good communication between the teams.

People were cared for by staff who were kind, caring and compassionate in their approach. Patients and their relatives were positive about their experiences of care and the kindness afforded them. We observed staff being friendly towards patients and treating them and visitors with understanding and patience.

Medical care (including older people's care)

Patients told us they were involved in decisions about their care and treatment and were given the right amount of information to support their decision making. Emotional support was provided by staff in their interactions with patients.

Medical specialties planned their services to meet the needs of the local population. They responded to the needs of an ageing population and were developing services to improve the experience of patients living with dementia.

A number of initiatives had been developed to ensure the service met peoples' individual needs and those of vulnerable groups. Systems were available to manage and learn from complaints.

There was good leadership and management within the medical directorate with strategies on how the services were to develop. Managers were visible and approachable. Staff were proud to work for the trust and enthusiastic in their work.

There was an appropriate system of clinical governance in the medical directorate that identified quality and risk issues. Trends could be readily identified and learning was disseminated to staff.

We saw examples of innovative practice.

However;

We found where patients were unable to consent to restraint, no mental capacity assessment had been undertaken and no best interest decisions had been recorded. This meant that patients had their liberty restricted without hospital staff being able to evidence that the patient did not have the capacity to agree to the treatment plan.

Rates of harm free care as monitored by the National Safety Thermometer were displayed and showed wards scoring between 77% and 91%, which was below the England average of 94%.

Adequate personal protective equipment (PPE), hand washing facilities and hand gel were available for use at the entrance to the wards / clinical areas and standards of hand washing and cleanliness were regularly audited. However we observed poor infection control and hygiene practices.

Compliance with mandatory training for the medicine directorate was 75% for medical staff and 85% for nursing which was below the trust target of 95%.

The trust used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to direct the treatment they provided and policies, procedures and local guidance were being reviewed to ensure they met NICE guidance. However following the acquisition of Barnet Hospital by the Royal Free Hospitals NHS Foundation Trust staff were still able to access the policies and procedures from the Barnet and Chase Farm NHS Hospitals Trust which could lead to confusion.

Medical care (including older people's care)

Are medical care services safe?

Good

We rated safety for medical care as Good because;

- There was a positive culture of incident reporting. There were established processes for investigating incidents, and there was a range of forums for staff to receive feedback and learn from investigative outcomes.
- Duty of Candour was considered as part of the investigations into serious incidents.
- Staff were aware of their role in relation to safeguarding children and adults and knew how to access the safeguarding team for advice and guidance.
- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.
- Wards were staffed depending on the acuity of the ward so planned staffing levels varied from 1:4.8 to 1:6 nurse to patient ratios with assistance from an allocated nursing assistant.

However;

- Rates of harm free care as monitored by the National Safety Thermometer were displayed on the wards and showed scores between 77% and 91% which was below the England average of 94%.
- Mandatory training helped to ensure staff had current knowledge and skills in key safety areas. However, compliance with mandatory training for the medicine directorate was 75.1% for medical staff and 85.4% for nursing which was below the trust target of 95%.
- Adequate personal protective equipment (PPE), hand washing facilities and hand gel were available for use at the entrance to the wards / clinical areas and standards of hand washing and cleanliness were regularly audited. However we observed poor infection control and hygiene practices.

Incidents

- Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The service reported one never event for the period December 2014 to November 2015 which related to a surgical/invasive procedure which met serious incident criteria. The trust advised that the investigation was still on-going, however provided details of the interim findings and of actions already completed. We saw that in clinical governance meeting reports learning from never events was discussed.
- The service reported 35 serious incidents requiring investigation during the period December 2014 to December 2015. The majority of these were pressure ulcers (77%) which represented 77% of all serious incidents. In clinical governance meeting minutes we saw investigations into serious incidents were discussed.
- During the period January 2015 to September 2015 183 incidents were logged for included falls or potential falls, medicine prescribing or administration errors and pressure ulcers and were recorded as either no harm, low harm or moderate harm.
- There were 100 falls or potential falls reported as incidents, most of which were reported by Rowan (21) Spruce (18) Walnut (14) Quince (13) and CCU (12).
- Incidents regarding medicines totalled 25; most of these were reported by the CDU (8), and Quince (5).
- There 58 incidents reported involving pressure ulcers grade 1-3. Almost all pressure ulcer incidents were reported on Walnut (16), CDU (10) and Quince (10).
- An online computer incident reporting system was used to report incidents and staff told us it was easy to report incidents when they occurred.
- Most staff we spoke with said they received feedback and action was taken to reduce the risk of similar incidents occurring in the future. Staff told us incidents were discussed at safety huddles and at staff handovers. Doctors advised they also received feedback and lessons learnt were also discussed at multidisciplinary meetings.
- We saw evidence of mortality and morbidity clinical governance meetings for the medical divisions. Action

points and lessons learnt were identified. We saw that as part of the haematology teaching programme 2016 for doctors, mortality and morbidity and learning from events were scheduled to take place on a monthly basis.

Duty of Candour

- 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.
- Duty of Candour was considered as part of the investigation into serious incidents. We saw the involvement and support of patients and relatives were documented detailing the actions taken.
- Staff were aware of their responsibilities under Duty of Candour, which ensured patients and or their relatives were informed of incidents which had affected their care and treatment and they were given an apology. Staff we spoke with understood the importance of being open and honest with the patients and their relatives and gave us different examples of when relatives had been spoken to when a patient had fallen.

Safety thermometer

- The medical care services at Barnet Hospital participated in the national safety thermometer scheme. The NHS Safety Thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections. Ward managers collected monthly data as part of the scheme. We asked about actions which had been taken to improve, and were told of initiatives introduced to reduce patients' risk of falls for example moving patients at risk to bays were they that provided better observation of patients.
- The safety thermometer point prevalence audits between December 2014 and December 2015 which was the most up to date information available at the time of our inspection identified a total of 17 new pressure ulcers, 29 cases of urinary tract infections (UTI) in patients with a catheter and 18 falls with harm on the medical wards. The highest reporting wards were Juniper with 11 UTI's, 6 new pressure ulcers and Spruce with 8 UTI's and 8 falls with harm.
- We saw on two wards (CDU, Rowan) the staff were using the HOUDINI protocol to enable nursing staff to remove urinary catheters as soon as clinically appropriate without a direct physician order, as long as the patient does not meet one of seven criteria indicated by the acronym HOUDINI. This was used to minimise the risk of UTI's.
- Safety Thermometer results were displayed centrally on the wards, which meant this information was available to patients and their families. These showed the number of falls, pressure ulcers and infections such as MRSA and C. difficile that had occurred during the month. The results were fed into the safety thermometer and ward to board assurance framework, which in turn contributed to the trust data.
- Safety Thermometer data for all the medical wards showed that for the period December 2014 to December 2015 the wards scored between 77% and 91%for 'harm free' care which is below the England average of 94%. Four wards (Juniper, Larch, Olive and Palm) scored less than 70% for harm free care in February 2015 (Larch, Olive and Palm), May 2015 (Juniper), October 2015 (Palm) and December 2015 (Juniper).

Cleanliness, infection control and hygiene

- All the wards we visited were visibly clean. We observed support staff cleaning throughout the day and undertaking this in a methodical and unobtrusive way. Wards had daily cleaning schedules in place, which staff would tick to indicate when specific areas had been cleaned.
- Most of the equipment we examined such as commodes, vital signs monitors, wheelchairs, toilet rising seats were visibly clean. We observed green 'I am clean' labels were in use to indicate when equipment had been cleaned. We also observed staff cleaning equipment with sterile wipes after use and beds being cleaned.

Medical care (including older people's care)

- The trust reported one incident of Methicillin-Resistant Staphylococcus Aureus (MRSA) and 15 incidents of Clostridium Difficile (CDiff) for the period April 2015 to October 2015.
- Adequate hand washing facilities and hand gel were available for use at the entrance to the wards / clinical areas, within the wards at the entrance to bays and side rooms. There was prominent signage reminding people of the importance of hand washing at the entrances to wards as well as within the toilet and bathroom areas. We observed staff generally washed their hands in line with the World Health Organisations (WHO) guidance "Five moments of Hand Hygiene." Hand hygiene audits showed during a five week period from September 2015 to November 2015 that the medical wards scored an average of 81%. The lowest scoring ward was the CDU where the ward scored 47% over the five week period. During a ward round on the CDU round we observed a doctor using the light of their mobile phone to examine a patient's throat and referring to guidelines on their mobile phone when assessing the next patient. On both occasions the doctor only cleaned their hands after they had finished the examination and the mobile phone was not cleaned.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this appropriately when delivering care. We noted that staff generally adhered to the "bare below the elbows" guidance in the clinical areas. Bare below the elbows audits showed that the medical wards scored 83% compliance over a five week period from September 2015 to November 2015. The lowest scoring wards were CDU and Juniper where the wards scored 60% over the five week period. On the CDU we observed a doctor wearing nail varnish and a ring with stones when treating patients which was in contravention of the trust's policy for staff working in clinical areas.
- Side rooms were used to care for patients where a potential infection risk was identified. This was to protect other patients from the risk of infection, however we found that doors to the side rooms were not always closed despite signs indicating that they should be shut. For example on CDU we found that a side room with 'enteric isolation' signage on the door was open, this meant the patient in the room had an active infection.
- Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room. We observed staff putting on gloves and aprons before entering and correctly removing them on leaving the side rooms. During our visit one of the bays on Juniper ward was closed as there had been outbreak of diarrhoea on the ward, staff informed us this was a precautionary measure and the patient had been moved to a side room.
- We observed clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high risk used linen. We observed staff complied with these arrangements.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used however we noted that not all sharps containers were dated and signed when brought into use. On CDU we observed the sharps bin had been filled beyond the line and a syringe handle was poking out of the top. This was raised with the ward sister who immediately rectified the situation and informed us they would also raise this at the next safety huddle that day.
- We observed a teaching session on Rowan ward which was led by the infection control nurse.
- Infection and Prevention Control training formed part of the mandatory training programme and was updated yearly. The trust target was 95% of staff having completed the training, within the medicine directorate 72% and 64% of medical staff had completed level one and two training, 98% and 73% of nursing staff had completed level one and two training which was below the trust target.

Environment and equipment

- Barnet Hospital scored higher than the England average 2015 for Patient Led Assessments of the Care Environment (PLACE) in the sections of cleanliness and below the England average for facilities.
- We observed ward bays and corridors were generally kept clear of equipment, therefore avoiding trip

hazards so people were kept safe. On Spruce Ward we found that equipment was stored in the shower/toilet which reduced the number of toilets and showers available for patients on the ward.

- On Spruce Ward we also observed that the bladder scanner had been broken since October 2015. Staff advised us that this had been reported and was still waiting for repair and they had to borrow one from other wards. Staff also advised that there was only one bladder scanner working in the hospital.
- On wards we found the utility areas were generally clean and locked.
- Larch ward had been refurbished to become dementia friendly; the ward was bright and airy, with each of the bays specifically themed and colour coded. There was signage to help patients identify male/female bathrooms, toilets and shower rooms. The bays had tables and chairs so patients and their relatives could sit together at meal time or be used for activities.
- Not all the care of the elderly wards were dementia friendly, two wards (Palm and Juniper) were not coloured coded to assist patients find their way to their bay or identify male and female facilities. However, there was signage to help patients identify male/female bathrooms, toilets and shower rooms.
- We found each clinical area had resuscitation equipment stored on resuscitation trolleys, readily available and located in a central position, however they were covered in plastic sheeting. Staff advised this was to prevent the trolleys getting dusty. We saw that the resuscitation trolleys were checked daily.
- We saw that all Electrical Medical Equipment (EME) had a registration label affixed and was maintained and serviced in accordance with manufacturer's recommendations. We also saw Portable Appliance Testing (PAT) labels were attached to electrical systems showing they had been inspected and were safe to use.
- The trust had a 95% target for all staff to complete Health and safety and fire safety training as part of their mandatory training programme. However health and safety completion rates for medical staff was 68% and 93% for nursing staff. 81% of medical staff and 70% of nursing staff had attended training on fire safety which was below the trust target.

Medicines

- Treatment rooms were clean and tidy, with medicines stored securely in locked medicines trolleys as well as in locked cupboards and a medicines fridge.
- Controlled drugs (CDs) were correctly stored in lockable wall units in the treatment room. CDs were audited on a daily basis by two nurses, with a separate signing sheet seen. CDs were correctly documented in the CD register. Pharmacists conducted quarterly CD audits and the results of these audits were sent to the ward managers.
- Pharmacists visited the wards during the weekdays and we saw evidence on the drug charts that medicine reconciliation was completed for each patient and pharmacy interventions noted.
- Pharmacy staff had access to a patient's GP summary care records. This meant a patient's medication record could be checked quickly and easily reducing the risk of any errors in prescribing.
- We observed nursing staff during medication rounds wearing red tabards indicating that they should not be disturbed when doing a medication round.
- Medicines were administered by appropriately trained staff following the Nursing and Midwifery Council's "Standards for Medicines Management". Nursing staff were aware of the policies on the administration of controlled drugs. Allergy statuses and venous thromboembolism (VTE) risk assessments were completed and the relevant low molecular weight heparin (LMWH) was prescribed if required. Pharmacists had been trained to complete VTE risk assessments.
- We found that fridge temperatures were monitored daily however on Juniper ward the records showed that the fridge temperature was out of range. For example, a minimum temperature of 1°C and max temp above 9°C were consistently recorded between 1st and 16th January 2016.

- On Spruce ward staff told us medication was not always given on time or was left on lockers as some patients took time to have their medicines as they were confused or had difficulty swallowing. This mainly occurred when staff were transferred from other wards due to Spruce ward's high vacancy rate.
- Staff on Juniper ward said there were issues with patients waiting for long periods for their discharge medicines (TTA). A wait of 2 hours or more occurred regularly and sometimes patients/carers would need to come back to collect the TTA, however this was difficult for patients discharged to a care home. We saw evidence that patients had waited at least 2 hours for their TTA during our inspection.
- We observed the TTA tracking system and were able to view the TTA in pharmacy and where it was in the queue. One patient was on antiepileptic drugs hence they needed to wait as there were no TTA packs available. A ward manager confirmed that sometimes discharges had to be cancelled because of late TTA dispensing, especially for care home discharges. This also affected bookings of the hospital transport which could not be arranged until the TTA was received. One major contributory factor was TTAs not being written in advance or after the cut off time of 4:30pm.
- The nursing staff were able to escalate to the hospital discharge team to help facilitate discharge by liaising with the pharmacy team to prioritise TTAs.
- Medicines errors were reported via an electronic reporting system. The incidents were reviewed by the medicines safety committee. Staff understood and demonstrated how to report medicines safety incidents. This was then escalated and fed back for learning through various channels, such as medicines safety newsletters, memos and face-to-face meetings.
- Medicines policies were available on the trust intranet (Freenet) and easily assessable to all staff.

Records

- Medical care services had integrated patient records shared by doctors, nurses and other healthcare professionals. This meant all professionals involved in a patient's care could see their full record and recorded information in chronically order in the clinical notes section. This section included the medical plan for the patient. The clinical notes provided a description of the patient progress.
- Patients' paper medical notes were stored in trolleys on the wards and we saw the patient records were stored securely and staff had to use a key code to access the records. This demonstrated that confidential patient records were kept securely.
- Medical staff had access to electronic patient records (EPR), so they were able to order tests and look at results and images.The computers were on trolleys based on the ward which meant that the doctors were able to take the computer to the patients' bedside to refer to their results when in consultation.
- We looked at 24 sets of patient records. These showed patients had been seen on a post take ward round within 12 hours of admission. Diagnosis and management plans were identified and nursing assessments and care plans had been completed. Risk assessments had been mostly completed and reviewed. These included pressure ulcer risk assessments, Venous Thromboembolism (VTE), nutritional and falls risk assessments.
- Documentation audits were undertaken which looked at three patient records. In January the wards scored between 77% and 97%. One of the wards (Spruce) scored 77% which demonstrated that documentation was not always completed.
- We looked at patient bedside notes and found these were generally completed; these included repositioning charts, food and fluid charts, Waterlow and observations. However on Walnut Ward we found a patient who had been catheterised didn't have a fluid balance chart in place, this was raised with staff who immediately put a chart in place.
- Information governance was part of the staff mandatory training programme. The trust target was 80% for all staff to complete the training. 80% of nursing staff had attended Information governance training whilst the rate was 66% for medical staff, which was below the trust's target.

Safeguarding

- Staff had access to the trust's safeguarding policy via the trust intranet and knew how to access the safeguarding team to access advice and guidance when required. Staff told us this team was supportive in giving advice and assisted them when concerns were raised or information was required.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral either on line through the trust intranet or directly with the safeguarding team. We were given examples of concerns they had identified and referrals made. Staff told us they occasionally received feedback on the outcome of referrals.
- Safeguarding adults and children was part of the mandatory training programme for staff and different levels of training were provided according to the job role. The trust's target was 95% of staff having completed the training. Within the medicine directorate 88% of medical staff had completed safeguarding adult's levels one and two and 90% and 88% had completed safeguarding children level one and two. 91% of nursing staff had completed safeguarding adults level one and 85% had completed level two, and 86% had completed safeguarding children level one and 74% had completed level two training. This was below the trust's target.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake, staff told us that this was mainly available on line.
- The mandatory and statutory training programme covered basic radiation safety, blood transfusion, conflict resolution, emergency planning, equality, diversity and human rights, fire safety, fraud and security, health and safety awareness, infection control levels one and two, information governance, mental capacity act and deprivation of liberty safeguards (DoLS), resuscitation levels one and two, safeguarding adults level one and two and safeguarding children levels one, two and three.
- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed or refreshed.
- The trusts target for staff having completed their mandatory and statutory training was 95%. As of the 31st January 2016, compliance with mandatory training for the medicine directorate was 75% for medical staff and 85% for nursing which was below the trust target.

Assessing and responding to patient risk

- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as the Patient at Risk Score (PARS) was used so staff would be able to recognise "at risk" patients and to trigger early referral to medical staff, for early intervention to help prevent deterioration.
- There was a clinical protocol in place for managing and responding to acutely unwell patients. Staff knew if a patient scored 3 or more to inform the nurse in charge, escalate to the medical team or the Patient at Risk & Resuscitation Team (PARRT team.
- The use of early warning systems was audited across the trust in December 2015 over a 4 hour period. At Barnet 177 patients observation charts and patients notes were reviewed. The audit found that PAR scores were added correctly, during the times of the data collection that patients who were triggering had appropriate plans in place and the ward based staff on shift were able to identify the triggers and describe the escalation process and patients had observations recorded at appropriate intervals and their plans of monitoring were individualised.
- Patients were risk assessed in key safety areas using nationally validated tools. For example we saw the risk of falls was assessed and the risk of pressure damage was assessed using the Waterlow score. We observed risk assessments were reviewed daily and where required, care plans had been updated with appropriate risk management actions.
- Risks were also communicated to staff on a whiteboard above each patient's bed, for example, the patient's mobility and what assistance patients would need to mobilise. This method of communicating patient needs appeared to be consistent across the medical wards. However on the CDU we found the information on the white board above one bed related

to a previous patient. The current patient was young and independently mobile and the information on the white board related to a patient who needed a Zimmer frame and help from one person.

- Resuscitation level one and two was part of the mandatory training programme for staff to attend. The trusts target was 95% of staff having completed the training. Within the medicine directorate 86% of medical staff had completed resuscitation level one and 72% had completed level two and 94%. Nursing staff had completed resuscitation level one and 65% had completed level two. This was below the trust target.

Nursing staffing

- The vacancy rate across all the medical specialities in December 2015 for nursing staff was 30%. Wards we visited had differing levels of nursing vacancies, the highest being on Spruce (46%), Larch (43%), Palm (37%), Juniper (37%), Olive (33%) and Walnut (31%).Ward managers told us they had been involved in the recruitment of new staff and a number of their vacancies had been filled by overseas nursing staff but they were still seeking to recruit. Staff told us that staffing was a particular issue for them at weekends, and that frequently they were short of staff on the wards.
- Ward manager advised when bank or agency staff were used to cover shifts they would try to use the same staff. We saw that wards had bank and agency induction folders which had local induction and orientation sheets for agency staff so that they could familiarise themselves with the ward quickly.
- Across medicine we found that the use of agency and bank nursing staff differed and was high across the medical specialities for the period January 2015 to December 2015. The average vacancy rate for acute medicine was 31%, stroke 29%, elderly care 21%, respiratory 21% and cardiology 12%.
- Ward managers would inform the site practitioners if staff levels or the skills mix were not as planned. Ward managers reported staff would be moved to different wards within the medical specialties to ensure safe staffing levels were maintained or bank or agency staff would be utilised.
- The numbers of staff planned and actually on duty were displayed at ward entrance in line with guidance contained in the Department of Health Document 'Hard Choices'. On the wards we visited we observed staffing levels were generally in line with planned staffing levels. Depending on the ward, nurses were attached to bays or allocated to specific patients. Staffing levels were determined using an acuity tool to determine safe staffing levels which were audited twice a year. Wards were staffed depending on the acuity of the ward so planned staffing levels varied from 1:4.8 to 1:6 nurse to patient ratios with assistance from an allocated nursing assistant. Ward matrons were supernumerary to the agreed staffing levels so that if required, they could support ward staff if patient acuity or occupancy increased. Staff that provided one to one support for patients (specials) were not counted in the staffing levels.
- Nursing assistants were specifically trained as 'specials' to support patients who had complex needs. We saw the specials were utilised across the wards overnight and during the day. We observed specials sitting with patients to ensure they did not fall out of the bed. The number of specials was reviewed daily and patients' needs assessed for so the wards could safely manage the risk.
- Staff we spoke with told us that at hand overs key issues were covered such as falls, pressure sores, PAR scores, and patients with one to one care (specials), and actions outstanding for patients were allocated. Staff had printed hand over notes, which they updated during the handover.
- Ward managers advised that a new handover tool using the recognised quality tool for the recording of information known as Situation, Background, Assessment, Recommendation (SBAR) had been introduced in the last month. However, on wards where we saw handover information we did not see the new handover tool used.

Medical staffing

- Across medicine we found that the use of locums differed across the medical specialities for the period

Medical care (including older people's care)

October 2014 to March 2015.Over this period the average locum usage in elderly care was 19%, acute medicine 15%, stroke 4%, cardiology 3%, and respiratory 0%.

- Medical staffing comprised of consultants, specialist registrars, senior house officers (SHOs) and foundation level doctors. There was medical consultant cover from 7am to 8pm Monday to Friday and weekends and out of hours available on call off site. At weekends ,medical consultants were based in the accident and emergency department and were available on call to the medical wards.
- At night the medical wards were covered by a registrar and three junior doctors with access to the on call consultant.
- All medical wards had a daily consultant ward rounds Monday to Friday with junior doctor ward teams working alongside the specialist teams, however in the CDU the board rounds were daily seven days per week.
- We observed two multidisciplinary team (MDT) board rounds and found they were carried out efficiently and effectively, with the appropriate staff present.
- Medical staff on Juniper Ward told us that on average they had to stay an hour longer at the end of their shift and that the discharge notes for patients hadn't been completed due to lack of time which meant that patient discharges had been delayed until later in the evening as there were not enough doctors on duty.

Major incident awareness and training

- The hospital had a site control room which operated 24 hours 7 days per week and provided a single point of coordination. The trust business continuity plan set out the level of escalation and response required.
- There was a bed management system to ensure that patients were placed appropriately. When there was an increased demand on beds and beds were not available on medical wards, patients were placed on surgical wards. There were procedures in place to ensure these patients were reviewed regularly by a consultant.
- Staff were aware of the trust's major incident procedure and how to access it via the trust intranet. Staff told us that they would wait instruction from their ward managers.
- Emergency planning was part of the trusts mandatory and statutory training programme. The trust's target was 95% of staff having completed the training. Within the medical directorate 72% of medical staff and 93% of nursing staff had attended training for emergency planning which was below the trust target.

Are medical care services effective?

Good

We rated medical care as Good because;

- The trust used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to guide the treatment they provided and policies, procedures and local guidance were being reviewed to ensure they met NICE guidance.
- There was a good medical audit programme in place across the medical division.
- The hospital achieved an 'A' rating in the Sentinel Stroke National Audit Programme (SSNAP) for their performance in January to March 2015 and April 2015 to June 2015 and scored above the England average in the Myocardial Ischemia National Audit Project (MINAP), National Diabetes Inpatient Audit (NaDIA, and National Heart Failure Audit.
- There was an effective multidisciplinary approach to care and treatment with good communication between the teams.
- Patients had sufficient food and liquid to keep them healthy and were offered support to eat of they needed it.

However;

- Where patients who were unable to consent to restraint, no mental capacity assessment had been undertaken and no best interest decisions had been recorded. This meant that patients had their liberty restricted without hospital staff being able to evidence that the patient did not have the capacity to agree to the treatment plan.

Evidence-based care and treatment

- Staff were aware of the National Institute for Health and Care Excellence (NICE) guidance in relation to their speciality. Staff reported that clinical policies and guidance were available on the trust intranet and we saw staff were able to access these easily. There was also a range of locally produced guidance which was available on the intranet. In clinical governance reports we saw that policies, procedures and local guidance were being reviewed to ensure they met current NICE guidance.
- We found that following the acquisition of Barnet Hospital by the Royal Free Hospitals NHS Foundation Trust that staff were still able to access the policies and procedures from the Barnet and Chase Farm NHS Hospitals Trust which could lead to confusion.
- There was a medical audit programme for 2015/2016, across the medical services of acute medicine, respiratory and neurology, elderly care, and cardiology 27 audits had been identified; nine of which part of the quality improvement project (QIP), six were local audits and three were national audits. Medical divisional performance reports showed what progress on audits was monitored and reviewed on a bi monthly basis. This demonstrates the trust was engaged in audits looking at the effectiveness of care.

Pain relief

- Patients told us they were asked about pain during medical administration rounds. We observed staff discussing patients' pain levels and taking appropriate actions to ensure pain relief was administered in a timely way. The patient prescriptions we reviewed indicated that as required medicines were prescribed for pain relief as appropriate.
- The palliative care team also provided support and advice in the pain control of those who were terminally ill.

Nutrition and hydration

- Nutritional documentation audits were undertaken which looked at three patient records. In January the wards scored between 41% and 100%. Seven of the wards (CDU, Palm, Larch, Walnut, Juniper, Spruce, and Rowan) scored 82% or less which demonstrates that nutritional documentation was not always fully completed.
- On a ward we observed a palliative care nurse asking for water for a patient who had been nil by mouth, the nurse advised that the patient needed to be reviewed by speech and language therapist (SALT) first. The nurse was unaware that the review had been done the day before and a decision had been made so that the patient could drink. This demonstrated that changes to the patient's nutritional needs had not been updated.

Patient outcomes

- The trust participated in the Sentinel Stroke National Audit Programme (SSNAP), which is an on-going national audit that investigates and analyses the quality of care in stroke services. Hospitals are awarded a score A to E where A is the best. At Barnet Hospital the stroke services scored an A rating in January 2015 to March 2015 and April to June 2015. This indicated the hospital was achieving good outcomes for patients with strokes compared with the national average.
- Barnet Hospital participated in the Myocardial Ischemia National Audit Project (MINAP), which is a national clinical audit of the management of heart attack. In 2012/13 and 2013/14 the hospital scored better than the England average in two of the three standards audited for care of patients with non-ST-elevation infraction (nSTEMI).
- In the National Diabetes Inpatient Audit (NaDIA) September 2013, Barnet Hospital's performance was monitored against 21 indicators. In twelve indicators the trust performed better than other trusts and in 6 indicators the trust was worse than other trusts.
- The hospital participated in the 2013/14 National Heart Failure Audit and scored higher than the England average in all four standards audited for clinical practice for in hospital care. The hospital also scored better than the England average in clinical practice for discharge the hospital in five of the seven standards audited.
- Across medicine the average length of stay was longer than the England average of 6.8 days. In general medicine and care of the elderly which represented the majority of activity, the average length of stay was worse than the England average in general medicine and similar to the England average in care of the elderly.
- Between December 2013 and November 2014 the standardised risk of re-admission for medicine and the

medicine specialities was lower than the England average for both elective and non-elective admission except for gastroenterology. This means there were fewer observed readmissions than expected.

Competent staff

- Nursing staff told us that they attended a trust induction programme which that included the trust values. The induction programme also included dementia training**.**
- Staff told us they participated in the appraisals process and we reviewed documentation on wards and found most wards had some staff appraisals outstanding. The trust reported 85% of nursing staff within the medical services had received an appraisal in the period April 2015 to November 2015. As appraisals were completed on annual basis it was anticipated that by March 2016 the trust target of 95% would be achieved.
- On wards nursing staff had lead functions; for example a nurse was responsible for infection control and led on related initiatives to develop staff skills and knowledge.
- Nurses told us there were opportunities for learning and development and they could access training online. Ward managers we spoke with told us that they had been participating in leadership training. On Rowan ward we observed a teaching session by the infection control nurse.
- Throughout our inspection we observed staff were professional and competent in their interactions with colleagues, patients and their relatives/carers.
- We saw there was 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 and dementia. We noted their presence on the wards and staff told us they valued their input on the wards.
- Junior doctors we spoke with reported that they were inducted into the trust and the hospital provided good training opportunities and were given time for training; they also had good support from consultants who also provided clinical supervision. There was also a mentorship programme for new doctors, with opportunities for become a mentor on the programme.
- Doctors were encouraged to attend weekly training sessions which looked at clinical cases, and they participated on the 'Grand Rounds.

Multidisciplinary working

- Medical and nursing staff of all grades that we spoke with all described good working relationships between healthcare professionals. The multidisciplinary records ensured there was good communication with input from each profession in the care of individual patients and care was co-ordinated for patients and their relatives. We observed the healthcare team worked well together to provide care to patients.
- Consultant led multidisciplinary board rounds were held on a daily basis Monday to Friday. 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. We saw that ward board rounds, which included physiotherapists and occupational therapists, were well attended and everyone's contribution was valued. There was evidence of a 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. Where allied health professionals and specialist medical teams had been involved with patients they had recorded this in the patient records.Patient flow coordinators and discharge coordinators were also on the wards to facilitate social care packages for patients on discharge.
- 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 service staff and would be refer patients to this service for assessment where there were concerns.

Medical care (including older people's care)

Seven-day services

- Consultants provided an on call service out of hours and at night after 8pm covering all the medical wards (10). At weekends an on call consultant was available from 7am to 8pm to cover the medical wards working from the accident and emergency department.
- The medical wards at weekends were covered by a registrar and three doctors and the CDU was covered by two doctors and the on call medical consultant.
- There was a 24/7 Endoscopy on call rota for gastro-intestinal bleeding.
- Staff reported there was seven day availability of all diagnostic services including imaging, and laboratory facilities. They told us they did not encounter any problems with diagnostic services out of normal working hours.
- Physiotherapists and occupational therapists were available on site and provided an on call service to the medical wards at the weekends;, however SALT provided a weekday only service.
- Pharmacy services provided on call out of hours service and at weekends there was a reduced clinical pharmacy service. Nursing staff reported that there were frequently delays in receiving TTA medicines and that this meant that patients had to wait a long time before they could be discharged.

Access to information

- Patient boards on the wards had details of patient's surnames which identified which bay and bed patients were in with their estimated date of discharge. Patients with particular needs were highlighted using symbols. For example, if a patient was at risk of falls or had dietary needs and whether a speech and language therapist (SaLT) was involved. A forget-me-not symbol to indicate a person was living with dementia was also used. The boards included which local authority the patient was from and whether patients had access to a social worker. The boards were updated as part of the daily MDT board round on a Monday to Friday. We saw that these boards could be closed to protect patients confidentiality.
- Staff had access to computers on the wards so they could access diagnostic results such as blood results and imaging to support them to care safely for patients.
- Staff had access to guidance and information on the trust intranet.
- Staff names, roles and photos were on display on wards so that patients and visitors would know which staff worked regularly on the wards. There was also information on nurse's uniforms so that patients and visitors would be able to distinguish between different roles.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- On Spruce Ward we were advised of a patient who was subject to a mechanical restraint by wearing mittens. The patient's records showed that an urgent application had been made for Deprivation of Liberty Safeguards (DoLS). However we found no mental capacity assessment had been undertaken, and no best interest decisions had been recorded. This meant that the patient had their liberty restricted without hospital staff being able to evidence that the patient did not have the capacity to agree to the treatment plan. There was no evidence that decision had been reviewed regularly. Staff were also unable to locate the trust policy on mechanical restraint. This was raised with the hospitals safeguarding lead who immediately followed this up.
- Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and told us they would refer patients to the safeguarding teams if patients required a MCA. All DoLS applications were also dealt with by the safeguarding team.
- Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training was part of the trusts mandatory and statutory training programme. The trust's target was 95% of staff having completed the training. Within the medical directorate 90% of medical staff and 89% of nursing staff had attended training which was below the trust target.

Medical care (including older people's care)

- Patients told us staff asked their permission before care or treatment was given and medical staff explained their treatment.We observed doctors asking patients before they examined them and took blood.

Are medical care services caring?

Good

We rated caring in medical care as Good because;

- People were cared for by staff who were kind, caring and compassionate in their approach.
- Patients and their relatives were mostly positive about their experiences of care and the kindness afforded them. We observed staff being friendly towards patients and treating them and visitors with understanding and patience.
- There were many thank you cards on display across the medical wards from previous patients and their relatives and results from the 'Friends and Family Test' showed most people would recommend the medical services provided by the hospital.
- Patients told us they were involved in decisions about their care and treatment and were given the right amount of information to support their decision making. Emotional support was provided by staff in their interactions with patients.

Compassionate care

- The trust used the Friends and Family Test (FFT) to gather patients' views on whether they would recommend the service to family and friends. We looked at the latest FFT scores available for the period November 2014 to October 2015. The average response rate for individual wards ranged from 24% to 49%. Overall, these showed satisfaction with the service, with the medical wards ranging from 50%, to 100% during the period. The CCU had the most consistent feedback scoring 100% in 5 of the 11 months; their response rate was also the highest at 45%.
- We observed interactions between staff and patients were professional, kind and friendly. For example, we observed staff responded quickly to a patient who called for a nurse, they were compassionate and helped the patient with their drink. Staff asked patients if they wanted drinks and made sure they were comfortable and during meal times checked that patients had finished their food before they removed their trays.
- Several patients told us they thought the staff were good and caring. Some of the positive comments we received from patients were: "care top notch", "exemplary", "like angels" "the staff are amazing," "staff are brilliant – they can't do enough". However on one ward we observed a patient coughing and retching, there were staff at the nurses' station and no one went to check the patient.
- We saw evidence of many thank you cards and letters on display on noticeboards throughout the medical wards. Staff were identified as "kind and caring" and relatives thanked them for looking after their loved ones.
- Patients told us the nursing staff were respectful to them and every effort was taken to ensure their privacy was protected when personal care was being given. On the whole we observed curtains were closed when patients were receiving personal care. However on one ward (Spruce) we observed two occasions when patient privacy and dignity was compromised. On one occasion, a patient's gown had been left open at the back so that their padded underwear was visible and on another, curtains were not closed properly where the patient was not adequately clothed.
- We looked at the results of the patient led assessments of the care environment (PLACE). In 2015 the trust scored 83% for privacy, dignity and wellbeing which was lower than a national average of 86%.
- On the medical wards we saw notice boards had numerous cards on display from grateful patients and relatives thanking staff for their help and support following their hospital admission.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they were involved in their care and understood their treatment and care plans. Patients described conversations with the doctors and consultants, they had been able to ask questions and had been told how their illness or injury might improve or progress. Positive comments we received were; "can't praise staff highly enough,

everything explained every step of the way", "treatment always explained to me", "the medical staff always explain everything to me". During ward rounds we observed doctors speaking to patients, and involving them in their treatment plans.

- Visitors we spoke with were happy with the care their relatives received and felt they had been kept involved with their loved ones' treatment. Patients and relatives commented that relatives were not offered refreshment when on the wards.
- The Larch and Juniper wards had flexible visiting hours which meant relatives could visit their loved ones from 8am until 8pm, with protected meal times from 12pm to 2pm. This meant relatives could assist at meals times and then leave the wards so patients could rest.

Emotional support

- Patients and their relatives told us the clinical staff were approachable and they could talk to staff about their fears and anxieties.
- The hospital chaplaincy service was multi-faith and provided support 24 hours per day. It provided services to patients across the hospital which included Christian and Muslim services which were held across the trust. Staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families.
- We looked at the results of the patient led assessments of the care environment (PLACE). In 2015 the trust scored a 90% rating for quality of food, which was better than the national average of 88%.
- We observed patients were served a choice of foods. The menus had been designed to include a range of special diets, high energy, soft, gluten free, high fibre, vegetarian, halal and healthy eating options. Dietary supplements were given to people when prescribed.
- Patients selected their food choices from prepared menus; we saw these were available in nine languages and in braille. We saw staff referring to patient choices during food service. This meant that staff responsible for serving patients food were informed about their needs.
- All the wards operated a protected meal time policy.
- We observed lunch time on two wards; we found they were well organised and there was a variety of food being served. At lunch time a bell was rung and the staff started to serve lunch. Patients who needed no assistance were served first, followed by patients who needed to be observed or required assistance with their food. This ensured all the patients had hot food and did not have their food left sitting in front of them. We observed staff taking time to assist patients but they were sometimes distracted by other staff and did not ask patients what food they wanted from the plate.
- We saw that patient trays had napkins and hand wipes; if patients needed assistance staff helped patients to clean their hands before eating. Patients who required assistance with their food were identified by using red trays and when they had finished eating the amount of food they had eaten was documented so staff could monitor the patient's food intake.
- On the care of the elderly wards relatives and carers were invited to visit patients at meal times to assist with feeding. Staff told us this initiative had greatly assisted them during busy times.
- Patients were offered sufficient quantities of fluids with a variety of hot and cold drinks available throughout the day including early morning and last thing at night. Drinks were left within reach and patients were given assistance to drink if required. At the end of lunch we saw that the drinks trolley was taken to patients and they were offered tea, coffee and juices.
- We saw there were adequate arrangements to ensure food safety. For example we found food service personnel wore suitable personal protective equipment (PPE), food and fridge temperatures were checked and the temperature of food was checked before service to ensure it had reached safe temperatures.
- The hospital undertook meal time audits across the medical wards. The audits sampled four patients' dining experiences on each ward focusing on five different standards. In the period November 2015 to January 2016 the wards scored between 89% and 100%. This demonstrated patients had a positive experience at meal time.

Are medical care services responsive?

Good

We rated the responsiveness of medical services at Barnet Hospital as Good because;

Medical care (including older people's care)

- Medical specialities planned their services to meet the needs of the local population. They had responded to the needs of an ageing population and were developing services to improve the experience of patients living with dementia.
- A number of initiatives had been developed to ensure the service met peoples' individual needs and those of vulnerable groups. Systems were available to manage and learn from complaints.
- The needs of patients with learning disabilities were accounted for and they had appropriate 'patient passports' to help them understand their care.
- Patients had access to a range of specialist nurses, for example dementia specialist, heart failure, diabetes and palliative nurses. On some wards staff were also dementia champions. These staff offered support to patients, their families and cares in relation to their psychological needs.

Service planning and delivery to meet the needs of local people

- Care of the elderly wards were seeking to improve the ward environment to make them more dementia friendly by becoming bright and airy, with each of the bays themed and colour coded. The trust was actively fund raising for this.
- Visiting times were 2pm to 8pm every day and visitors were limited to two per bed space, however the visiting hours had been extended to accommodate the needs of patients and visitors on the care of the elderly wards. Relatives were encouraged to visit elderly and frail patients during meal times to assist with eating.
- Demand for medical beds frequently outstripped supply especially in the winter period. In these circumstances patients could be placed in additional beds outside of the speciality. There were arrangements to ensure that outlying patients were reviewed by speciality teams and nursing staff reported they worked well.
- We saw there was a discharge lounge located close to the CDU where patients could wait for transport. Patients had access to sandwiches and hot and cold drinks.

Access and flow

- Discharge plans were commenced on admission and patients had estimated dates of discharge documented in their records. On some wards designated discharge nurses would oversee patients' discharge arrangements and discharge plans were discussed at multidisciplinary team (MDT) board rounds. Patients who were able to be discharged had their discharge plans discussed which confirmed arrangements were in place, such as care packages, transport, and TTOs had been ordered.
- The hospital had a discharge lounge which was staffed by nurses. Staff had facilities to make hot drinks and provide sandwiches and snacks.
- Discharge letters and summaries were sent to family doctors (GPs).
- Bed moves were coordinated through the site control room. During the period November 2014 to October 2015, 65% (16,297) of patients experienced no ward move, 20% (5,065) of patients were moved once, 8% (2,084) of patients were moved twice, 4% (885) patients were moved three times and 3% (721) of patients were moved four or more times. This demonstrated that 65% of patients were treated in the correct speciality bed for the entirety of their stay.
- For the period May 2015 to October 2015 Barnet Hospital reported the total number of bed moves across the medical wards at night between the hours of 10pm and 6am was 953.The largest number of moves involved patients in general medicine 77% (734) and care of the elderly 16% (155).
- Referral to treatment times (RTT) within 18 weeks were consistently above the 90% in all specialities other than dermatology which was 87% within the RTT in October 2015.
- For the period August 2015 to January 2016 Barnet hospital discharged a total of 294 patients out of hours which was 5% (5,533) of the total number of patients discharged over the period. The largest number of discharges were patients in general medicine 67% (198) and care of the elderly 19% (56).The trust queried the information they provided as they are unsure whether the time of discharge was correct due to staff entering discharge information on to an electric patient administration system after patients have been discharged.

- At the time of our inspection a number of patients across the trust were outliers (patients who were under the care of a consultant but looked after on a different ward). These patients were seen daily by the medical teams looking after them.

Meeting people's individual needs

- We saw patients had their needs assessed. We reviewed 24 sets of patient records and saw their care plans included all identified care needs.
- On care of the elderly wards there were a range of activities such as cards, games, puzzles. The wards also received the 'Weekly Sparkle" a newspaper that is full of articles, quizzes, old news stories, which is geared towards stimulating the mind and improving memory.
- The medical wards operated a protected meal time policy.
- On the care of the elderly wards relatives and carers were invited to visit patients at meal times to assist with feeding. Staff told us this initiative had greatly assisted them during busy times and they would also encourage patients to continue with their own routines; for example having their dinner in the evening rather than at the lunchtime, and encouraging patients to feed themselves.
- Ward boards were used to flag patients who were at risk of falls and patients living with dementia. We saw documentation called '8 important things about me' which relatives or carers patients living with dementia would be asked to complete so staff would know more about them, for example patient's likes and dislikes. Staff told us that they would ask patients families or relatives about how they best communicate with the patients.
- Patient passports were in use for patients with a learning disability, which were completed by their relative or carer. The passports were used so patients could outline their care needs, preferences and any other information which staff would find useful to assist with their care.
- We observed staff providing one to one care (specials) across the medical wards. On two of the wards we observed specials sitting with patients who required monitoring. We observed staff accompanying a patient who wanted to walk around the ward. This meant the patient was being monitored and kept safe from harm such as falls.
- We found that patients had access to a range of specialist nurses, for example dementia specialist, heart failure, diabetes and palliative nurses. On some wards staff were also dementia champions. These staff offered support to patients, their families and cares in relation to their psychological needs Dementia champions on the wards.
  - All the medical wards were divided into bays which provided single sex accommodation with designated male and female facilities in the bays. Hospital data showed there were no mixed sex accommodation breaches on any of the medical wards from October 2015 to December 2015.
  - We saw call bells were mostly within reach of patients and observed staff generally answered the bells straight away. One patient told us that they had used the call bell a couple of times to call nurses for other patients as their call bell were not within their reach.
- Staff had access to translation services for patients for whom English was not a first language. This was available via the telephone and could also be provided to face to face.
- Wards had a range of information leaflets available. This included generic trust information on topics such as infection control, Patient Advice and Liaison Service (PALS), complaints and VTE, plus some relevant diagnosis/condition specific information on what to do following a heart attack, blood thinning and depression after a stroke. Patient information and advice leaflets were available in English, but were not available in any other language or format.

Learning from complaints and concerns

- Leaflets on how to make a complaint and about PALS were available on the wards. One of the patients we spoke with said they were aware of how to make a complaint.
- Staff told us they tried to resolve complaints and concerns at the time where ever possible. They told us they received feedback about complaints and the learning from them.

Medical care (including older people's care)

- Ward performance score cards monitored the number of complaints received within a month, In January 2016 the number of complaints received were nine.
- We saw complaints were discussed at monthly clinical governance meetings.

Are medical care services well-led?

Good

We rated the leadership of medical care at Barnet hospital as Good because;

- There was good leadership and management within the medical directorate with strategies on how the services were to develop.
- Managers were visible and approachable.
- Staff were proud to work for the trust and on their wards and were enthusiastic in their work.
- There was an appropriate system of clinical governance in the medical directorate which identified quality and risk issues. Trends could be readily identified and learning was disseminated to staff.
- We saw examples of innovative practice.

Vision and strategy for this service

- A discharge and flow strategy was launched by the trust as part of the five year transformation strategy. There were four work streams relating to different stages of the patient pathway identified, for example admission, inpatient stay and discharge planning.
- The trust identified 24/7 working as an integral part of its quality strategy and staff within medical care were aware of this. Senior staff told us there were certain limitations to a full seven-day service which included aspects out of the trust's control, for example availability of new care packages over weekends
- The divisions within the medical services were in the process of developing and submitting business cases to develop their area of speciality. These included increased cross site working and the development of a breathlessness clinic in respiratory medicine.
- The trust identified the vision of training all nursing staff as "dementia specialists" as a goal to be achieved. The trust were particularly keen that staff working in elderly care were prioritised for this and staff we spoke with working on the care of the elderly wards were aware of this aim.
- Staff were aware of the trust's values and vision.Staff could name them, knew what they meant and the value of applying them to their everyday practice.

Governance, risk management and quality measurement

- Clinical governance structures were in place across the medical specialities, led by the clinical leads and staff felt this was effective. Each speciality held regular clinical governance meetings. We reviewed the minutes across the specialities and saw there was good attendance from the multidisciplinary teams. Adverse incidents, infection control, performance indicators, patient feedback and complaints were reviewed at these meetings.
- Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives.
- We saw ward managers were provided with regular reports on incidents that occurred in their areas, as well as complaints, survey results and staffing data. This information was discussed with the matron for the area who monitored for themes and trends.
- We spoke with the ward managers across all medical services who demonstrated a good awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, keeping a ward based risk register and undertaking audits.
- Each of the medical specialities had performance score cards. We saw evidence of a report for each of the specialities, which brought together information on their performance in relation to a range of indicators of quality and throughput. Wards also had patient experience boards on display, which included performance on patient feedback which included FFT.
- We looked at the risk registers for each of the medical specialities and saw that the level of registered nurse vacancies were included on the risk register. Each risk had a red, amber or green (RAG) rating, a review date,

and there was a named manager responsible for the risk. There were details of the action taken to mitigate the risks and progress was recorded, demonstrating active management of identified risks.

Leadership of service

- Clinical directors reported that the fundamental change with the medical specialities being clinically led had made them more accountable, more autonomous and enabled them to find solutions rather than receiving 'top down' decision making. Clinical directors felt they were supported and felt the trust was more responsive to the needs of their services.
- A good structure was in place to provide support to staff at ward level through ward managers and matrons. The matron's were visible on the wards. We saw that wards had monthly wards meetings and that these were minuted.
- Staff said the director of nursing was visible on the wards.
- Staff said managers were supportive and approachable, they also had opportunities for personal development and when they raised concerns they were listen to and their concerns addressed. Staff fell respected and valued.
- We saw on wards they had a team member who was star of the month, which recognised a member of staff who colleagues felt had gone the 'extra mile'**.**
- Medical staff were also positive about the support they received from their senior colleagues and their peers.

Culture within the service

- Staff were proud to work for the trust; they were enthusiastic about the care and services they provided for patients. They described the trust as a good place to work.
- Staff said there was an open and transparent culture where people were encouraged and felt comfortable about reporting incidents and where there was learning from mistakes.
- 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.

Public and Staff engagement

- The trust had various means of engaging with patients included surveys such as Friends and Family Tests and other inpatient surveys. The comments and results from feedback surveys completed by patients prior to discharge were reviewed at governance meetings and used to identify changes needed.
- Wards operated a staff recognition programme and during our inspection we saw different examples of staff being named as team member of the month.
- The consultants we spoke with identified challenges faced in the acquisition with the Royal Free Hospital, but overall they viewed it positively.

Innovation, improvement and sustainability

- One of the wards (Larch) had been refurbished to create a dementia friendly environment to help orientate frail elderly patients with cognitive impairment and make navigation around the ward easier.
- The care of the elderly wards had been brought together to create a dedicated area in the hospital where elderly patients were care for by consultants doctors and nurses who worked with in the speciality.

Surgery

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

Information about the service

Surgery and associated services at Barnet hospital were managed by the Division of Surgery at the Royal Free London NHS Foundation Trust, which included three surgical wards, Beech, Cedar and Damson. There was a day surgery unit which had three day case theatres. There were five main theatres and a pre assessment unit.

The hospital currently provides emergency, trauma and elective surgery.

The hospital provides a variety of specialities including colorectal, general, ear nose and throat, gynaecology trauma and orthopaedic surgery.

There were 54,138 surgical procedures performed at Barnet hospital over the last 12 months and the pre assessment unit assessed 8,707 patients between May 2015 and December 2015.

We reviewed data and a variety of information supplied to us prior to and during the inspection. We received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection. We also reviewed the trust's performance data.

We reviewed 12 sets of patients' records, medication charts as well as other documentation.

We spoke with 12 patients and their relatives.

We spoke with over 20 members of staff who were working in a wide variety of roles including matrons, doctors ward managers, nurses, health care assistants, ward clerks, housekeeping, domestic staff, student nurses and trauma co-ordinator.

The CQC held a number of focus groups and drop-in sessions where staff could talk to inspectors and share their experiences of working at the hospital.

During our inspection, we reviewed information from a wide range of sources to get a balanced and proportionate view of the service.

During our inspection we visited all inpatient areas of the surgical services.

We also observed care being delivered in a variety of care settings.

Surgery

Summary of findings

Overall, we rated surgery and associate services at Barnet Hospital as Good because;

The general environment was visibly clean and a safe place to care for surgical patients.

We found that services for surgery at Barnet Hospital caring and compassionate and were well led.

There was a good approach to team work and a good team ethos to achieve the best care for patients. Senior staff were visible, available and supportive to all staff.

Staff were aware of the safeguarding policies and procedures and had received training. Most staff understood their responsibilities under the Duty of Candour and were able to provide examples.

Mandatory training was up to date and staff gave examples of specialist courses undertaken.

There was a good culture of reporting incidents and we saw evidence of changes to practise as a result of investigations, and there were robust systems in place.

Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.

There were systems to regularly monitor and review the quality of service provided.

All patients were treated with respect and dignity, and services were responsive to patient's complex needs.

Staff were competent, knowledgeable and passionate about their specialties on both the surgical wards and in the theatre department.

Wards and departments undertook frequent audits such as environmental, theatre checklist, infection control, hand hygiene, falls and pressure areas. Clinical governance teams analysed the audits and fed the results back to staff.

Where risks were identified such as falls and pressure area management there were action plans to resolve or manage them in a timely fashion.

However;

There was insufficient monitoring of fridge temperatures on Damson ward.

There was inappropriate storage of medicines in the day surgery unit.

Recovery is used regularly to accommodate patients overnight.

Barnet hospital performed badly in the national emergency audit. (NELA)

Physiological and Operative Severity Score for the enumeration of Mortality and Morbidity (POSSUM) is widely used in the UK in surgery it measures surgical outcomes based on a standardised scoring system. It provides the patient with as much information as possible to make fully informed consent. This is not being used at Barnet Hospital.

Surgery

Are surgery services safe?

Good

We rated the safety of the service as Good because;

- Clinical safety was monitored throughout the service such as infection control, slips, trips and falls and manual handling.
- Safety was monitoring included the five steps to safer surgery and the World Health Organization's (WHO) procedures for safely managing each stage of a patient's journey from ward through to anaesthetic, operating room and recovery.
- Regular audits were undertaken on compliance with the five steps to safer surgery, however steps 1 and 5 have only been audited recently and data was unavailable at the time of inspection.
- The theatre department had recently re launched the WHO checklist following three never events at the Royal Free Hospital and Chase farm Hospital.
- There was sufficient emergency resuscitation equipment available and we saw evidence of equipment checks.
- We found staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable patients.
- The hospital had systems to identify when patients' condition deteriorated and were becoming increasingly unwell. This enabled staff to provide increased support. Recognised tools were used for assessing and responding to patient risks.
- The general environment was visibly clean and a safe place to care for surgical patients. There were robust systems and processes to ensure that a high standard of infection prevention and control was maintained.
- We found patients were protected from avoidable harm, there were systems in place to report, monitor, investigate and take action on any incident that occurred.
- Environmental safety was assured through regular monitoring and on-going checking of issues such as infection control, equipment and facilities. Surgical services used the safety thermometer to monitor and assess the quality of care delivered and results were displayed on wards.
- Managers and matrons had live information as to the current staffing on the wards and in theatres and were able to take immediate action where staffing levels fell below the required levels. Managers discussed staffing levels at regular meetings where the staffing level statistics were updated throughout the day.

However;

- Although the majority of the surgical records and medical notes we reviewed were well completed, the records did not always meet best practice, for example in the recording of VTE (venous thromboembolism) assessments.

Incidents

- Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were no never events at Barnet hospital between January 2015 and December 2015. However, there were four never events in theatres across the Royal Free and Chase Farm sites between January 2015 – December 2015
- There was an action plan in place to prevent similar issues happening again. The Barnet hospital site was also included in the action plan. Staff gave us clear examples of changes to practice following never events.
- All five steps of the WHO checklist were classed as mandatory within the organisation.We saw evidence that a patient safety programme was ongoing which aimed to improve the 5 steps of safer surgery.
- A Stop, Quiet ,Listen, Please campaign was being undertaken in relation to the use of team briefing prior to the start of an operating list and debriefing at the end of operating lists.
- We observed team briefing prior to the start of the operating list that was adequate and well led however was not formally recorded.
- Work was being undertaken to put greater importance and awareness on swab, needle and instrument counts and empowering staff to speak up when inaccuracies happened.
- There was a new swab, needle and instrument policy awaiting ratification following the never events to prevent reoccurrence.

- We were provided with a copy of 5 steps to safer surgery bulletin that was circulated to staff in January 2016.This provided shared learning from never events and changes in practice.
- We saw a stop before implant policy displayed in theatres which had been implemented after a never event at Chase Farm Hospital, when a wrong sided prosthesis was implanted.
- We saw minutes of regular staff meetings, which contained evidence of discussing risks with the top three risks listed each month.

- It is mandatory for NHS trusts to monitor and report all patient safety incidents through the National Reporting and Learning System (NRLS). If an incident is assessed as a serious incident it is also reported using StEIS (Strategic Executive Information System). Serious incidents can include but are not limited to patient safety incidents, for example loss of confidential information. Any serious incident which meets the definition of a patient safety incident should be reported to both StEIS and NRLS.
- Between January 2015 and December 30215 surgery across all three sites had the third highest number of incidents of any core service: 1,593 incidents which were about 17%. There were three incidents resulting in death 11 resulting in severe harm with the remaining incidents resulting in no harm.
- Patient accidents were the most commonly reported category of incident, accounting for 23% of incidents. However 74% of these incidents resulted in no harm.
- There were 14 serious incidents reported in surgery at Barnet hospital over the 12-month period January 2015-December 2015.
- Grade three pressure ulcers were the most commonly reported incident (five). This was followed by two relating to delay in treatment. We observed there were lessons learned from these and monitoring of local action plans. For example patients who may be at risk of developing pressure areas are discussed at the safety briefing.
- It appeared that the timeliness of incident reporting had improved over the reporting period. All the incidents in September 2015 and all but one of the incidents in October 2015 were reported within 90 days. In November all incidents were reported within 60 days.
- Trust policy stated that incidents should be reported through a commercial software system enabling incident reports to be submitted from wards and departments. All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system.
- Staff described the process for reporting incidents and told us they were encouraged and felt comfortable using the system. They told us they received feedback which was disseminated by email, monthly ward meetings and safety briefings.
- We saw that a root cause analysis (RCA) was completed as part of the investigation of incidents. RCAs identified learning from incidents and lessons learned from incidents were shared across teams.
- Learning from incidents across the trust was fed back to staff and had led to changes in practice to improve patient safety.
- 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. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person.
- We saw staff, patients and relatives were supported and informed of the outcome in accordance with the trust's Duty of Candour.
- The service kept appropriate records of incidents that had triggered a Duty of Candour response.
- Staff did not always understand the terminology, however the process they described in communicating with patients and their relatives reflected openness and transparency.
- Staff told us that when things went wrong it was used for learning and they were not shouted at.
- We spoke with consultants, managers and clinical staff who told us about the clinical governance, risk and mortality and morbidity (M&M) meetings, which were held monthly by directorate and were used to discuss any learning from incidents. Minutes of the M&M meetings were provided. These demonstrated learning from recent incidents.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers,

catheter and urinary tract infections and venous thromboembolism (blood clots in veins). We found that the NHS Safety Thermometer information was available on all of the surgical wards we inspected.
- We saw evidence that safety thermometer data was being routinely used to improve the quality of care. For example the numbers of days since last infections and falls were clearly displayed in each area.
- We noted the Patient Safety Thermometer data was discussed at the ward meetings and safety briefings.

Cleanliness, infection control and hygiene

- For 2015- 2016 there were no Methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus (MSSA) cases and 66 C Dificile cases (infections per 10,000 bed days) for the twelve month period. As of the beginning of February 2016, 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 C Dificile cases, 54 of which were attributable to surgery and associated services.
- There were infection prevention and control policies and procedures in place that were readily available to all staff on the trust's intranet. We found the surgical wards and theatre department to be adhering to national infection control guidance.
- We saw a high standard of cleanliness in all the areas that we visited.
- There were designated staff in wards and departments with infection control responsibilities. The hospital had a dedicated infection control team.
- We saw regular infection prevention and control audits took place in order to make sure all staff were compliant with the trust's policies such as hand hygiene and the use of personal protective equipment (PPE).
- Monthly hand hygiene audit results were displayed on notice boards within wards.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected.
- The 'bare below the elbows' policy was adhered to in all clinical areas.
- There was access to personal protective equipment, (PPE) including gloves and aprons in all areas we visited and staff used these whilst going about their activities.
- Equipment was marked with a sticker when it had been cleaned and was ready for use.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment.
- The cleaning of the hospital was undertaken by an outside contractor. Cleaning equipment was colour-coded and used appropriately; we saw evidence of cleaning rotas and checklists.
- Infection prevention and control was included in the trust's mandatory training programme. The staff we spoke with all confirmed they had completed this training.
- 86% of staff had completed level one infection control training and 70% of staff had completed level two infection control training.
- Decontamination and sterilisation of instruments was managed in a dedicated facility on site that was compliant with the EU Sterile Services Medical Devices Directive.
- The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, wards, clinics and departments.
- Audits also took place to monitor standards of practice in relation to national infection control guidelines and to improve patient outcomes related to surgical site infections.
- The service had a waste management policy, which was monitored through regular environmental audits.
- 84% of staff had completed waste management training.
- We saw evidence of the deep cleaning programme within theatres.
- 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. Disposable sharps were managed and disposed of safely.
- Linen cupboards were clean and tidy with bed linen managed in accordance with best practices.
- In main theatres they had separate clean preparation areas and facilities for removing used instruments from the operating theatre ready for collection for re-processing by the trusts decontamination service.

Environment and equipment

- Surgical services had a comprehensive equipment record which allowed for the monitoring of equipment in addition the trust provided evidence of an equipment replacement programme.
- Although we did not see the relevant training records, staff told us they had received relevant training on how to use equipment and felt confident and competent to use it.
- We saw portable appliance testing (PAT) labels were attached to electrical systems which showedthat it had been inspected and was safe to use.
- We saw there was signage indicating where emergency equipment was located
- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate log books being kept and we saw evidence of these.
- We saw theatres and anaesthetic rooms were generally well organised, clutter free and single use items such as syringes and needles were readily available.
- Theatres had a 'Difficult Airway' trolley, which were checked daily by the operating department practitioners.
- We found resuscitation equipment stored on the resuscitation trolley was readily available and located in a central position. The trust policy identified the systems to ensure it was checked daily, fully stocked and ready for use, daily checks should be recorded.
- We checked four different trollies and found out of date equipment on the resuscitation trolley on Cedar ward. We highlighted this to the nurse in charge who was able to explain the process for replacing the items from a central store. We returned to the ward later in the day and the out of date items had been replaced.
- We saw on two resuscitation trolleys that the laryngoscope blades (an instrument used to examine the throat) were non sterile.
- The staff we spoke with confirmed they had access to the equipment they required to meet peoples care needs. Although wards held their own equipment there was also an equipment library, which staff could access for equipment such as infusion pumps.
- We saw on the risk register that the call bells within theatres were not very audible. Staff said there had been no incidents relating to this and the matron confirmed there was a plan to replace the call bell system.
- We saw the fire doors at the entrance to recovery from theatres were propped open. Staff told us this was a habitual occurrence to enable easy assess to recovery when entering with a patient on a trolley. Staff told us that all staff knew that if the fire alarm was activated, the door needed to be closed immediately. We did not see a risk assessment or policy relating to this issue however the theatre matron told us there was a plan to replace the doors with an automatic door.

Medicines

- The trust has a Medicines policy which was issued on October 2015
- The medicines and safety group reviewed any medicine management incident that was reported on the trust's electronic reporting system. Themes and trends were identified and any learning shared through safety briefings, staff meetings and the medicines and safety group minutes.
- Latest results of trust wide audit of medicine management showed: 100% of drug room doors locked;100% fridge doors locked; 100% fully/mostly temperature recorded; 100% drug cupboards locked ; 85% intravenous fluid rooms locked.
- We saw management controls were in place in drug rooms on the wards which could only be accessed with a swipe card. Keys to controlled drug cupboards were held by the nurse in charge.
- We observed all the drug cupboards on the wards were locked and medicines were stored securely in locked medicine trollies.
- Pharmacists visited the wards during the weekdays and we saw evidence on the drug charts that medicine reconciliation were completed for each patient and pharmacy interventions noted.
- All trust sites had access to an on-call pharmacist out of hours.
- We saw in the day surgery unit there was a storage room which stored medications and expensive items of equipment.
- The storage room was not fit for purpose to store medications. There were vast amounts of a variety of medications kept in this store room, some of which may

be liable to be mis-used such as Co- Codamol (a painkiller containing Codeine Phosphate and Paracetamol)The medications were not secured inside lockable cupboards and were stored loose. There was no stock list of the medicines and there was no way of knowing if any of the medicines were missing.
- Although the storage room was kept locked, equipment was also stored within the room so staff would be in and out of the room frequently.
- Staff confirmed that every member of the day surgery and day theatre team, such as occupational therapist, and care assistants had access to the room.
- The theatre matron told us concerns regarding safe storage of medicines in day surgery had been discussed at managers meetings however this was not on their risk register.
- The theatre matron told us there were plans to relocate the medication store room but due to a technical problem this had yet to be completed.
- We looked at controlled drugs (CD) (medicines liable to be mis-used and requiring special management) in wards and theatres. We checked order records, and CD registers and found these to be in order. We saw evidence that ward staff checked stock balances of CDs daily.
- Many drugs need to be kept within certain temperatures for them to remain effective.
- We saw fridge temperatures were monitored daily and recorded accurately in all areas except Damson ward.
- We saw on Damson ward that fridge temperatures were monitored daily, and were consistently out of range with maximum temperature as high as 32°C over the last six months. No action was taken and the ward continued storing medicines in this fridge. This meant that it was possible drugs stored in these fridges are not as effective as they might have been.
- The charge nurse told us that there may have been something wrong with the thermometer as it has been replaced at least six times in the last year.
- The pharmacist had recently advised that the ward should obtain a new fridge and this had been ordered.
- Wards had a pharmacist to help facilitate discharge by verifying take home medications on the ward. However staff told us if the take home medication was prescribed after 2pm there was likely be a long delay in the pharmacy dispensary which may lead to a longer stay for patients.
- We saw wards had pre-packed medicines to speed up patient discharges.
- We reviewed 12 prescription charts and found them to be legible and completed appropriately. Patient allergies had been clearly noted on charts and on their identity band. The 12 charts we reviewed demonstrated that 10 prescription charts were in line with national guidance and were compliant with the National Institute for Health and Care Excellence (NICE) VTE guidance with a section in the front of the chart confirming a completed VTE assessment and that prophylaxis had been prescribed and administered.

Records

- The WHO (World Health Organisation) checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre.
- Since the four never events that happened in theatres across sites the trust had re-enforced the importance of compliance with the WHO checklist with surgeons, anaesthetists and theatre staff. We were told that regular and routine compliance was monitored through audit, peer reviews and feedback from patient safety staff.
- We observed demonstrations of the WHO checklist for each of the elective and emergency surgical procedures undertaken. They followed a standardised accurate approach, however the team brief was not formally recorded.
- We found evidence of staff completing WHO checklist documentation when we reviewed patients' notes postoperatively. Staff told us that compliance with the checklist was now closely monitored and audits of compliance took place on a routine and regular basis.
- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- We looked at 12 medical and nursing records on the surgical wards and in theatre. The wards used a mainly paper based system of recording care and treatment. Theatres mainly used an electronic based system which was printed off and placed in the paper notes.
- Requests for diagnostic procedures were undertaken via an electronic database.

- Patients were given a paper copy of their discharge summary and a copy of this was manually sent to their GP.
- We saw that some patients undergoing specific operations followed a standardised pathway. This was personalised through individual risk assessments and notes made in the care plans, for example patients undergoing fracture neck of femur operations.
- The surgical care pathways included pre-operative assessment such as previous medical history, social history, anaesthetic assessment, input from physiotherapy, discharge planning and allergies together with baseline observations.
- The care records included multidisciplinary input where required, for example, entries made by dietitians, physiotherapy and occupational therapists with referral to specialist advice, such as the dietitian and tissue viability nurses.
- We observed that nursing staff used pre-printed stickers which they completed with date, time, name, signature and grade and these were stuck in the patients notes each time they made an entry. This was an easy and accurate way of recording entries.
- Nursing and medical records were accurate and fit for purpose and completed to a good standard.
- We saw assessments of falls, pressure areas and nutritional status were well documented in patient's notes.
- We saw photographs of patient's bruises within the notes; no consent could be identified within the notes for these photos. We informed the nurse in charge of this issue and she said the patient was unwell and disorientated and this was why consent had not been obtained.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on the trust local internet, which staff demonstrated easily.
- The ward manager showed us an example of a safe guarding referral which was fully completed.
- There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team.
- Safeguarding training was included in the trust's mandatory training programme.
- 90% of staff had completed level one adult safeguarding training and 87% of staff had completed level two adult safeguarding training.
- Staff we spoke with confirmed they had received safeguarding training as part of mandatory training. They told us they would report their concerns to the nurse in charge and contact the safeguarding team if needed.
- Staff told us that they received good support from the safeguarding team, there was a single point of referral and referrals were dealt with promptly.

Mandatory training

- Mandatory training was monitored and all staff expected to attend on an annual basis.
- Staff told us mandatory training was a mixture of on-line training and face to face training, staff told us it was always completed in work time.
- Mandatory training was monitored and compliance discussed during staff appraisal.
- Monitoring and compliance were managed by a computer database and staff told us they received emails when training was due for completion.
- Staff were able to give us examples of when their personal training needed updating.
- We spoke with doctors of all grades and they told us mandatory training, such as safeguarding and infection control, was available.
- Junior doctors told us their induction programme was extensive and included mandatory training updates.
- Junior doctors told us consent training was mandatory for every doctor performing operations.
- The hospital tried to use the same agency staff that were familiar with the trust. We saw the orientation and induction sheets available to support new temporary staff to the trust.

Assessing and responding to patient risk

- The trust was currently in the process of aligning physiological scoring systems, but currently there were two separate systems in place:
- The Royal Free early warning system (EWS) used single triggers rather than a cumulative score. The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support.
- Barnet Hospital used patient at risk score (PARS) which was designed to enable health care professionals to

recognize “at risk” patients and to trigger early referral to medical staff, so that early intervention could help to prevent deterioration. The PARS was calculated by using the chart on the reverse side of the observation chart.

- Any abnormal measurement recorded during taking a set of patient observations should trigger a calculation of the score. Points were allocated according to the reading and once a full set of observations had been made a total score was calculated.
- When a patient triggered a PAR score the nurse in charge should be informed, the nurse would then conduct a further assessment and refer to the medical team for advice and review if necessary.
- During our inspection we witnessed this in practice; a student nurse escalated a patient’s deterioration and alerted the nurse in charge.
- Nursing staff told us medical support was readily available when required as the surgical team and consultants attended to patients quickly.
- We saw evidence of the situation, background, action, recommendation (SBAR) tool in use when patients were referred to other services.
- Local preoperative assessment policies should ensure that pregnancy status is checked within the immediate preoperative period in accordance with NICE guidelines. The check should be recorded on preoperative documentation used by staff performing final clinical and identity checks before surgical intervention. We observed evidence of this guideline being used in practice.
- We saw patients generally had a VTE assessment completed and patients undergoing surgery wore anti-embolic stockings.
- There were daily handovers, one at the beginning of the day, one at lunchtime and one towards the end of the day. We observed one nursing handover which was well organised and comprehensive. At the end of handover a safety briefing checklist was used which identified :patients with infections, medication, sick patients, patients at risk of falls, patients identified as potential absconders, same name patients, patients not for resuscitation, hand hygiene, pressure areas, cannula care, documentation assessments and care plans. We judged this to be a well imbedded practice throughout the surgical wards.
- We observed a medical handover and found these to be well structured and patients were reviewed in detail by a consultant prior to evening handover.
- General surgical doctors told us there was always a consultant in theatre during emergency procedures that happened out of hours.
- Surgeons told us they had concerns regarding the availability of specialists not provided at Barnet Hospital for example urology, however there were no reported incidents related to this.

Nursing staffing

- There was an overall vacancy rate at Barnet Hospital of 18% within nursing and midwifery. The largest vacancies were within the day surgery unit (51%) and Fern Unit (35%)The surgical wards were well supported by additional specialist services such as the tissue viability and pain teams. Posters with details of how to access the services were displayed. We reviewed nursing rota's and were assured that rota gaps were covered with Bank and Agency staff, with the appropriately qualified staff.
- The average sickness absence rate for nursing in surgery and associated services at Barnet Hospital was 5%.This was higher than the trust target of 3%.
- Theatres used The Association for Perioperative Practice (AfPP) staffing guidelines to ensure there was an adequate number of appropriately trained staff available for each theatre.
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients. We saw a safe staffing board that demonstrated planned staffing met actual staff ratios for each. The nurse to patient ratios were monitored and the trust supplied data which demonstrated that safer staffing rules were adhered to. All wards had planned versus actual staffing displayed.
- The nurse to patient ratios were monitored and the trust supplied data which demonstrated that safer staffing rules were adhered to.
- Staff told us that an electronic rota system was used which staff felt was a fair way of allocating shifts.
- Staff told us understaffing would be reported on the trust’s electronic incident reporting system. This was confirmed by patients who said there were enough nurses to provide safe compassionate care.
- Agency staff usage was minimal within surgical services, but were in higher use within theatres at Barnet Hospital.

Surgery

Medical staffing

- There was a -0.8% vacancy rate in medical and dental staffing at Barnet Hospital and 1% sickness absence rate which is below the trust target.
- In general surgery six out of 12 consultants were permanent locums, staff felt there was a lack of registrar trainees and minimal managerial duties as a result of this. However, trainees reported feeling well supported and we observed good cross-site coverage of medical staff during the time of our inspection.
- There was a consultant on call for general surgery on site at Barnet hospital site Monday – Friday 8:00am - 8:00pm.A second consultant is on site 8:00am - 5:00pm. The consultant on call was non-resident from 8:00pm. There were two registrars on site for up to 12.5 hours between 8:00am - 8:30pm and one on site all night.
- There was a consultant for trauma and orthopaedics on call at Barnet hospital Monday – Friday 8:00am – 07:00pm who was free from other duties. There was a consultant on call non-resident every night and at weekends, there was a consultant on call on site 8:00am- 08:00pm. There was a registrar on site 24/7 and a senior house officer was on site 08:00am - 8:00pm 7 days per week.
- Some specialities operated a consultant of the week model for example there was an orthopaedic trauma consultant of the week. Staff said this ensured consistency and ownership of acute trauma.
- Consultant cover was available for the wards and theatres seven days a week. This meant that consultants were on site from 8:00am to 08.00pm and an on call system operated out of hours and at weekends.

Major incident awareness and training

- The trust had Emergency Preparedness, Resilience and Response Policy issued in November 2015.
- Major incident training was part of mandatory training, all staff we spoke with said they has received training.
- Staff were aware of the trust's Major Incident Plan which was available on the trust's intranet, were aware of their role in the event of a major incident.
- Staff told us that they did not take part in major incident training as a hospital or with other emergency services or health and social care providers.

Are surgery services effective?

Good

We rated the effectiveness of the service as Good because;

- Patient surgical outcomes were monitored and reviewed through formal national and local audits to ensure care was evidence based and adhered to best practice guidance.
- Supporting information such as trust's policies and guidelines were available to staff via the trust's internet.
- Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes.
- There were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists.
- We found staff had undertaken training to their specific roles and had completed competence assessments, new staff and newly qualified staff were well supported to ensure patient safety. The majority of staff received an annual performance review and had specific learning needs and development discussed during this review.
- Staff assessed the nutritional needs of patients, supported patients to eat and drink with the assistance of a red tray system and protected mealtimes. Specialist medical, cultural, vegetarian diets could be catered for.

However;

- In the National Emergency Laparotomy Audit (NELA) Barnet Hospital's self-reported data indicated the provision of facilities required to perform emergency laparotomies were unavailable for 20 out of the 28 measures reported on.

Evidence-based care and treatment

- Staff were able to access national and local guidelines through the trust's intranet, which was readily available to all staff. Staff demonstrated the ease of accessing the system to look for the current trust guidelines.
- The anaesthetic department at Barnet Hospital was preparing for accreditation with the Royal College of Anaesthetists however the accreditation had financial implications which were still under discussion.

Surgery

- There were a range of clinical pathways and protocols for the management and care of various medical and surgical conditions which had been developed in conjunction with healthcare professionals from a range of specialties, for example the sepsis pathway.
- Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations for example patients undergoing surgery for fracture neck of femur (NOF) had their surgery fast tracked.
- Following surgery, patients were nursed in accordance with the NICE guidance CG50: 'Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital.'
- Within the theatre, we observed staff adhered to the (NICE) guidelines CG74 related to surgical site infection prevention and staff followed recommended practice.
- National clinical audits were completed, such as the national hip fracture database, national emergency laparotomy audit and lung cancer audit.
- Barnet and Chase Farm Hospitals participated in the bowel cancer audit 2015 and had a good attainment rate of 96%. The hospitals had a better post-operative mortality rate compared to the England average. However a higher percentage of patients had a length of stay of more than five days and there were a higher rate of unplanned re-admissions within 90 days compared to the England average. 57% of patients had a stoma after 18 months which was lower than the England average of 50%.
- The trust had mixed results in the patient reported outcomes measures (PROMS) audit when compared to the England average.
- Hip-related PROMs were flagged as an elevated risk and knee-related PROMs as a risk, in the May 2015 Intelligent Monitoring report. These related to comparison measures of function and pain of patients before and after their surgery.
- The trust took part in the Lung Cancer Audit 2015. The trust met the 95% target for percentage of patients discussed at multi-disciplinary meetings.
- Participating hospitals collect data relating to surgical site infections (SSI) for different kinds of surgical procedures over a minimum period of three months. From the data provided the trust has generally performed better than the England average in surgical site infections in relation to hip replacements, knee replacements and fracture neck of femur operations. It should be noted however that there were no patient questionnaires completed at this trust and the data had not been adjusted for patient type which may affect overall performance.

Pain relief

- Barnet Hospital pain management service was supported by the recovery unit which was nurse led, with support from consultant anaesthetists with an interest in pain management.
- There was a single point of contact to the pain team. Ward nurses told is the pain nurses proactively visited wards daily reviewing patients and supported staff in managing patients' pain.
- Nurses on the medication ward rounds would ask each patient if they were in any pain and would give pain relief and we saw this happen.
- All the patients who had recently undergone surgery told us there were no problems in obtaining adequate pain relief.
- Patients told us nurses responded quickly when extra pain relief was required and the effect was checked by nurses.
- There was no standardised trust wide pain tool in use; The Royal Free Hospital used a 0-3 rating and 0-4 rating was used at Chase Farm and Barnet hospitals. The trust was currently trying to standardise pain tools.
- Recovery staff told us that no patient left recovery with a pain score of more than two.
- The staff we spoke with had been trained on the use of patient controlled analgesia (PCA) and epidural pumps, and the pain team provided support with these if required.
- Chase Farm and Barnet sites had two pain nurse specialists who would assist with training and giving expert advice where necessary. They were working with the four pain nurse specialists at the Royal Free site to harmonise the pain tools and PCA pumps so there would be a more consistent approach to pain management.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of being under nourished.

- Generally the records we reviewed had a nutrition and hydration assessment undertaken.
- Staff advised us there was a quick response rate from dietitians and speech and language therapists (SALT).
- A SALT completed the initial swallowing assessments on new patients who had swallowing difficulties and then provided advice to nursing staff.
- We saw a red tray food/water jug lid system in use highlighting patients who needed assistance with feeding for example patients living with dementia.
- Staff confirmed meal times were protected and staff assisted patients with feeding when necessary.
- We reviewed a patient menu which included options for people with specialist dietary needs such as religious beliefs or vegetarians.
- Specialist nutritional drinks were readily available for patients on Enhanced Recovery After Surgery (ERAS). We saw posters educating staff on different types of specialist drinks and which drinks were suitable for specialists' diets such as religious beliefs.
- A recent audit undertaken at the Royal Free hospital looked at the length of time patients were fasting prior to surgery. This showed that 62% of patients fasted over 2.5 hours, 47% of patients fasted over 4.5 hours and 27% of patients fasted over 6.5 hours.
- We saw posters displayed 'think drink' in pre-assessment which reminded staff to check how long patients had to wait prior to surgery and to ensure those patients waiting more than two hours should be given a drink if appropriate.

Patient outcomes

- Staff understood the National Institute for Health and Care Excellence (NICE) guidelines and stated that these were referred to in discussions with staff about patients' care and treatment.
- Staff told us they were able to assess relevant NICE guidelines on the trust's internet.
- Mortality and morbidity trends were monitored monthly through Summary Hospital-level Mortality Indicator (SHIMI) and Hospital Standardised Mortality Ratio. (HSMR) This data was only available at trust level.
- The Royal Free NHS Trust was a positive outlier on both measures, a feature consistent across The Royal Free Hospital and Barnet Hospital, and had been maintained over several years.
- The trust monitored mortality using the Doctor Foster tools. Occasional alerts for disease or procedure codes had led to deeper enquiry in the last 12 months. No cause for clinical concern had been identified as a result of these enquiries.
- Comprehensive mortality reports were taken to the Clinical Performance Committee, a Non-Executive Director (NED) chaired the board committee. We saw meeting minutes from this committee.
- In the National Emergency Laparotomy Audit (NELA) Barnet Hospital's self-reported data indicated the provision of facilities required to perform emergency laparotomies were unavailable for 20 out of the 28 measures reported on. The trust does not have an action plan on how to address this.
- In the Fracture of Neck Femur audit 2015, Barnet Hospital performed worse than NHS Trusts in relation to: admitted to orthopaedic care within four hours and mean total length of stay.
- However Barnet Hospital performed better in; surgery on the day of or after day of admission, pre assessment by geriatrician, bone health medication assessment and fall assessments.
- The trust reported low rates of pressure ulcers, falls with harm and catheter acquired urinary tract infections reported between December 2014 and November 2015.
- In general surgery the elective average length of stay at Barnet Hospital was double the England average.
- The elective average length of stay was above the England average at Barnet Hospital.
- The non-elective average length of stay was below the England average at Barnet Hospital.
- The risk of readmission for elective and non-elective care at Barnet Hospital was lower than the England average at trust level.
- The trust scored in the bottom 20% for 24 out of the 34 questions in the Cancer Patient Survey 2013/14.
- Theatre utilisation for Barnet Hospital was 63.0% (capped) and 67.8 % (uncapped) for October 2015.

Competent staff

Surgery

- The trust had in place appropriate job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post.
- Staff members' registration status was monitored by a local electronic database and managers received emails prior to a staff members registration expiry.
- Staff also received an email when the registration was due for renewal.
- 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 check their compliance against NHS employment standards. This provided assurance that agencies ensured their staff met these standards.
- Ward managers told us there was minimal agency use within surgical services at Barnet hospital, we saw evidence of checklists and induction packs for agency staff.
- Between April 2015 and November 2015 71% of nursing staff had an appraisal completed.
- Learning and development needs were identified during the appraisal process.
- Staff told us the hospital was a good learning environment with easy access to mandatory training and further development.
- There was a preceptorship programme for all newly qualified band five nurses.
- There were leadership programmes available for band 7 and 8 nurses, and development programmes for band 6 and 7 nurses.
- We saw each area had clinical educators who were senior nurses who worked clinically with staff to support training and supervision.
- We spoke to two student nurses who said they felt supported and staff were happy to teach them and they felt part of the team.
- The trust had four positive findings and four negative findings in the NHS Staff survey. The remaining 21 questions were consistent with other trusts.
- The trust was within expectations for 12 of the General Medical Council (GMC) survey questions and worse than expected for two questions.
- Barnet hospital submitted 69 revalidation recommendations to the GMC between 1st April 2015 – 27th January 2016.
- Junior doctors told us they were well supported and had access to training.
- 82% of anaesthetists working at both Barnet and Chase Farm sites attained level two resuscitation training, 62% intensive life support training (ILS) and 50% paediatric life support (PLS) training.

Are surgery services caring?

Good

We rated the caring for the service as Good because;

- We spoke with 12 patients during the inspection who told us they were treated with dignity and respect at all times and had their care needs met by caring and compassionate staff.
- Patients felt involved in their care and participated in the decisions regarding their treatment, and staff were aware of the need for emotional support to help them cope with their treatment.
- We saw how staff were able to build a rapport with patients quickly and effectively.
- The hospital had a number of specialist nurses who were able to assess patients and make referrals to external services for support if necessary.
- We observed patients being treated in a professional and considerate manner by staff.

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. We saw that Friends and Family information was displayed on notice boards around the wards and departments.
- The trust had a 47% response rate in the FFT which was 13% higher than the England average.
- Damson ward had a response rate of 47% in FFT in December 2015 which was better than the England average, 84% of patients would recommend the ward to friends and family which was worse than the England average.

- Cedar ward had a response rate of 30% in FFT in December 2015 which was better than the England average, 90% of patients would recommend the wards to friends and family which was worse than the England average.
- The patients we spoke with were all very positive about the care they had received and said nurses had time to give compassionate care.
- We saw thank-you cards from patients displayed and recent changes made as a result of patients feedback.
- Throughout our inspection, we witnessed good staff interaction with patients. We observed how the nurses assisted patients, with compassion and skilled care.
- Patients said they were treated with compassion, dignity and respect and had their care needs met by caring and compassionate staff.
- In theatres we observed staff delivering care with empathy and compassion. We saw theatre staff offered caring and compassionate care, safeguarding the patients' dignity including when they were not conscious.
- During our inspection we observed patients being treated in a professional and considerate manner by staff.
- The hospital had a number of specialist nurses who were able to provide emotional support to patients and make referrals to external services for support if necessary.
- Patients told us nurses worked as a team and supported each other
- We did not receive any negative comments from patients regarding their care.

Understanding and involvement of patients and those close to them

- We spoke with patients at different stages of their surgical journey, they told us they felt involved in their care and in decision making about their treatment.
- The patients we spoke with told us they were given adequate information about the specific surgical procedure that applied to them.
- We saw that specific information leaflets were available which were given to patients at pre assessment therefore they had time to read the information prior to their operation. They felt they had time to ask questions and that their questions were answered in a way they could understand.
- We spoke with a mother, whose son had complex needs; who told us s that care had improved at Barnet hospital since the merger with The Royal Free Hospital. In addition she said the staff were amazing and proactive rather than reactive. She felt her son was safe, the care was spontaneous and the cleaner was really thoughtful. The communication with her was good and she was involved in decision making and the consent process.

Emotional support

- Barnet Hospital had arrangements in place to provide emotional support to patients and their families when needed.
- We saw posters giving details on a variety of support groups or services which could be accessed for example bereavement services and dementia support groups.
- We were given an example of a mother attending the anaesthetic room with her son who had specialist needs and was called into recovery to be with her son after the operation.
- Staff confirmed they had access to the End Of Life Team and previous referrals had been acted upon promptly.
- The trust has a weekly pattern of Christian and Muslim services which were held throughout the trust.
- There is a 24-hour emergency on-call chaplaincy service operated throughout all hospital sites.
- Staff told us the trust was committed to offering pastoral, religious and spiritual support throughout the trust. It benefited from a multi-faith chaplaincy team, supported by a dedicated team of chaplaincy volunteers.
- The trust hosted events recognising significant times, including, Remembrance Day, Holocaust Memorial Day, World Aids Day and a service of annual remembrance for those who had lost a loved one in one of the trust's hospitals.
- The patients and staff we spoke to said the food was of good quality with a variety to choose from which catered for individual needs for example Kosher food and vegetarian options.
- Patients told us the food was generally good and there was plenty of choice and patients had access to drinks by their bedsides.

Are surgery services responsive?

Surgery

Good

We rated the Responsiveness of the service as Good because;

- The needs of local people, commissioners and stakeholders were taken into consideration when planning services.
- The service had identified the 24/7 working scheme to be an integral part of its quality strategy and had undertaken a preliminary self-assessment exercise to review the extent to which services were provided seven days a week to help assess the capabilities moving forwards.
- As part of the trust's strategic patient safety programme, it had been identified that there was a need to clarify, strengthen and harmonise across sites key processes and capabilities that ensure they were delivering optimal levels of patient safety. Staff told us that this strategy was not always communicated effectively with doctors.
- There were established surgical pathways of care through the hospital from admission to discharge.
- A 24/7 medical cover working group had been set up and consisted of the following work streams: overnight medical cover and team working, site patient safety briefings, ward safety briefings, seven day consultant review and escalation.
- Complaints were acknowledged, investigated and responded to.

However;

- In times of high demand patients were nursed overnight in the day surgery unit at Barnet hospital.
- Staff told us that patients' acuity and dependency was assessed as to their suitability to be cared for in this environment. However we saw no formal process or standard operating procedure to support this practice.
- Five patients stayed in recovery overnight in November 2015 and two patients in December 2015.
- Staff told us it was difficult to secure a place in the day surgery unit for a patient who was at home awaiting minor trauma or emergency surgery.
- Staff told us there were frequent delays due to lack of flow of patients when patients stayed overnight in recovery, which meant it was difficult to organise and plan because of capacity within the day surgery unit.

Service planning and delivery to meet the needs of local people

- The trust was in the process of consolidating services across sites, managers told us that staff, local people, commissioners and stakeholders were involved in the process and had an opportunity to have their views heard.
- Patients were offered a choice of appointment and treatment times either through 'Choose and book' or through personal contact.

Access and flow

- Daily bed occupancies were completed for the hospital which identified potential service problems, reviewed demand, capacity and workforce. Daily operational meetings with representation from surgery took place.
- The use of the theatre recovery area as an inpatient bedded area had a big effect on the flow of patients requiring operations and frequent single sex breaches occurred. There was 12 single sex breaches in recovery between January 2015 – September 2015. Five patients stayed in recovery overnight in November 2015 and two patients in December 2015.
- The number of cancelled operations trust wide has been mixed, dropping to its lowest of 63 in quarter one 2014-2015. This data was not available by site.
- 17 patients trust wide were not treated within 28 days after their operation was cancelled between quarter one 2013/14 and quarter one 2015/16.
- Trust referral to treatment time performance was below the 90% standard from September 2014 to October 2015. Over the same period six specialty groups failed to meet the standard; ear nose and throat surgery, general surgery, ophthalmology, plastic surgery, trauma and orthopaedic surgery and urology surgery. The service had an action plan in place to address this issue.
- Elective access to specialty surgical services was via a two week rule and urgent clinic slots. Patients were triaged where appropriate. The trust cancer referral data indicated that in October 2015 97% of all patients were seen within two weeks.

Surgery

- July 2015 – June 2015 54% of all operations undertaken at Barnet Hospital were day case procedures
- Emergency surgical services were in place for all specialities, with priority access to theatres via consultant led reviews. There was a dedicated emergency theatre that was always available.
- We found that only seriously ill patients were operated on at night in line with the Royal College of Surgeons Unscheduled Surgery Guidance.
- We saw the wards used good visual tools on the patients information boards ,it was easy to identify who was nil by mouth, at risk of falls ,patients who had dementia, patients who required red trays and patients at risk of pressure areas. These boards were of a fold up design which maintained patient confidentiality.
- We saw theatres used a similar visual tool on the emergency and trauma boards, patients awaiting surgery were given a symbol when they had been seen by an anaesthetist and surgeon and if they were awaiting anything such as equipment.
- We saw it was easy to identify from these boards when patients were ready for surgery and the planned operation dates for patients.

Meeting people's individual needs

- We heard that the hospital was generally able to meet patients' individual needs for example there were positive initiatives in place to support patients living with dementia.
- Health care assistants told us they were proud of their involvement as dementia leads; they had the idea of the initiative for dementia patients' to use red trays for meals.
- Theatres had some bariatric equipment available to meet the needs of patients with a high BMI (Body Mass Index),however there was no policy for patients with a high BMI.
- Staff told us that translation services were available in a variety of forms, for example face to face or telephone translation.
- There was access to patient information literature however we noticed it was only available in English but staff told us they were available in other languages on request.
- There were two acute liaison nurses (ALN's) for adults with learning disabilities across the sites; one was based at the Royal Free site the other based at Barnet and Chase Farm.
- Staff told us all patients with learning difficulties had a hospital passport when they came into hospital to ensure their needs were understood.
- There was an electronic flagging system in place for people living with a learning disability at the Royal Free Hospital. The flagging system at Barnet and Chase Farm was in the development stage, according to data supplied to us.
- There were no specific pathways for patients living with dementia or experiencing delirium. However, staff told us there was a piece of work underway to design and implement a specific delirium and dementia pathway for all patients affected by those conditions.

Learning from complaints and concerns

- There are well established Patient Advice Liaison Services(PALS) teams at the Royal Free Hospital and Barnet Hospital the Barnet team also cover the Chase Farm hospital.
- Managers said they would try to resolve complaints before they escalated as usually the best way to resolve matters quickly as possible when they happen and encouraged their staff to resolve complaints themselves wherever possible.
- Patient information advising patients how to make a complaint or raise a concern with PALS was available on the trust website. An easy-read leaflet 'Comments, concerns and complaints', was available around the hospital. We saw posters 'Have you got a concern or complaint and don't know where to turn', throughout the hospital.
- Complaints were regularly discussed with senior staff and escalated, where appropriate, to the risk and safeguarding teams.
- Complaints were also discussed at the quarterly operational adult safeguarding group and equality steering group.
- There were mechanisms in place for shared learning from complaints through the staff meetings, trust briefings and safety briefings.
- There were 99 complaints received in surgery trust wide between December 2014 and November 2015.
- The average trust wide (mean) time that complaints were open for was 43 working days.
- The top subject for complaints trust wide related to all aspects of clinical treatment (59%).

Surgery

Are surgery services well-led?

Good

The surgery and associated services division at The Royal Free Hospital NHS Foundation Trust was led by a divisional director, a divisional director of operations, a divisional director of nursing (this role was vacant at the time) and two heads of nursing.

The service was led at site level by a tripartite model of Clinical Lead, Matron and Service Manager. This reported to the Divisional Surgical Director, Deputy Head of Nursing and Divisional General Manager.

We rated the leadership of the service as Good because;

- Nurse managers spoke enthusiastically about their ward or department and were proud of the teams they had working with them.
- We saw the trust encouraged local initiatives to improve patient experience, care and treatment and we were given examples of these.
- There were systems to ensure patients and staff were heard and listened to.
- Staff were passionate about team work and created a friendly welcoming environment.
- Matrons were dynamic, supportive and visible in clinical areas and they inspired others to work together.

However;

We considered clinicians were not so well led, we were told there was a 'them and us' culture between clinicians and discontent across the different sites. Clinical staff told us they felt that there was little communication or involvement with regard to changes to services They also said they were not encouraged to speak during Divisional meetings.

Leadership of service

- The service was led at the site level by a tripartite model of a service line lead, matron and operations manager. This reported to the clinical director, head of nursing and senior operations manager.
- The leadership team was well established and had clearly defined roles and responsibilities which demonstrated good leadership across the service
- We saw clinical leaders and managers encouraging supportive, co-operative relationships among staff and teams, and compassion towards patients.
- Staff were highly complementary about the frontline management team.
- We spoke with the directors and clinicians with responsibilities for the surgical divisions. They told us that the Chief Executive was very approachable and they felt supported.
- We saw that managers and clinicians monitored performance against key performance indicators or clinical outcomes.
- Senior nurses undertook relevant leadership and management training.
- There was clear leadership, and staff knew their reporting responsibilities and took ownership of their areas.
- Staff told us that members of the senior nursing management team were visible and approachable.
- Staff told us the nursing leaders and managers in their areas of work inspired them and encouraged them to work together in achieving enhanced patient care. Staff told us that nursing leaders had a positive attitude and saw problems as opportunities to learn.
- We saw nursing leaders and managers were able to respond to an ever-changing healthcare environment, organisational expectations and changes to local and national policies.
- We saw nurse managers led with sincerity, were self-motivated and had the ability to motivate others.
- Clinicians told us there was poor visibility of senior medical management team at Barnet Hospital and described a silo thinking approach within the Divisional structure.
- Clinicians told us there was poor leadership amongst the medical teams at Barnet hospital, due to the lack of senior management supervision and presence.
- All staff spoke with passion and pride about working at Barnet Hospital and all spoke enthusiastically about what the future held for the hospital.
- Group emails were frequent and positive in nature and the Chief Executive undertook monthly briefings which were recorded and which staff could access.
- The Director of Nursing undertook weekly video conferencing with the matrons this ensured matrons at different sites could be included in these meetings.

Vision and strategy for this service

Surgery

- The trust had a vision for the service which was "Successful integration of the two trusts will be a fundamentally important focus of the years 2014-19." Royal Free Strategic Plan 2014-2019.
- The service had a variety of developments to further enhance the provision of surgical services in the future on the different sites.
- Some specialities had their own strategies: breast, vascular, urology, paediatric, elective orthopaedic, renal transplant, liver transplant, renal cancer and plastic surgery all had their own.
- 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.
- We observed the trust's vision and values were prominently 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.

Governance, risk management and quality measurement

- 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 were satisfied that the risk register was reflective of the risks we observed.
- There were meetings every six weeks of the Barnet Hospital and Chase Farm Hospital Surgical Specialties Clinical Governance & Risk Committee where the minutes from the Divisional Quality and Safety Board meetings were circulated and discussed. This structure was mirrored across the sites, and the location of the Divisional meeting altered across the sites on a rolling basis.
- Other items were discussed such as patient safety and risk issues, clinical performance and patient experience and included learning from serious incidents and complaints.
- Theatres demonstrated the recent never events across sites had been taken seriously and were committed to learning from these events and preventing them from reoccurring.
- The service had strong governance reporting systems in place.
- Nursing staff confirmed clinical governance information and changes to policies and procedures and guidance had been cascaded down by the matron and ward manager via emails, communication diaries, team meetings, and safety briefings.
- Matrons and ward managers had governance meetings monthly and weekly.
- The service has a strong governance structure with all grades of staff having a voice.
- The service investigated its serious incidents and action was taken to prevent reoccurrence. We reviewed root cause analysis reports which demonstrated clear actions and changes to practice.
- There was a surgical risk register and was under continual review to ensure that the content of the register reflected the actual risks within the department.
- Managers we spoke to were able to explain items on the risk register and how risks were mitigated.

Culture within the service

- We considered clinicians were not so well led, we were told there was a 'them and us' culture between clinicians at the different sites, discontent and the feeling that they were the "poor relation" to the Royal Free Hospital, medical staff being unhappy about different job plans across sites and workloads not being equal and little communication or involvement regarding changes to services.
- Surgeons also told us it was unfair that some surgeons got to do more interesting and challenging operations than others depending on the site they worked at.
- We observed a lack of cohesive working between clinicians at different sites and a lack of knowledge of services provided.
- Staff reported the leadership culture made them feel valued, included and respected.
- Staff told us they were extremely proud to work for the organisation and felt that the care they provided was excellent.
- Staff told us the culture of the service was focused on meeting the needs of patients.

Surgery

- We heard there was a strong culture of openness from junior to senior staff, clinical and non-clinical.

Public engagement

- The hospital used various means of engaging with patients and their families. These included surveys, such as the 'Friends and Family Test', inpatient surveys and 'You said We Did' initiative.
- Patients and the public were given a wide range of information from the trust's website for example information regarding NHS choices and performance outcomes.
- We read a trust newsletter which was a valued and interesting publication. It contained an interesting article about a member of staff who had just donated a kidney.
- Patient safety and patient experience boards were displayed in public areas on the wards which gave relevant up to date information to patients and visitors. For example the number of days since a patient had had a fall, developed a pressure ulcer or had an infection.
- The Family and Friends test results were displayed, along with any actions from patient feedback.

Innovation, improvement and sustainability

- We saw staff wanted to learn, develop and improve their skills, they were given the time, resources and encouragement to do so.
- We saw a new staff nurse had developed a care bundle for patients with tracheostomies (a surgical procedure to create an opening through the neck into the trachea) where a small tube was placed for breathing.
- We found that innovation and improvement was recognised, shared and celebrated.

Critical care

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

Information about the service

Critical care services were delivered across two wards, Intensive Care Unit (ICU) North and ICU South, which operate as one unit.

The critical care units had 23 beds with 10 beds (including two side rooms) on ICU North and 13 beds (including three side rooms) on ICU South. There was potential to open up an additional bed on ICU North if required.

The unit treated 777 patients between April 2014 and March 2015 and the unit is part of the North East North Central London Critical Care Network.

Patients are mainly admitted from the emergency department, but a proportion are also admitted via the hospital wards, either due to becoming more unwell, or after emergency surgery. The Patient at Risk Resuscitation Team support ward staff to care for deteriorating patients prior to their transfer to critical care, as well as reviewing patients following discharge from the unit.

We visited the critical care unit over the course of one announced inspection day. During our inspection, we spoke with 24 members of staff including doctors, nurses, allied health professionals and support staff. We spoke with the divisional leadership team within critical care at the trust. We also spoke with four patients and two relatives. We checked eight patient records and observed the wards and its equipment.

Summary of findings

We rated critical care at Barnet Hospital as Good overall because;

Staff were proactive in reporting incidents and there was evidence that learning from investigations had taken place consistently with an effective system in place to ensure all staff were aware of updates to practice.

We found good levels of cleanliness, infection control and hygiene across critical care and rates of hospital acquired infection were low.

Staffing levels were reviewed continually using an established nursing acuity tool staff to provide care and was in line with national guidance.

Patients on the critical care unit received effective care and treatment that met their needs. Their care and treatment was planned and delivered in line with national and local guidelines.

Patients were treated with compassion, dignity and respect and staff provided emotional support to patients and relatives. All of the patients we spoke with praised the staff for the care they provided and said that they would recommend the critical care services.

There was very effective multidisciplinary team working between doctors, nurses, physiotherapists and other allied health professionals. The electronic patient record allowed information to be shared proactively between staff groups to ensure good coordination of patient care.

Critical care

Staff were supported by their managers and there was a culture of openness to learn and develop services. They were also supported by managers and the education team to develop their knowledge and skills to improve the quality of care provided to patients.

However;

The leadership team had oversight of the issues affecting the unit but it was unclear what plans were in place to address these.

Staff were positive about the local leadership team but felt the trust leadership of critical care services was more focused on the Royal Free site.

Are critical care services safe?

Good

We rated safety in critical care as Good because;

- There were effective systems in place to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us about improvements in practice that had occurred as a result.
- The environment was fit for purpose and all staff complied with infection prevention and control guidelines. Staff had access to a wide range of equipment and all equipment was adequately maintained.
- Staffing on the unit was in line with national guidelines, although there was a reliance on agency staff. Patient records were comprehensive, with all appropriate risk assessments completed.
- The Patient at Risk Resuscitation Team reviewed all deteriorating patients during day time and ensured patients received the appropriate level of care, while awaiting admission to the critical care unit.
- The electronic patient records allowed staff to maintain high standards of record keeping. Medicines were generally stored safely and securely, except for emergency drugs.

However;

- Nursing staff had achieved the trust target for most of the mandatory training modules but training rates for medical staff were not provided.

Incidents

- Staff used an electronic reporting system to document incidents in the unit. There was a transparent and proactive culture that empowered all staff to report incidents in a 'no blame' environment. Staff told us that this system worked well and they felt the outcomes of investigations were used primarily to avoid future incidents and to improve good clinical practice. When staff completed an incident form, they always received feedback via email of the outcome of the investigation as well as verbal feedback from the matrons. Learning from incidents was shared with all staff during 'safety

huddles' at handover. This included incidents that happened in other parts of the hospital but had the potential to impact on critical care patients. The electronic record system contained a 'blog' feature, which senior staff also used to share learning with all staff, including members of the multidisciplinary team (MDT).

- The senior nurses had also established a system of sharing important information to all staff groups, known as 'hot topics.' These were three items of information including learning from incidents, changes to pathology reporting and specific training for staff, which was discussed as part of handover daily for a week. Staff we spoke with were able to tell us what the hot topics were for that week and felt it was a useful way of ensuring staff on all shifts received consistent information.
- Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The trust did not report any never events in critical care in the last year.
- There was one serious incident (SI) reported for the period of January 2015 to January 2016, which related to the deterioration of a patient following transfer from the critical care unit. Staff we spoke with were clear about the investigation process required for a SI, in line with NHS England Serious Incident Framework. We saw evidence that this incident was fully investigated and the lessons learnt, actions taken and plans to share this learning were clear in the investigation report. A change to the transfer policy was made as a result of this investigation.
- 165 other incidents were reported between October 2014 and September 2015, although the large majority of these were low harm incidents.
- Staff told us mortality and morbidity meetings were held as part of the monthly audit afternoon. We requested minutes from these meetings but had not received them in time for inclusion in this report.
- 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 spoke to staff of various grades about the Duty of Candour and they all had a good understanding of the Duty of Candour requirement and were able to explain how it applied to their specific roles. We also saw evidence of 'being open' in incident investigation reports we reviewed, with a nominated individual responsible for keeping the patient and family up to date during investigation process and providing feedback as well as a copy of the report once the investigation was completed.

Safety thermometer

- The critical care unit participated in the NHS Safety Thermometer scheme used to collect local data on specific measures related to patient harm and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas. This data was collected electronically and a report produced for each area.
- The information on harm free care was clearly displayed at the entrance of each unit along with the expected and actual staffing levels for that day. On the days of our announced inspection, we observed the critical care unit had the required number of nursing staff on duty.
- Safety thermometer data we reviewed for the period of August to December 2015 showed the unit had not achieved harm free care, with patients acquiring pressure ulcers (grade 2) or urinary tract infection in each month of this period. The matron informed us the mattress used in the critical care unit provided adequate pressure relief and all patients were risk assessed for pressure ulcer on admission. For high risk patients, more specialist pressure relieving equipment was loaned from an external company and staff did not report any delay in accessing these equipment, once a need had been identified. Staff had access to the trust-wide specialist Tissue Viability Nurse (TVN) service as well as a link nurses for pressure ulcer prevention.
- All patients had their level of risk assessed for Venous Thromboembolism (VTE), falls and malnutrition, which was reviewed at regular intervals. We saw evidence of these in the electronic records we reviewed and the safety thermometer data also showed good compliance with VTE risk assessments and administration of preventative treatment.

Cleanliness, infection control and hygiene

- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required. Staff

adhered to infection control precautions throughout our inspection such as cleaning hands when entering and exiting the unit and bed spaces, and wearing personal protective equipment when caring for patients. Side rooms also had signs displaying presence of infection and the doors remained closed.

- Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed no concerns in relation to hospital-acquired infections, such as MRSA or C. difficile and performance in these areas was similar to comparable units.
- The units we visited were clean and all the patients we spoke with were satisfied with the cleanliness. Other areas within the critical care unit, such as the relatives waiting area, quiet room and nursing stations, were clean and tidy. We saw that bed space curtains were labelled with the date they were last changed.
- Staff used 'I am clean' green labels to indicate that an item of equipment had been cleaned and decontaminated. Clinical bed-space equipment was cleaned before being stored in a locked storeroom. In the storeroom, we noticed a trolley, with a green sticker attached, which had some dusty equipment on the bottom shelf. We pointed this out to staff, who took immediate actions to rectify the matter.
- The cleaning audits we reviewed showed the critical care unit achieved over 97% consistently and actions were clear when an issue was identified. Hand hygiene audits for the last year also showed compliance to be between 95% and 100%.

Environment and equipment

- The environment on the unit was bright and airy and the critical care unit was in a good state of repair. The corridor leading to the bed spaces had a noticeboard with a variety of useful information displayed for both staff and visitors. The side rooms on the critical care units were not pressure controlled and did not have a decontamination lobby, which was not in line with best practice guidance.
- There was one arterial blood gas analyser available in each unit and these machines were calibrated daily; we saw documentary evidence of this with no gaps evident. We observed staff leaving blood samples unattended in the machine during analysis and returning later to collect result. We raised this with the matron, who was not aware of this practice, and assured us this would be addressed.
- Nursing staff on the unit had maintained resuscitation and emergency intubation equipment with daily, documented checks. A nurse from the hospital's resuscitation team conducted a routine monthly audit of the equipment, which was repeated after the trolley was used. There were no gaps in the daily checks of the resuscitation equipment.
- We found that the cleaner's cupboard used to store chemicals was unlocked on both ITU North and South. This was not in line with Controlled of Substance Hazardous to Health (COSHH) guidelines.
- Needle sharp bins were available at each bed space and within the medicines preparation area. All bins we inspected were correctly labelled and none were filled above the maximum fill line.
- Medical equipment including ventilators and arterial blood gas analysers were maintained by the in-house equipment technicians. We saw evidence equipment servicing was up to date and items had recently been 'portable appliance safety' tested.
- Therapy staff we spoke with told us they had access to equipment required to carry out rehabilitation, although they were unable to acquire certain equipment due to lack of storage on the unit.

Medicines

- One full time pharmacist provid input to the unit Monday to Friday and was supported by a pharmacy technician. The pharmacist was unable to participate in the daily ward rounds due to time constraints and commitments in other areas of the trust. Weekend and out-of- hours pharmacy input was available via the on-call pharmacist.
- We reviewed four paper based prescription charts and saw they were fully completed, including details of any missed doses. Allergies were clearly documented and staff informed us the prescription charts were re-written every weekend.
- Controlled drugs (CDs) were stored in lockable wall units and the authorised signatory list was available. Documentation showed the stock of CDs was checked once per day alongside the CD book.
- Other medication, including these required to be stored in a fridge, were stored in a temperature controlled room and the room and fridge temperature checks were recorded daily and were in range. However, we found the room was left open, despite having a keypad lock, and we observed the cupboard containing emergency

drugs was unlocked. The stock level of the emergency drug cupboard was not recorded, which meant all staff were able to access these medication. The transfer bags were stored in this room and also contained emergency drugs, accessible to all staff, including non-clinical staff. We raised this issue with the senior nursing team and they informed us the decision to leave the room and cupboard unlocked had been taken after discussions with senior management team. This was to ensure quick access to emergency drugs, although there had been no incidents involving delayed access. This was not included on the risk register.

Records

- Patient records and clinical notes were created and stored using a paperless electronic system, which had been designed specifically for critical care by one of the current consultant. All staff we spoke with were very proud of the electronic system and felt it met the requirements of the whole MDT. Any adjustment required to the system, for example updates or addition of new trust documentation, were done quickly by the consultant on site.
- All records we looked at included details of allergies, a daily treatment plan and evidence of daily consultant reviews. Specialist assessments were conducted and recorded appropriately, including for feeding, neurology and respiratory needs.
- We saw staff updated the patient records following a therapy session and observed the system allowed staff to document rehabilitation plan and outcomes measures such as the Chelsea Critical Care Physical Assessment Tool (CPAx).
- Nursing documentation included routine risk assessment for falls, malnutrition and pressure ulcers and we saw in the six records we reviewed, that this was all completed within hours of an admission.

Safeguarding

- Staff knew their responsibilities regarding the safeguarding of patients and were able to demonstrate this in practice. Staff we spoke with were able to give examples of when they would raise a safeguarding referral and felt confident they could access additional support from the trust's safeguarding team.
- Safeguarding policies were up to date and readily available for staff on the unit, who knew where to access them.
- The trust target for all mandatory training was 95%. 97% of nursing staff had completed the safeguarding adults Level 1 training and Level 2 training rate was 94%.
- Safeguarding children Level 1 and Level 2 training was completed by 97% and 85% of nursing staff respectively.
- There was no safeguarding training data available for medical staff working in critical care.

Mandatory training

- Key aspects of mandatory training such as information governance and fire safety were undertaken as part of the induction process for new starters. Additional mandatory training such as infection prevention and medicines management were undertaken as e-learning modules and further classroom based sessions.
- The matron tracked the training needs of nurses in the unit and planned ahead to reduce the risk that training would expire. We saw a training spreadsheet displayed on the staff noticeboard, clearly displaying the training attended and training required for all nursing staff working on the unit.
- 94% of nursing staff on the unit had up to date mandatory training, against the trust's target of 95%.

Assessing and responding to patient risk

- There was a newly established Patient At Risk Resuscitation Team (PARRT), staffed by specialist nurses and led by a nurse consultant. The nurse consultant predominately worked at the other site but was involved in training and complex cases at the Barnet site. The PARRT consisted of two Band 7 nurses during weekdays and one nurse at weekend. The team was on site from 8am to 8pm daily and a thorough face to face handover took place with the hospital at night team at the end of each shift. No consultant was attached to the PARRT but the team worked closely with the critical care consultants. The PARRT was responsible for reviewing all patients following discharge from ITU and the nurse consultant told us the team aimed to review patient prior to them leaving the unit and within six hours of being on a ward. This was not always possible since PARRT was not a 24 hour service and a large number of patients were discharged out of hours or late in the afternoon.
- For patients on the wards, staff used a cumulative early warning scoring system, closely aligned to the National Early Warning System (NEWS). Ward staff would contact

the medical team and the PARRT if a patient triggered escalation and were supported in managing deteriorating patients by the PARRT specialist nurse and critical care medical staff, as required.
- Patient's conscious levels were recorded using the Glasgow Coma Scale (GCS) and Richmond Agitation-Sedation Scale (RASS) was used to monitor agitation in sedated patients. We saw evidence of this in the records we reviewed.
- Staff told us the Confusion Assessment Method for the intensive care unit (CAM ICU), was used to assess whether patients were delirious while on the unit. This practice was in line with current best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. Staff showed us a quick reference flow chart that was designed to guide clinician in monitoring analgesia, sedation and delirium for patients on the unit.

Nursing staffing

- The current vacancy rate was 21%, which the senior staff explained were mainly for junior nursing post. Senior staff felt the unit struggled to recruit newly qualified nurses due to the location not attracting the inner London allowance. The unit therefore relied on bank and agency staff to maintain safe staffing numbers. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that all ventilated patients (level three [L3]) are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and for level two (L2) patients a ratio of 1:2. We reviewed patient allocation records and staffing during our inspection which showed the critical care complied with these required staffing levels.
- Agency staff underwent a thorough induction to the unit and senior nurses told us they tried to use the same agency staff whenever possible to maintain the continuity of care and avoid repeated inductions to the unit; which would be time consuming for the shift leader. Agency nurses we spoke with confirmed they regularly worked on the unit and their competencies had been checked prior to starting their first shift.
- Best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units suggests no more than 20% agency staff usage per shift. Senior staff told us they always tried to comply with this guidance although it was not always possible; nursing rota we reviewed confirmed this.
- A handover took place at the beginning of each shift, which incorporated a safety briefing and discussion about 'hot topics' for that week. Nursing staff received an overview of all critical care patients from the shift coordinator at the start of their shift and then a thorough bedside handover once they had been allocated a patient.

Medical staffing

- There were, at the time of our inspection, 12 critical care consultants who participated in the rota which covered the critical care unit. Since the acquisition by the Royal Free, the clinical director was the only consultant who worked cross site.
- ITU North and South had cover from one consultant and two trainees each during the day, with the team covering ITU North reviewing all new referral and liaising with referring teams. When a decision to admit to critical care was taken, patient could be admitted to ITU North or South, depending on bed availability.
- Consultants were allocated to cover the critical care unit in weekly blocks and did not have additional responsibilities within the hospital while responsible for critical care. This type of rota system ensured continuity of care and was in line with best practice guidance. The consultants were present on the unit between 8am and 6pm. Outside of these hours consultants were available to attend deteriorating or newly admitted patients, with a 30 minute response time.
- Overnight, patient care was led by two airway trained registrars with support from a consultant on an on-call basis. There was an additional anaesthetic registrar to review new referrals and also assist on critical care as required.
- Doctors completed a formal ward round twice each day and decided upon a management plan for each patient. This was in line with recommendations by the Faculty of Intensive Care Medicine Core Standards for Intensive Care.
- Medical handover meetings took place twice each day, during which staff finishing their shift would handover patient details and any relevant updates to doctors starting work.
- We saw copies of the medical rota and staff we spoke with told us the level of cover meant there was always a

doctor present on the unit in an emergency. Nurses we spoke with told us that they were happy with the level of medical cover and there was always a doctor available to review patients.

Major incident awareness and training

- All staff received fire safety training as part of their mandatory training programme; staff told us they had practiced drills as part of their training days and were clear how patients would be protected from harm in an emergency situation.
- There was an up to date major incident plan for the trust with a specific action card for the critical care unit and senior staff we spoke with were aware of this and understood their roles in the event of a major incident.

Are critical care services effective?

Good

We rated the effectiveness of critical care as Good because;

- Patients were cared for by competent medical staff following evidence based policies and care bundles. Multidisciplinary working was effective and access to physiotherapy and diagnostic imaging was good.
- Staff could readily access important information and were aware of the need to obtain consent, taking into account mental capacity principles.
- Nursing staff had access to a range of training, including post registration training in critical care. 100% of nursing staff had undergone an appraisal in the last year.

However;

- Mortality ratio was slightly worse when compared to similar units and we did not see evidence this had been discussed by the leadership team and there was no action plan in place.
- There was a higher number of patients discharged from critical care out of hours when compared with similar units.

Evidence-based care and treatment

- The critical care unit contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally.
- Intensive care specific policies and procedures we looked at were up to date and referenced to current best practice from a combination of national and international guidance. References included National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations.
- Polices and guidelines were accessed by staff via the intranet, although some printed copies were available in folders at the nursing station for quick reference. We found these folders contained the most up to date policies, although staff acknowledged work was needed to harmonise all policies since the merger with Barnet and Chase Farm Hospital.
- All patients received daily physiotherapy as required by the National Institute for Health and Care Excellence (NICE) guidance and intensive care society standards. All patients were screened within 24 hours and their rehabilitation needs were identified at the time. Rehabilitation progress was measured using the evidence-based Chelsea Critical Care Physical Assessment Tool (CPAx), so patient progress could be monitored.
- Intravenous lines (IV) and care bundles audits were completed on a monthly basis and staff were reminded of key aspects of care following audit findings. We reviewed the audit data for the months of August to December 2015 and compliance was between 98 to 100%, except for the month of December where compliance in the IV lines audit dropped to 90% due to the absence of the insertion date on the dressing.
- Audit of compliance with lung protective ventilation strategy showed the unit was achieving over 98% for the last three years.

Pain relief

- Staff used a combination of verbal and non-verbal assessments to manage pain. The Critical Care Pain Observation Tool (CPOT) was used to assess pain in non-communicating patients. The CPOT assessment was completed in all records we reviewed for appropriate patients.
- Patients we spoke with on the unit told us their pain was well managed and the staff always asked them about their pain and would act promptly to administer additional pain relief if required.
- Pain relief was managed primarily by consultants on critical care, although input from the specialist pain

management team was available on request. We saw staff engaged the specialist pain team when preparing a patient for transfer to the wards to ensure an effective pain management plan was in place.

Nutrition and hydration

- There was dedicated dietician input for all critical care patients and the dietician and a nurse conducted a nutritional assessment of each patient on admission and thereafter at regular intervals depending on patient condition. The electronic patient records system included fluid balance checks, which we saw were used appropriately.
- Our review of clinical notes showed us that staff used the Malnutrition Universal Scoring Tool (MUST) to identify those at risk of malnutrition and appropriate feeding regimes were in place for each patient.
- Protocols were in place for total parenteral nutrition and percutaneous endoscopic gastrostomy (PEG) feeding tubes and staff had received appropriate training in their use.

Patient outcomes

- The average length of stay for patients was 9 days, which was impacted by one patient with an exceptionally long stay of over six months.
- Unplanned re-admissions to critical care within 48 hours from unit discharge and after 48 hours were slightly better when compared to similar units for the period of April 2014 to March 2015.
- ICNARC data showed the critical care mortality ratio was 1.12, which was worse than other similar units. The rate of post critical care hospital deaths was also higher when compared to other similar units.
- Patients discharged 'out of hours' between 10pm and 7am were associated with worse outcomes and ICNARC data demonstrated there were more patients discharged from critical care out of hours than in other similar units.
- The majority of patients returned to their pre-admission residence and previous level of independence on discharge from hospital.

Competent staff

- Nursing staff had access to on-going specialised training that was managed by a dedicated team of Clinical Practice Educators (CPE), who worked cross-site. One member of the CPE team was based at Barnet hospital and provided support to new nurses on the unit. Nurses we spoke with told us that they were very happy with the standard, frequency and quality of training and felt the education aspect had greatly improved since joining the Royal Free.
- All nurses we spoke with during the inspection told us they had an allocated mentor who was responsible for regular one to one sessions and appraisals. The appraisal rate for critical care nurses was 100%.
- A team of 110 nurses worked on the critical care unit, 45 of whom held a post-registration award in critical care nursing. This was below the minimum recommended requirements of the Royal College of Nursing. The CPE team informed us a cohort of nurses was awaiting their results from the in-house post registration course and the percentage of staff with this qualification would meet the required 50% very soon.
- All new nurses working in critical care were allocated a six week period of supernumerary practice, during which they were expected to complete a series of competencies which had to be signed off prior to independent working. We saw evidence these competencies were being completed by supernumerary members of staff. We saw the National Competency Framework for Critical Care in place for nurses which had to be signed off before caring for patients with specific needs, such as patients with a tracheostomy.
- The CPE team monitored nurse competencies on a rolling basis to ensure that nurses maintained currency in practice based on national benchmark standards. The CPE team had initiated some discussions about the nurse revalidation process and were planning how to support the critical care nurses through this process.
- The nurse in charge of each shift checked the skill mix and competencies of their team before allocating work and ensured staff were looking after patients with varying needs to facilitate learning and maintain competencies.
- We saw evidence which showed new medical staff underwent a comprehensive induction programme on their first day. This included sessions on infection control, role of the PARRT team, computer systems training and simulation training for emergency situation in critical care.
- Scheduled teaching for trainees took place weekly. The trainees were also expected to lead a journal club

weekly and trainees we spoke with told us these teaching sessions and teaching during ward rounds gave them confidence and equipped them to carry out their role on the unit.

Multidisciplinary working

- A MDT meeting took place every week to discuss treatment and rehabilitation plans for long stay patients. Medical and nursing staff and the wider MDT (physiotherapist, pharmacist, dietician, and Speech and Language therapist) attended this meeting and we saw documentation outlining the discussions at these meeting when we reviewed patient records. Staff told us these meeting were extremely beneficial in planning holistic care as well as longer term requirement of individual patients following discharge from critical care.
- Therapist and nursing staff worked collaboratively to implement rehabilitation plans for each patients and we saw nursing staff and therapists working together to complete patient care tasks and rehabilitation during the inspection. Critical care patients also had rehabilitation sessions with physiotherapist from other specialities such as orthopaedic and neurology.
- Physiotherapists worked collaboratively with nursing and medical staff to plan and implement ventilator weaning programmes (when patients' reliability on breathing machines was reducing and they were able to do more breathing on their own).
- The critical care unit did not have dedicated Occupational Therapist (OT) cover and staff told us the physiotherapists led rehabilitation on critical care and would usually make the referral to OT when needed.
- All patients discharged from the unit were followed up by the PARRT nurses and patients with tracheostomies were followed up by the critical care therapists.

Seven-day services

- A pharmacist was available to support critical care at weekends, although they also had responsibilities in other areas of the trust. Microbiology support was available via telephone within the trust at all times.
- Physiotherapy staff provided a seven day service between 8.30 am to 4.30pm but there was no on- call service out of hours. Physiotherapy staff told us the on-call service had stopped about two years ago and they did not feel patient care had been affected as a result. Medical and nursing staff confirmed this.
- Staff ordered diagnostic imaging services via an electronic referral process. Staff told us the radiology department completed all imaging according to clinical need and there were very rarely delays to investigation for critical care patients, including out of hours.

Access to information

- Staff obtained most of their in-house information via the hospital intranet site. This included links to policies, procedures, mandatory training, and emails from matrons. Mobile computer terminals were readily available, which allowed easy access to the information.
- There were folders at the nursing station with specific information such as Dementia and safeguarding. The Dementia folder contained up to date information on how to access specialist input as well as a 10 point dementia portal guide on topics such as communication, night-time agitation and delirium. This guided staff on how to adapt care to meet the needs of patients living with dementia.
- All staff were able to access MDT records via the electronic system and the paper-based medical records were also stored on the unit during a patient's critical care stay. On discharge from critical care, a copy of their electronic records were printed and filed in the paper based records**.**

Consent and Mental Capacity Act

- Staff completed Mental Capacity Assessments for people who were suspected as not having capacity to consent. Key information about mental capacity protocols and Deprivation of Liberty Safeguards (DoLS) were available on the intranet and staff knew where to find this.
- All staff we spoke with understood the need to obtain consent from patients before performing care tasks, investigations or giving medicines. Where staff could not obtain consent, for example unconscious patients, staff explained they provided care in the patient's best interests. We observed staff seeking consent from patients throughout critical care, including explaining the rationale behind the procedure they were performing.
- The noticeboard at the entrance of the unit contained up to date information on mental capacity and DoLS including contact numbers for the trust wide leads**.**

Critical care

Are critical care services caring?

Good

We rated the caring in critical care as Good because;

Staff were passionate and dedicated to providing compassionate care and emotional support to the patients on the unit. We witnessed some outstanding care and emotional support being provided during the inspection.

Staff understood the anxiety patients and relatives experienced and were resourceful in ensuring the emotional support required was available. Nursing staff had worked hard to implement initiatives such as the 'visiting dog' scheme and made good use of other counselling services in the trust and externally.

All patients and relatives we spoke with were complimentary of the care they received and felt staff consistently kept them informed and involved.

The MDT staff on the unit had devised a 'Rehabilitation Manual', which contained a wide range of information about the critical care unit; the equipment used and encouraged patient involvement in their rehabilitation.

Compassionate care

- The interactions we observed between staff and patients on the unit showed a tireless and on-going dedication to treating patients and their relatives with compassion, dignity and respect. On the day of our inspection, we saw how staff dealt with a child who was visiting a parent receiving end of life care on the unit. Staff took time to prepare the child before entering the unit and the nurse in charge ensured the family were supported and all their questions were answered in a calm and reassuring manner.
- Patients told us the care they had received on the unit was 'exemplary' and 'all the staff go out of their way to make sure I am ok.' Relatives were also very complimentary of staff on the unit and felt staff treated the patients 'like they would treat family'.
- The unit did not participate in the Friends and Family Test and the critical care unit did not currently have a way of continuously collecting patient feedback. This has been recognised by staff and one of the band 6 nurses was currently developing a patient survey as a service improvement project.
- We noted many thank you cards and letters, displayed on a board, from patients praising the care they had received throughout their critical care stay.

Understanding and involvement of patients and those close to them

- The entrance to the critical care unit had a picture board of all staff and friend and relatives were encouraged to speak to a member of staff if they had any questions or concerns. We saw the relatives room also had posters up about 'speak to a doctor' and relatives we spoke with said 'the doctors were always willing to answer our questions and they were very patient.'
- Staff told us they often held meetings for families with relatives on critical care so that any questions about their relative's time in hospital could be answered. All family discussions were documented in the patient records.
- The MDT staff on the unit had devised a 'Rehabilitation Manual', which contained a wide range of information about the critical care unit; the equipment used and encouraged patient involvement in their rehabilitation. The booklet also contained information on relaxation and breathing techniques and patients were able to refer to these even after discharge from the unit.
- Patient told us staff always kept them informed of the treatment plans and staff explained any test they were due to have. We observed the medical team interacting with patients, who were awake, and explaining their treatment plan.

Emotional support

- A multi-faith spiritual team was available to provide support within the hospital 24 hours per day.
- The critical care unit contacted all patients three months after discharge to invite them to a follow up clinic which was run by the MDT. This was an opportunity to discuss their stay on the unit and answer any questions they may have about their care. This was in line with NICE guidelines CG83 'Rehabilitation after critical care in adults'. Staff told us patients were very appreciative of this service, although they did not collect data on the number of patients seen or patient feedback.

Critical care

- There was a counselling service available to staff and we saw the nurse in charge had arranged for a member of the counselling team to come to the unit when a junior member of staff, caring for an end of life patient, needed some support.
- Staff told us the senior nursing team were caring towards them and organised debrief sessions following a death on the unit. Staff felt this support was particularly important for new nurses on critical care and gave them an opportunity to reflect.
- The staff on the unit were very proud of their work in establishing a 'visiting dog' initiative. Relatives were encouraged to discuss bringing in the patient's dog to visit and staff worked hard to facilitate this. The senior nursing team explained staff sought guidance from the infection control and prevention team and had established certain criteria but this scheme was now running successfully.
- Staff were proactive in identifying the emotional needs of relatives and were able to direct them to specialist charities offering support during and after a critical care stay. Staff also accessed specialist services on site, for example we saw staff contacted paediatric services on site to access some support for a young child whose parent was receiving end of life care on the unit.
- Patients who were able to eat and drink were seen to be offered a choice of food and drinks. Drinks were observed to be within patients' reach when appropriate and patients told us they were offered a choice of food and were assisted with feeding, when required.

Are critical care services responsive?

Requires improvement

We rated the responsiveness of critical care as requires improvement because;

- Discharges out of critical care were regularly delayed due to lack of bed availability in the rest of the hospital and this had a knock-on effect of creating further access difficulties for other patients.
- An increasing number of patients were transferred from critical care out of hours. Regular delays in discharges led to mixed sex patients being cared for in an open ward.
- Patients did not have access to a call bell although this had been identified as a risk by the senior team.

However;

- Visiting hours were flexible and staff made an effort to accommodate requests from patient's relatives.
- Staff had access to communication aids and translators when needed, giving patients the opportunity to make decision about their care, and day to day tasks.
- Patient passports were used for patients with a learning disability.
- Staff received training to care for patients living with dementia.

Service planning and delivery to meet the needs of local people

- The majority of admissions to the critical care unit were unplanned admissions through the emergency department, theatres or the wards. For the period of July to December 2015, only 10% of admissions were planned. Senior staff told us the low number of booked admissions made service planning difficult, as patient flow was unpredictable.
- Between July and December 2015, 43% of patient admitted to critical care were emergency medical admissions. During that period, 30% of patients were receiving level 3 care.
- The PAART team were actively monitoring their workload and there were plans in place to increase the staffing establishment and establish local leadership for the team. Expansion of the service to 24 hours a day would be considered, depending on the demand.
- The senior nursing team had recognised the large number of delayed discharges from the unit but there were currently no plans for how this issue would be addressed. Staff we spoke with were not aware of any discussions with the bed management team and felt delayed discharges were a trust-wide issue.

Meeting people's individual needs

- A translation service was available for patients and families. The main service was available via a telephone system but face-to-face translation could be booked if needed. Staff told us they might also use patients' family members or other members of staff if difficulties with obtaining translation services occurred.
- Patients with a learning disability had information passports which were used throughout the hospital to

identify important information about the patient and how best to interact with them. Staff told us they also relied upon the patients' family to support their admission.
- Staff had received training to care for patients living with dementia and were able to access other resources within the hospital to meet the need of each patient.
- Patients could be referred for a psychiatric review, which could be initiated by nursing or medical staff. Staff told us they could obtain support from the team quickly if needed.
- Patients had access to freely available and up to date information in the relatives' rooms and on request from staff. Printed information was available to explain to relatives and patients what they could expect in the unit, how to make a complaint and the visiting hours policy.
- The hospital did not have accommodation on site for relatives who lived a significant distance away or who had difficulties accessing the hospital while patients were admitted. One of the relatives' rooms had comfortable armchairs and relatives were able to spend one night there, if required. The trust offered discounted parking fees for relatives of critically ill patients.
- Mixed sex breaches had occurred frequently over the six months prior to inspection. A mixed sex breach occurs when level one or zero 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. Due to the lack of beds within the hospital, patients from critical care were not always discharged in a timely manner, leading to these breaches occurring.
- Patients on the critical care unit did not have access to a call bell to request assistance from nursing staff. This was not identified as a safety issue as patients were generally receiving one to one care and patients told us there was always a member of staff nearby. The senior nursing team had recognised this as an issue and plans were in place to introduce a wrist worn call bell system.

Access and flow

- The critical care unit had a clear admissions policy and admission to critical care was usually agreed between the critical care consultant and the treating consultant. Patients were reviewed by the PARRT team and critical care medical staff prior to admission.
- The bed occupancy levels were over 100% in data we reviewed for July to December 2015 and the unit had a significant number of delayed discharges. Although this was a common issue in critical care, ICNARC data showed the number of delayed discharges was higher than comparable unit between April 2014 and March 2015.
- 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. The critical care activity data from July to December 2015 showed over 55% of discharges were delayed by more than four hours.
- During the same period, 68 patients experienced delays in admissions, although audit data showed the majority of patients did not experience delays of more than 4 hours. Patients awaiting admissions would normally be cared for in the emergency department or theatre recovery. Data provided by the trust showed four patients were ventilated in recovery in the last year. The PARRT team would remain with the patient and provide one to one nursing, as required.
- An increasing number of patients were discharged from the unit between 10pm and 7am. ICNARC data showed over 20%of patients were discharged out of hours, which was worse when compared to similar units. Discharges from critical care out of hours is against national patient safety guidance and the core standards.
- The number of patients transferred out of critical care for non-clinical reasons were in line with similar units nationally.
- Very few patients were admitted to critical care following elective procedures. This meant that it was rare for elective operations to be cancelled on the basis that there were no critical care beds available.

Learning from complaints and concerns

- Some relatives told us they were aware of how to make a complaint and could reference posters advertising PALS in the waiting area. They felt they could also discuss any problems with staff on the unit and any issues would normally be dealt with straight away.
- Most concerns raised by relatives were dealt with informally on the unit by nursing staff. There had been two complaints relating to critical care since January 2015. We noted the trust dealt with the majority of the complaint within agreed timescales. Senior staff we spoke with were aware of the recent complaints and

explained their role in the complaints investigation process. They felt it was useful to reflect following a complaint and ensure the learning is shared with the rest of the team. Senior nursing staff fed back during the daily handover and via the 'blog' on the electronic record.

Are critical care services well-led?

Good

A matron and clinical director had responsibility for the leadership of the critical care unit. The matron was supported by the directorate Head of Nursing.

We rated the leadership of critical care as Good because;

- The team of senior nurses and doctors were engaged in their vision to harmonise clinical guidelines and practice across the three sites and improve cross-site working relationships.
- There was a robust governance structure, both within critical care and also within the directorate, although the governance meeting minutes we reviewed had few discussions specific to the Barnet site.
- There was a well-respected, coherent and highly visible local leadership team in the unit. Staff had a positive approach to their work and the culture on the unit empowered staff to develop and contribute to changes to working practices.
- The management team had oversight of most of the risks within the services although the risk register did not include some risks we identified during the inspection.

However;

- Although there was evidence of staff engagement and changes being made as a result, patient engagement on critical care was not well developed.
- Some issues such as increased mortality, out of hours discharges and delayed discharges did not have action plans in place so it was unclear how the leadership team were planning to address these.
- Staff told us the trust leadership and executive team did not always recognise the good work happening on the Barnet site and the focus was more on the Hampstead site.

Vision and strategy for this service

- The leadership team provided evidence of a local strategy document, which outlined their key areas for improvement and their vision for the service. The strategy for the Barnet site focused primarily on addressing the high number of delayed discharges and establishing stronger link with ward teams to facilitate transition of care. The strategy had been agreed locally but the strategy document was not a formal paper presented to the Trust Executive Committee (TEC) so it was unclear how this strategy was aligned to the trust's overall strategy. This was of particular importance since addressing delayed discharges would require a trust wide approach to address bed pressure in other areas of the hospital.
- Ward staff understood the current difficulties in discharging patients, but those we spoke with were not aware of a plan to address this issue. The strategy document we reviewed clearly identified change was required in the way the bed management team operated, but there had been no engagement with the bed management team to discuss this.
- The leadership team were clear in their vision to harmonise clinical guidelines and practice across the three sites and improve cross site working relationships. They planned to appoint staff to work cross site in the future and felt this would further enhance the sharing of best practice and learning in the trust.
- The nursing leadership team were confident the in-house critical care training and excellent support from the CPE team would help the service attract more nurses and hence reduce reliance on agency staff.
- Ward staff knew how their work contributed to the wider vision of the trust and were aware of the trust values. Staff told us values were discussed at their supervision and appraisal sessions and was embedded in their practice.

Governance, risk management and quality measurement

- Consultant meetings took place twice monthly and provided another forum to discuss incidents and risks, review scorecards and audit outcomes and undertook mortality and morbidity reviews. However some issues such as increased mortality and delayed discharges did not have action plans to demonstrate how the critical care team were planning to address these. These

meetings were not attended by consultants from the Royal Free site due to the amount of travelling involveded and there were currently no minutes for these meetings.
- There was a monthly risk and governance meeting where incidents were discussed by senior nursing staff and the medical team. Information from governance meetings was disseminated to ward staff via handovers or email.
- Operational management meetings were led by the head of nursing for critical care and senior nursing staff were able to discuss staffing and performance issues, concerns and complaints.
- The critical care department maintained a cross-site risk register, including concerns and assessments of potential risks on the units. This was reviewed regularly within risk meetings and classifications discussed and modified as required. One item on the register, which related to paper based nursing rota, had been recorded as a risk since 2014 but staff we spoke with told us this risk had been addressed since the introduction of an electronic system in August 2015. The risk register did not reflect all the risks identified on the inspection, i.e. out of hours discharges and the unsecured storage of emergency drugs.
- An allocated consultant took the lead for patent safety and clinical risk. This role involved promoting safety throughout clinical process, reviewing all clinical incidents and educating staff about concerning incident trends. In addition, the nurse consultant for the PAART team was on the Serious Incident review panel and played a vital role in sharing the learning from other areas of the trust with the critical care team.

Leadership of service

- A matron and clinical director had responsibility for the leadership of the critical care unit. The matron was supported by the directorate deputy Head of Nursing. We noted these senior staff were visible on the wards throughout our inspection and knew ward staff across the service.
- A supernumerary shift coordinator was allocated to each nursing shift to provide immediate leadership and facilitate service delivery on ITU North and South. Staff across critical care spoke positively about the shift coordinators, praising their supportive attitudes and open approach. We also observed the two shift coordinators worked closely together and had a good understanding of patient needs on both ITU North and South.
- The nursing and medical clinical leadership teams worked closely together to plan and deliver a safe and responsive critical care service. Two way communications around safety and capacity issues occurred frequently and a good relationship between the teams was evident.
- Lines of accountability and responsibility in the unit were coherent and staff were clear about their roles and how to escalate problems. The matron and deputy director of nursing were visible and staff felt able to approach them with any concerns.
- Doctors felt supported by the wider team, as well as their medical colleagues, and told us they received good support from the consultants.
- Although staff were very positive about the local leadership, they said the overall trust leadership team did not always recognise the good work happening at Barnet Hospital as the focus tended to be on the Hampstead site.

Culture within the service

- Staff had a positive and cohesive approach to their work. Staff worked together to complete patient care tasks and senior colleagues were always available for guidance and advice. Nursing staff were able to discuss patient care with the medical team and felt their input was well received and respected.
- There was evidence of arrangements for developing staff with good support, including mentoring and training. Senior staff spoke of the strong commitment to equality and diversity on the unit.
- Staff commented that there was a culture of 'no blame'. Everyone was encouraged to learn from incidents and staff said the individual feedback they received after any incident was constructive and helpful.
- Staff had good working relationships with each other and told us they worked as a team across the ITU north and South. Agency staff who worked regularly in critical care felt part of the team and were often included in social events.
- Staff at all levels were proud of the service provided on the critical care unit and felt their work was recognised

by the local leadership team. However some staff commented on how the executive focus was predominantly on the Royal Free site and some of the good work at Barnet was overlooked as a result.

Public and Staff engagement

- Staff were encouraged to come forward with ideas to develop the service and to provide feedback about recent changes. We saw the risk register was displayed to all staff and staff were invited to discuss new risks identified with the leadership team.
- Staff told us they were aware of who the executive board members were and had seen them previously, but that they rarely visited the unit.
- A recent service improvement project aimed at gathering patient feedback was being led by one of the junior nurses, as part of their development. The senior nursing team engaged staff in identifying areas for improvement and empowered them to contribute to continued improvement of the unit.
- The critical care team held away days for nursing staff, where nurses across the two sites could reflect, share areas of good practice and support each other's development. It was also an opportunity to discuss issues affecting both sites.
- The Critical care information leaflet and the rehabilitation manual encouraged patients and their relatives to provide feedback. Although staff made every effort to engage friend and family in patient care while they were on the unit, there was no system in place to collect feedback to help improve patient experience on the unit. Senior staff had recognised this gap and a new project, aimed at recording patient satisfaction, had recently been started.

Innovation, improvement and sustainability

- The Critical care team developed a smart phone application which contained up-to-date critical care policies and guidelines and best practice recommendation. Medical staff we spoke with told us they have found this extremely helpful to access key information on the go.
- In response to the difficulties experienced in the recruitment of new graduates, the CPE team developed an in-house, university accredited, post registration course to attract nurses wishing to pursue a career in critical care.
- The tailor made electronic patient records used in critical care was fit for purpose and enabled staff to maintain up to date patient records, accessible to all members of the MDT. Staff told us having all risks assessment and care plans, as well as MDT notes in one place enabled better communication and more efficient use of time.
- The staff on the unit were very proud of their work in establishing a 'visiting dog' initiative. Relatives were encouraged to discuss bringing in the patient's dog to visit and staff worked hard to facilitate this.

Maternity and gynaecology

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

Information about the service

- The Royal Free London Hospital NHS Foundation Trust acquired responsibility for Chase Farm and Barnet NHS Trust in July 2014. The maternity services provided at Barnet Hospital were merged with those provided at the Royal Free Hospital. The Royal Free London Hospital NHS Foundation Trust now provides integrated hospital and community maternity services across both sites and at Edgware Birth Centre.
- This report focusses on the maternity and gynaecology services provided at Barnet Hospital and the maternity services at Edgware Birth Centre. Edgware Birth Centre is a free standing maternity unit (FMU) and both services are part of the Royal Free London Hospital NHS Foundation Trust, Women Children and Imaging Directorate which also provides gynaecology, genito-urinary medicine, neonatal and paediatric and imaging services.
- A total of 4915 babies were born at Barnet Hospital between April 2014 and March 2015. A total of 105 babies were born at Edgware Birth centre in 2015.
- Barnet Hospital has a 48 bed maternity ward; 13 rooms on the labour ward including two close observation beds, two obstetric theatres and four recovery beds; four maternity day unit beds; two rooms in triage; and a birth centre with five birth rooms and three postnatal rooms.
- The maternity service at Barnet Hospital offers: a consultant-led labour ward; birth centre; outpatient antenatal and gynaecology clinics; a maternity day unit (MDU); a triage unit; and antenatal and postnatal inpatient wards. Women can also choose to have a home birth supported by community midwives. Eight teams of community midwives provide antenatal care, parent education classes, home births and postnatal care in children's centres, GP surgeries and women's own homes. The maternity services also include specialist provision, for example for women with diabetes. An outreach clinic was located at Chase Farm Hospital offering support for women with perinatal mental health needs.
- The gynaecology services at Barnet Hospital offers inpatient care on a 17 bed mixed female surgical and gynaecology ward, outpatient care and emergency assessment facilities, including an Early Pregnancy Assessment Unit (EPAU) and Emergency Gynaecology Unit (EUG). Outpatient care includes colposcopy, hysteroscopy, treatment for miscarriage and pre-operative assessment. A team of gynaecologists receive support from specialist gynaecology nurses, general nurses and healthcare assistants.
- Barnet hospital did not have a termination of pregnancy service. However, they did carry out termination of pregnancy for foetal abnormality.
- We visited all wards and departments relevant to the services. For maternity services we spoke with eight patients, two relatives, 17 midwives and support workers individually, and seven midwives in a focus group. For gynaecology services we spoke with three patients, two relatives and four nurses. We also spoke with eight medical staff who worked across both maternity and gynaecology services.
- A gap analysis was undertaken following the acquisition of Chase Farm and Barnet NHS Trust. Concerns were

identified at Barnet Hospital that included poor clinical governance structure, lack of timely response to SIs and poor embedding of lessons learned from SIs. There was also lack of action in response to maternity dashboard triggers such as high caesarean section rate and third and fourth degree tears, themes from SIs including issues with antenatal and newborn screening. The leadership structure and midwifery establishment, education and training were also identified as areas of concern.

- We saw considerable progress towards compliance with the integration action plan, including a reduction in the caesarean section rate from 32% in October 2015 to 24% by December 2015.
- The maternity service at Edgware Birth Centre offers midwifery led care including antenatal and postnatal clinics, care for birth and inpatient postnatal care.Women can also choose to have a home birth supported by community midwives. A team of community midwives provide antenatal care, parent education classes, home births and postnatal care in children's centres, GP surgeries and women's own homes. We visited Edgware Birth Centre and spoke with four midwives and one support worker.

Summary of findings

Overall we rated this service as Good because;

- We saw examples of safety incident reporting systems, audits concerning safe practice, and compliance with best practice in relation to care and treatment.
- Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed that staff carried out care in accordance with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.
- The ratio of clinical midwives to births was one midwife to 29 women which is slightly higher than the national average of one to twenty eight women. The trust provided evidence of one-to-one care during labour which is recommended by the Department of Health. Women confirmed that had had one to one care in labour and told us they felt well informed and were able to ask staff if they were not sure about something.
- Patients and their relatives spoke highly of the care they received in both the maternity and gynaecology services.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

Overall we rated the safety of the service as Good because;

- All areas of the maternity and gynaecology service we visited were visibly clean and well maintained with display boards detailing cleanliness and safety information.
- We saw documentary evidence that 100% of women said they received one-to-one care in labour.
- Portable appliance testing or external company servicing of all equipment we looked at was found to be in date, meaning that the equipment was safe for use. We found that equipment was checked daily consistently to ensure that it was ready for use.
- The planned and actual staffing levels were displayed on all wards in the gynaecology and maternity units and were in accordance with national requirements. The midwife to birth ratio was 1:29 which is slightly higher than the national average of 1:28.
- At the Edgware Birth Centre, we saw there were arrangements in place to safeguard mothers and their babies from harm, patients' individual needs and preferences were considered when planning and delivering services, the maternity service was flexible and provided choice and continuity of care and the individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support people with particular needs.

However;

- Ante-natal record keeping was inconsistent and ongoing risk assessment in pregnancy was not recorded in patient records.
- The named midwife model was not in place and women told us they would prefer to have a named midwife responsible for their antenatal care.
- Birth pool areas at the Edgware Birth Centre were cramped and the arrangements for evacuating the pool in an emergency were not robust.

Incidents

- The governance structure was harmonised across both sites following the merger in July 2014.
- We met with the senior team who explained that prior to the merger, financial cutbacks, lack of administrative support and a poor governance structure had resulted in delays in the management of incidents and SIs. We were assured that the trust approach to incident management was now timely and enabled quick mitigation of the risks relating to the health, safety and welfare of service users.
- Staff told us that they were able to raise concerns and were confident that their concerns were listened to.
- Escalation of risk was identified through a computer based incident reporting system, Datix™. Incidents are flagged via Datix to clinicians and the executive team. This allows them to question the clinical teams and review the incident to gather all information. The nationally recognised Royal College of Obstetricians and Gynaecologists (RCOG) trigger tool was used for incident reporting. We were told that all incidents were reported according to the Serious Incident Framework (NHS, March 2015).
- There was a strong reporting culture in the maternity unit, however this was not the same for gynaecology. We saw that 1050 maternity and 103 gynaecology incidents were reported between October 2014 and November 2015, 16 of which related to Edgware Birth Centre. We witnessed maternity staff using Datix to report an incident during our visit.
- Six serious incidents were notified for maternity to the Serious Incident Review Panel (SIRP) and were reported to the Strategic Executive Information System (STEIS). We saw a sample of completed investigations, which were robust, contained action plans and demonstrated that lessons learned had been identified and duty of candour observed. There had not been any serious incidents or never events at Edgware Birth Centre.
- We saw that staff were informed of the learning from incidents by the lesson of the week that was displayed on noticeboards and discussed at handover. All midwives we spoke with could articulate the lesson of the week.
- We found that not all learning from incidents was embedded. For example in response to three never events on the Royal Free site, a new swab count form had been introduced across the trust. On reviewing

documentation we saw no evidence of swabs being checked and counter signed by two people and that the previous form was still in use. Also, we saw no evidence that the learning around swabs was shared at the Edgware Birth Centre.

- Staff told us about changes that had been made in response to lessons learned. A theme from SIs was the interpretation of cardiotocography (CTG) recordings of the fetal heart. For example, the trust was participating in the ongoing work of the North Central London Maternity and Newborn Network to introduce the International Federation of Gynaecology and Obstetrics (FIGO) consensus guidelines on intrapartum fetal monitoring that were published in October 2015. This was mitigated on the risk register. Biannual external CTG masterclasses were introduced to the trust and weekly CTG training was introduced at Barnet. We observed a weekly CTG review session during our visit. This was well structured, enthusiastically delivered, well attended and clearly identified issuein care delivery.
- Changes in practice were introduced following the recognition of an increased number of third and fourth degree tears (damage to the perineum involving the anus and anal sphincter). Midwives were supported in adopting a 'hands on' approach to delivery of the baby's head and Epi-scissors (specially adapted scissors that ensure episiotomy positioning is correct) were introduced to help staff perform episiotomy (a cut into the perineum to enable delivery of a baby) correctly. Doctors were supervised by the consultant when undertaking instrumental deliveries. An audit demonstrated that 80% of instrumental deliveries were supervised by a consultant. At Edgware Birth Centre, despite one such incident occurring there, we did not see information about lessons learned.
- We saw evidence that practice around antenatal screening had been changed in response to an SI. An ultrasound test called nuchal translucency measurement is a test for Down's syndrome undertaken between 11 weeks and 13 weeks and six days of pregnancy. We saw that it was the accepted practice for sonographers to refer for quadruple test (a later test for Down's syndrome) following one attempt at nuchal translucency measurement and not after two attempts as recommended by the Fetal Anomaly Screening Programme was changed. Learning from this was shared in the screening newsletter.
- We were told by managers that women and those close to them were involved in reviews they ensured that requirements under the duty of candour were met. Consultants offered parents the opportunity to meet to discuss events. We saw from a RCA that parents had been given a verbal apology and that a duty of candour letter had been sent offering them the opportunity to participate in the investigation.

Safety Thermometer

- The Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care.It is intended for public display so that the public are informed about the level of harm free care they can expect. The Maternity Safety Thermometer measures harm from perineal and / or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety.It also records babies with an Apgar score of less than seven at five minutes and/or those who are admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.
- The trust did not display all the metrics of the national maternity safety thermometer and at the Edgware Birth Centre, there was no information on display. This meant that the public could not readily see the harm specific to maternity care that they may expect to experience.
- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism.
- We saw a 'Patient Safety and Quality' information board for January 2016 on the labour ward that demonstrated there had been no reported cases of Clostridium difficile infection and Methicillin-resistant Staphylococcus aureus (MRSA) in the past 406 days; compliance with hand hygiene was 100% and 99% of women were satisfied with the care they received.

Maternity and gynaecology

Acuity Tool

- Acuity tools are used to measure and respond to capacity on the delivery suite and indicate to staff when the escalated policy should be used to ensure the safety of women and their babies. A matron told us the labour ward coordinator and manager on call cross site used an acuity tool contained within the escalation policy. Each week one of the matrons carried a bleep in order to manage the response required to changes in acuity and activity. In periods of increased activity, staff would be moved to delivery suite and community midwives called in to support as required.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were mostly visibly clean and well maintained. We saw light dust on a radiant heater in one of the delivery rooms. An external company was responsible for cleaning and we saw cleaning schedules on all wards. For example, we saw that the cleaning score for the maternity ward was 96% and labour ward was 98%. At the Edgware Birth Centre, we did not see evidence of cleaning schedules but we saw that the cleaning score for the centre was 99% in February 2016.
- We saw that equipment was labelled with tags to indicate when it had been cleaned. Sluice areas were clean and had appropriate disposal facilities, including for disposal of placentae.
- We observed compliance with the trust infection prevention and control policy. We saw that staff used hand gel, protective clothing and adhered to the bare below the elbow policy. However we noted an absence of hand gel on access to ward areas which meant that visitors were unable to clean their hands on entry to and exit from the wards.
- The Patient Safety and Quality board on labour ward demonstrated that there was 100% compliance with hand hygiene and the Patient Safety and Quality board on the maternity ward demonstrated that there was 95% compliance with hand hygiene in December 2015 in comparison to the trust target of 90%.

Environment and equipment

- An intercom and buzzer system was in use to gain entry to the labour ward and maternity wards and the Edgware Birth Centre. This meant that staff could identify visitors and ensure that women and their babies were kept safe.
- We found equipment was clean and fit for purpose. Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that it was safe for use.
- We found that resuscitation equipment was checked daily consistently to ensure equipment and supplies were complete and within date. This meant that equipment was ready for use.
- Maternity staff we spoke with knew the pool cleaning and evacuation procedures.
- The Edgware Birth Centre pool areas in the birth rooms were cramped. In an emergency, furniture would need to be moved to access birth pools which could cause delay in treatment, for example, the bed was obstructing the door to the pool area in one room which would make it difficult to get a trolley into the room.
- Maternity staff we spoke with knew the pool cleaning and evacuation procedures. Nets were available on the birth centre for pool evacuation in an emergency but these were kept in the office and not in the birth rooms.This meant that women were at risk of not receiving timely evacuation of the pool in an emergency.Furthermore, we were told by staff that security officers would be called at night time to assist with getting a woman out of the pool which would compromise her privacy and dignity. The team leader told us that there had not been an emergency with a woman in the pool in the past 10 years.
- We saw that the base of a double bed in one of the birth rooms was not washable and was in a poor state of repair.

Medicines

- Medicines were mostly safely and securely stored. We saw that the non-controlled drugs were not stored in the controlled drugs cupboard on the gynaecology ward. We were told that this was because EPAU may need access to medicines and they did not have a medicine cupboard.
- We saw that two ampules of sodium bicarbonate and adrenaline (medicines used in resuscitation) were stored in each resuscitaire (emergency neonatal

resuscitation equipment). We escalated this to the delivery suite matron who told us that pouches for safe storage had been ordered by pharmacy and were expected to be on site within a month.
- Records demonstrated that twice daily stock checks of controlled drugs were maintained and that these were correct.
- Temperatures of refrigerators used to store medicines were monitored daily to ensure that medicines were stored correctly and that women and babies were not at risk of the administration of ineffective medicines.
- The temperature of the treatment room on the gynaecology ward was being monitored and had reached 28.6°c on February 1st 2016. This meant that medicines were not stored at the correct temperature and there was a risk that patients could be administered ineffective medicines. The door to the treatment room was wedged open to cool the room down. We saw that whilst all medicines were locked away, syringes and needles were stored in unlocked cupboards. The ward sister told us that pharmacy and the trust were aware of the situation and that the room needed air conditioning. This was not on the risk register.
- Additionally, at the Edgware Birth Centre, we found the drug fridges were not locked and were stored in the office which was also unlocked.

Records

- We saw that patient records were stored securely on the gynaecology and maternity wards.

Maternity records

- We reviewed five sets of maternity records. We saw that initial risk assessments were not consistently carried out and not revisited in the antenatal period. Record keeping around CTG was poor: there was no maternal pulse recorded at the start of a CTG trace and no second signature to confirm fresh eyes reviews. We noted that the fresh eyes stickers were different to those used on the Royal Free Hampstead site and did not have a space in which to enter the second signature.
- On the maternity unit we saw individual maternity records being reviewed as part of the women's care and the personal child health record (red books) were introduced for each new born. Red books are used nationally to track a baby's growth, vaccinations and development.

Gynaecology records

- We reviewed five sets of records and saw that appropriate assessment, planning and evaluation was taking place.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and national and local policy.
- Staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process.
- We were told by senior staff that all midwives and maternity care assistants had access to level 3 safeguarding children training in line with the intercollegiate document (2015). Updates at level three were provided annually at the mandatory clinical skills update week. Safeguarding training compliance at level three was recorded at 95% which was the same as the trust target.
- There was a child and baby abduction policy in place to ensure the safety of babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984.
- Information regarding women with safeguarding concerns were kept on an electronic folder on the computer system. A flag showed on the maternity service information system for any woman identified with a safeguarding concern to alert staff to the concern.
- Triage of referrals to the maternity service was tasked to administrative staff without clinical input. This meant that that vulnerable and high risk women were not being identified in a timely manner and receiving the appropriate level of care.
- We saw that prompt referral had been made to social services by a registrar, which was an example of excellent practice.
- Staff were aware of the female genital mutilation (FGM) policy and their responsibility to report suspected or possible FGM. Training was ongoing to safeguard people at risk of, and treat those affected by, FGM. The trust has

provided evidence that 74% of staff had been trained compared to the trust target of 85% compliance to be achieved in line with the Training Needs Analysis by 31 March 2016.

- Staff told us that women who have been trafficked from Eastern Europe and asylum seekers are treated at the hospital. They liaise with the local Salvation Army in relation to the care of some of these women.
- We were told of and saw evidence of systems in place to monitor the disclosure of Domestic Abuse by midwifery staff in line with NICE guideline [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded.
- There was a Did Not Attend (DNA) policy that the trust adhered to. This meant that staff were aware of women who had missed appointments and could arrange follow up to ensure that women attended for care and safeguarding concerns were raised when they did not do so.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). When asked, community midwives told us they did not receive safeguarding supervision. We spoke with senior staff about the provision of safeguarding supervision and were told that the trust did not provide this for all staff working in maternity services. The trust commented that the lead midwife for safeguarding received safeguarding supervision from the trust lead for safeguarding and external approved institution, the lead midwife for safeguarding provided safeguarding supervision for the midwives in the vulnerable women's teams and maternity staff had the opportunity to attend group supervision facilitated by the lead midwife for safeguarding. Safeguarding supervision was reported quarterly to the trust integrated safeguarding committee.

Mandatory training

- Trust mandatory training covered subjects including adverse incident reporting, conflict resolution, equality and diversity, fire prevention, infection control, learning disability awareness, load handling, and positive mental health. We saw that 50% of the gynaecology nurses and 93% of midwives had completed mandatory training compared to the trust target of 95%.
- Specific maternity mandatory training took place over a week and covered subjects including: maternal and neonatal resuscitation, electronic fetal monitoring, and management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Staff told us that the content of the maternity specific study days were changed annually to reflect incidents that had taken place. For example training sessions on controlled delivery in the second stage were introduced in response to the high numbers of third and fourth degree perineal tears. We saw that 94% of staff had completed this training by December 2015 which exceeded the trust expectation of 85% by April 2016.
- Multidisciplinary 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breech presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse.
- The CTG (cardiotocograph) machine was used by midwives on the labour ward to measure contractions and baby's heart rate over a period of time. We saw that staff were required to undertake an online CTG learning package training annually and that 96% of midwives and 94% of medical staff had completed the training.

Assessing and responding to patient risk

- For women using maternity services the booking visit took place before 12 weeks of pregnancy and included a detailed risk assessment. An initial maternity booking and referral form was completed by community midwives at the booking visit. In December 2015 81% of women were seen by a midwife by the completed 12th weeks of pregnancy. We saw that on-going risk assessment was not documented at subsequent antenatal visits which meant that we were not assured that referral to the obstetric team would be made if risk factors were detected.
- Women who had problems in pregnancy were reviewed on the MDU. From here they could be admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.

- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour.
- The Fetal growth assessment protocol (GAP) charts were introduced in the Barnet Hospital Maternity unit in 2014. It was identified that there was a lack of a systematic programme in place to adopt this new initiative and ensure all staff had been trained in the new way of measuring the fundal height as required by the protocol, in order to detect issues of intrauterine growth restriction or tailing off fetal growth. This was on the risk register.
- A compliance audit undertaken on the BH site undertaken in June 2015 showed that 84% of women had growth plotted on the customized chart and that 77% of growth was plotted correctly. All midwifery and obstetric staff received training in the protocol. Following this we saw that Barnet Hospital had a detection rate of 28% of growth retarded babies compared the national average of 33%.
- We saw that in the records we reviewed customised fetal growth charts were in use and completed to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy. However, women expressed concern that they would have preferred to see the same midwife throughout her pregnancy as 'all measure your tummy slightly differently'.
- We saw from notes we reviewed that women were offered vaccinations against influenza and whooping cough. We also saw notices on the maternity unit advising people who may have travelled to South America to seek advice about the Zika virus.
- Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman. We observed appropriate use and scoring of the MEOWS to identify deteriorating women.
- We saw evidence of a guideline for management of sepsis in the obstetric patient which helped staff identify women at risk of sepsis and initiate required treatment.
- Women requiring management of complications were cared for in one of two close observation rooms on labour ward. Care was provided by a midwife trained in high dependency care. MEOWS triggers were acted upon and support from the critical outreach team provided. Any woman who needed additional support and care was transferred to the intensive therapy unit (ITU).
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organisation's (WHO) Five Steps to Safer Surgery' guidelines. We saw documentary evidence that all the stages were completed correctly and that checklists showed that this was usual practice.
- NHS Safety Alert 1229: Reducing the risk of retained swabs after vaginal birth and perineal suturing states that swabs should be counted whenever they are used. The trust had three never events concerning swab counting. The weekly spot check of the completion of World Health Organisation (WHO) Surgical checklist for maternity demonstrated 100% compliance for December 2015. Compliance with swab counting was 99% after delivery of the baby and 100% after a woman had perineal sutures. This meant that women were protected from the risk of a retained swab.
- Senior midwives provided CTG review known as 'fresh eyes'. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that is it was within normal parameters. We were told that this had been introduced in the past year and had not yet been audited.
- Midwifery hand over took place at the change of each shift. Handover included a review of all women on the wards and allocation of work.
- Formal multi-disciplinary handovers were carried out four times during each day on the labour ward attended by medical staff and the labour ward coordinator. We observed the 8.30am handover which was structured and included discussion on all maternity and gynaecology inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to the appropriate doctor.
- At the Edgware Birth Centre, we saw no evidence of risk assessment for the birth pools. Also, with regard to NHS Safety Alert 1229, the trust had three never events concerning swab counting. We did not see evidence of compliance with swab counting for the birth centre.

Maternity and gynaecology

Midwifery staffing

- Birthrate Plus® is a midwifery workforce planning tool which demonstrates required versus actual staffing need to provide services. Birthrate Plus® is recommended by the Department of Health; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.
- The trust was in the process of conducting a reconfiguration of the maternity service and management told us they planned to conduct a Birthrate Plus® assessment once this was completed.
- At the Edgware Birth Centre, there were core staff who managed the centre supported by the on call community midwives who were called in when a woman was in labour.
- We saw evidence that the midwife to birth ratio was 1:29 which is just above the national target of 1:28.
- Midwives worked a mixture of 8 and 12 hour shifts. We saw that the band 7 labour ward coordinator was supernumerary. Labour ward coordinators were responsible for the management of the activity on the ward and required constant oversight of the ward so that decisions can be made regarding care and treatment and flow of patients
- The planned and actual staffing levels were displayed at the entrance to each maternity ward. The labour ward required nine midwives and two maternity support workers (MSWs) on each shift. We saw that required and actual staffing was met on this ward during our inspection.
- Staffing requirements for the maternity ward was seven midwives and three MSWs on the day shift and six midwives and three MSWs on the night shift. We saw that required and actual staffing was met on this ward during our inspection.
- Staffing requirements for the birth centre was two midwives and one support worker. We saw that required and actual staffing was met on triage during our inspection. Community midwives were on call and attended the centre to support women in labour. There were core staff who managed the centre, supported by the on call community midwives who were called in when a woman was in labour. We saw that the Edgware birth centre establishment was 2.6 whole time equivalent (WTE) midwives. This comprised of three band seven midwives and one band six midwife who were supported by two maternity support workers(MSW) and a MSW who rotated to the unit from the birth centre at Barnet Hospital. Staff we spoke with told us that the trust was reducing the establishment by one WTE.
- We were told by the matron that the reason for having three band seven midwives was to enable one of them to work on marketing the birth centre by engagement with local General Practitioners (GPs).
- The planned and actual staffing levels were not displayed on the birth centre. Staff told us that planned staffing was two midwives and one support worker over a 12 hour shift.
- Staffing requirements for triage was one midwife and one support worker. We saw that required and actual staffing was met on triage during our inspection.
- Staffing requirements for the MDU was one midwife for the early shift, one for a 12 hour shift and one on a twilight shift and one support worker.
- We were told and saw documentary evidence that the vacancy rate was 6 WTE; the sickness rate was 4% WTE and maternity leave rate was 6%WTE.
- The maternity unit used agency staff and had its own bank of temporary staff which was made up of permanent staff who undertook extra work to cover shortfalls. Bank midwives undertook the same mandatory training as substantive staff. However, the trust relied on agencies to provide training for agency midwives. We saw that agency staff were required to report to the labour ward coordinator who had access to a register of agency staff. If problems were identified with agency midwives, staff told us they would escalate their concerns to the matron or supervisor of midwives on call.
- We were told that the trust had a direct employment scheme which mean that they were able to retain student midwives on qualification.
- Birthrate Plus® recommendation is that community midwives have caseloads of 1:96. The trust was using a team model and therefore could not provide individual caseload numbers. Community midwives could be called into the hospital as part of the staffing escalation policy and were expected to work on delivery suite. They told us that this happened occasionally and that

when they were called in they typically stayed for the whole of a shift. This could impact upon their workload the next day and meant that visits and appointments were rescheduled.
- There were three community midwives on call to support both the Barnet and Edgware birth centres in the day time and four at night.
- Maternity support workers provided support to midwives and undertook delegated duties such as breast feeding support, weighing babies and taking the newborn blood spot sample.
- There was only one midwifery support worker to support five teams of community midwives. Staff expressed the need for more such support.
- There was a lone worker policy which community midwives adhered to.

Nursing staffing

- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients. The early shift required four registered nurses and three support workers and the night shift required three registered nurses and one support worker. We saw a safe staffing board that demonstrated planned staffing met actual staff ratios for each shift.
- The patients we spoke with on the gynaecology ward expressed dissatisfaction with the level of staffing at night time. One patient told us it took 30 minutes for her call bell to be answered. Another told us it took a long time for staff to respond to requests for example, one patient waited three hours for pain relief the night before our visit. One relative told us that the care in the day was 'fantastic' but the care at night time was 'diabolical'.
- We asked the trust for information on the staffing of Willow ward. We saw documentary evidence that it was agreed to reduce the support workers on night duty from two to one. This was because the second person was taken most nights to staff other areas. We were told this has been monitored and that no adverse impacts on patient care have been reported and the staff agreed it was working well. We saw that the sister and matron worked on the ward when short of staff on day shifts and that shortness on night shifts was escalated to the site team and covered by agency staff.
- Many of the outliers placed on the ward were orthopaedic patients who required more hands on nursing care because they were not as ambulant as gynaecology patients. Staff told us that the staffing establishment was based upon the needs of gynaecology patients and not on the heavier workload of orthopaedic patients; they felt that this contributed to the ward feeling short staffed.
- The combined early pregnancy assessment unit (EPAU) and Emergency Gynaecology Unit (EGU) required two nurses and one care assistant for each shift. We saw that the actual staffing on duty met this.
- Specialist gynaecology nurses worked in outpatient clinics to provide colposcopy services.

Medical staffing

- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations.
- The trust employed 90 WTE medical staff in the maternity and gynaecology services. The level of consultant cover was 33% which is similar to the national average of 35%. The percentage of registrars 60% which is greater than the national average of 50%. The percentage of middle grade doctors was 1% which is fewer than the national average of 8%. There were 6% junior grade doctors which is similar to the national average of 7%.
- There were 98 hours of consultant cover per week on the labour. At the time of the inspection a consultant was present on the labour ward daily from 8am until 11pm Monday to Friday, and from 8.00am until 7.30 pm on Saturdays and Sundays. Out of hours cover was provided by the consultant on call and two consultants covered wesekend. A second consultant attended labour ward for elective caesarean sections.
- Dedicated registrar and senior house officers were on labour ward from 8am to 5.30 pm.
- A consultant anaesthetist provided cover for labour ward between 9.00am and 5.00pm weekdays. Out of hours cover was provided by the on-call consultant.
- We saw that Deanery senior house officer posts were not filled. The trust employed locum staff to meet this shortfall. However, we were told it was difficult to source sufficient staff. Staff told us that there were unfilled shifts at registrar level. At the time of the inspection the

trust was in the process of actively recruiting to senior house officer and had recruited to the registrar level posts. There was a cross over between those working notice and those starting.

- The gynaecology service was covered by a registrar and a senior house officer. Consultant cover was provided by the 'hot week' consultant, who also covered the Maternity Day Unit. The consultant on call at weekends covered both maternity and gynaecology.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) by consultants and/or middle grade staff.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents and fire safety incidents.

Are maternity and gynaecology services effective?

Good

Overall we rated the effectiveness of the service as Good because;

Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care. However, some of these guidelines were out of date. The trust was in the process of harmonising maternity and gynaecology guidelines across the two sites. At the time of our visit 50 out of 125 guidelines had been harmonised.

Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care.

Women we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24-hour period.

Staff were competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working in the maternity service. Staff worked collaboratively to serve the interests of women across hospital and community settings.

Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.

Evidence-based care and treatment: Maternity

- Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and procedures via the trust intranet. Hard copies were also available in ward areas.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- One to one care in labour was audited one week a month which demonstrated 100% compliance. A questionnaire was used to survey postnatal women. Outcomes were presented at directorate governance days and were sent to the Clinical Commissioning Group (CCG). Women told us that they were not left alone in labour.
- We found from our discussions and from observations that care was mostly being provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- The booking appointment is the first appointment with a midwife when medical, obstetric and social histories are recorded, risk assessments carried out, options discussed and plans made for pregnancy. We found that the trust was carrying out group bookings. Women were not booked under a named midwife and those we spoke with they reported lack of continuity of carer: 'I didn't see the same midwife twice throughout pregnancy'.
- We saw from the risk register that there had been five identified near miss safeguarding incidents due to the group booking system since August 2015. We saw that the community integration action plan included changing to individual bookings with a midwife to ensure assurance of a systematic identification and risk

assessment of vulnerable women at the time of booking. However, at the time of our visit this risk remained because group booking were still taking place.

- Triage of referrals was tasked to administrative staff without clinical input. This meant that that vulnerable and high risk woman were not being identified in a timely manner and receiving the appropriate level of care.
- The trust offered screening in line with the National Screening Committee (NSC) recommendations. Patients were supported to make decisions around screening and were provided with the NSC leaflet at booking. We saw documentary evidence to show that the 10 week KPI for haemoglobinopathy screening was 52% and the uptake for Down's screening was 73%.
- Following the merger, a gap analysis of antenatal and newborn (ANNB) screening programmes was undertaken in January 2015 which identified a significant risk within the ANNB screening programmes on the Barnet site. Gaps were identified under 3 themes. The unit was unable to track their maternity cohort to provide a fail safe for antenatal, screening incidents were under reported and there was a lack of current guidelines in place for any of the antenatal or newborn screening programmes. Following the identification of these problems, the issues were presented to the Women's and Children's divisional board and added to Trust risk register.
- The Director of Midwifery invited the London Screening Quality Assurance Services (SQAS) to review the screening service. A Quality Assurance Workshop was held on the 26th February 2015 and recommendations made. The trust met with the SQAS in December 2015 who noted 'Overall, the Trust's ANNB screening programmes are well managed and there is visible senior oversight, with clear lines of responsibility and accountability. The cross site ANNB Clinical Lead provides the necessary senior leadership and specialist oversight of all ANNB screening programmes across the three maternity sites. Governance across the screening pathways is evidenced by clear and up to date guidelines that demonstrate accountability. Screening pathways have been aligned safely whilst taking into account local variations'.
- We found evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, and care of the new born baby. We saw that a decision tool was used for midwives to discuss birth options on the Barnet and Edgware Birth Centre sites. This was based upon the outcomes of a major study into the safety of home, birth centre and hospital birth.
- There was a default pathway for all low risk women to birth on the birth centre and birth centre midwives provided advice to these women. Women due to have their babies on labour ward were assessed on triage and admitted to the labour ward.
- The fetal monitoring guideline was not compatible with NICE (2014) recommendations for categorising fetal heart rate monitoring during labour and the trust was still using the 2007 NICE guidance. The trust had mitigated against this by clearly stating in the guideline that this was the case and that they were working with the North Central London Maternity and Newborn Network to introduce the International Federation of Gynaecology and Obstetrics (FIGO) consensus guidelines on intrapartum fetal monitoring which were published in October 2015.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 132.
- The caesarean section rate for April to September 2015 was 30.2%%, which is higher than the national average of 25%. The trust's trigger on the dashboard was 26%. We saw that the rate had risen to 32% in October 2015 and that it had dropped to 24% by December 2015.
- We asked about the drop in the caesarean section rate and they told us that the new consultant obstetric lead for labour ward had been a key influence in getting 'buy in' to reduce the rates. The key strategy introduced was that women's concerns were addressed individually, for example all first time mothers requesting elective caesarean section were seen in the VBAC clinic to enable time for a full discussion of the risks and benefits of the procedure. Case reviews took place of all emergency caesarean sections and were undertaken along with CTG review to identify lessons learned. The consultant told us that the next step towards addressing the caesarean section rate was to look at induction of labour in first time mothers by all such cases being discussed with the consultant.

- We saw that there was a VBAC clinic held by the consultant midwife who utilised a pathway aimed at reducing the caesarean section rate.
- We saw that an enhanced recovery programme was used for women who had elective caesarean sections which meant that women were prepared and underwent early transfer home. This practice had been rolled out at the Royal Free Hospital following merger.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect of postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Evidence-based care and treatment: Gynaecology

- Minor gynaecological surgery was undertaken on a day case basis. The expectation was that the woman went home on the day of the procedure.
- We asked about the care of people under the age of 16. A safe contact number was provided to younger patients and they were required to bring someone over the age of 18 with them when they attended for treatment. All people under 16 are referred to the safeguarding team. Children under the age of 14 are referred to the paediatricians.

Audit

- The trust provided us with the clinical audit plan for 2015/16 which showed two site specific and 20 cross site obstetric audits and 10 cross site gynaecology audits listed. Audits were presented and discussed at the Clinical Governance and Audit meeting which was open to all staff. We saw that data was analysed and that recommendations and action plans were made as a result of audits.
- The trust actively participated in national audits including the National Screening Committee Antenatal and Newborn Screening audit, the National Diabetes in Pregnancy Audit and Mothers and the national report for perinatal mortality for births: Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE).
- Examples of obstetric audit included induction of labour, postpartum haemorrhage pain relief in labour, instrumental deliveries, VTE and record keeping.
- Examples of gynaecology audits included colposcopy patient survey, postoperative complications of surgery, medical management of miscarriage and MVA.
- The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report made 44 recommendations for the trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon.
- We saw documentary evidence that the supervisors of midwives team had monitored its performance against the recommendations of the report for supervision of midwives using the Local Supervising Authority (LSA) benchmark tool and assessed that it was compliant with all recommendations. We did not see documentary evidence that the trust had carried benchmarked against the recommendations related to trusts. However, senior managers told us the 'maternity integrated action plan', which we saw, was based on the recommendations of the Morecambe Bay report. The action plan fed into board assurance that the trust complied with the recommendations.

Pain relief

- Women we spoke with in maternity and gynaecology felt that their pain and administration of pain relieving medicines had been well managed.
- On the labour ward (and at the Edgware Birth Centre) we saw a variety of pain relief methods available including Tens machines and Entonox, a ready to use medical gas mixture of 50% nitrous oxide and 50% oxygen that provides short term pain relief. Epidurals were available 24 hour a day although women at the Edgware Birth Centre requiring an epidural were transferred to the labour ward at Barnet Hospital.

- A birth pool was available in three rooms on the birth centre and one room on the labour ward so women could use water immersion for pain relief in labour.

Nutrition and hydration

- The Infant Feeding midwife was responsible for the oversight of infant feeding. The trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby.
- Barnet Hospital had been awarded UNICEF Baby Friendly Initiative stage one accreditation and was preparing for trust wide stage three validation in March 2016. This meant that the trust supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- Women told us that they received support to feed their babies. We saw that the initiation of breastfeeding rate was 86% for Barnet Hospital and 94.5% across site in 2015 which was better than the national average of 75%.

Patient outcomes: Maternity

- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The Maternity Dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.
- The trust was using a dashboard that had been developed by the North Central London Maternity and Newborn Network. This enabled comparative data to be used across the trust and across the maternity units in North Central London.
- Information on the dashboard from April to November 2015 demonstrated that:
- The induction rate was 25.2% which was below the trust target of 25.8% and the above national target of 22%.
- The caesarean section rate was 30%, worse than the national average of 25%. However, the caesarean section rate had reduced from 32% in October 2015 to 24% by December 2015 following the appointment of new obstetric labour ward lead.
- The elective caesarean section rate was 13% compared the national average 11%
- Emergency caesarean rate was 18% compared to the national average of 15%.
- The instrumental delivery rate was 14%. The differentiation between Ventouse and forceps delivery was not recorded. The national average for Ventouse delivery is 7% and the national average for forceps delivery is 6%.
- The third or fourth degree tear rate was 4% for all patients.
- The trust recorded postpartum haemorrhage above1.5 litres on the dashboard and there were 74 such haemorrhages which equated to 3% of patients.
- For the Edgware Birth Centre, outcomes were not recorded on the dashboard. We asked for data such as transfer rate was were told that this is collected with the birth centre at Barnet Hospital.
- Data provided by the trust for Barnet hospital, which included the Edgware Birth Centre demonstrated that:
- The normal delivery rate was 54% in 2015, which is below the RCOG recommendation of 60%.
- The transfer rate from the birth centre to labour ward was 27%.
- The homebirth rate was 1.7% which was lower than the national average of 2.3%.
- The third or fourth degree tear rate was 4% for all patients.
- The trust recorded postpartum haemorrhage above1.5 litres on the dashboard and there were 74 such haemorrhages which equated to 3% of patients.
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) audit stillbirths in the UK. The latest report (December 2015) demonstrated that the stillbirth rate was 3.6 per 100 births across the trust, which is more than 10% lower than the average for similar sized trusts.
- We saw documentary evidence that 439 term babies were admitted to the Neonatal Unit across site.
- The latest CQC Intelligent Monitoring report (May 2015) found no maternity outliers for this trust.
- Two standards of the National Neonatal Audit Programme 2013 relate to maternity care. The

percentage of babies below 29 weeks gestation that had their temperature taken within an hour after birth was 90% compared to a target of 98 – 100%. The percentage of mothers who received a dose of antenatal steroids was 91% compared to a target of 85%.

Patient outcomes: Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the gynaecology outpatients during the week. A team of professional staff supported patients in investigative procedures, giving advice as necessary. Emergency scans and assessments were available out of hours. We were told that there was a gynaecology operation scheduled on most days.

Competent staff

Maternity

- Maternity specific mandatory training and other learning and development was managed by the consultant midwife. We saw that 92% of midwifery staff and 84% of medical staff had completed mandatory PROMPT (Practical Obstetric Multi-professional Training) training.
- An induction period of two weeks orientation was offered to newly appointed staff. In addition, all newly qualified midwives undertook a nine month preceptorship period prior to obtaining a band 6 position. This meant that they were competent in cannulation and perineal suturing and had gained experience in all areas of the maternity service.
- Appraisal rates for staff were provided for us and these demonstrated that 95% of midwives had been appraised. The consultant appraisal rate was 80%.
- Staff told us that opportunities for professional development had improved since the merger with the Royal Free London NHS Foundation Trust. However, they found it difficult to access mentorship training which meant that student midwives were not mentored by appropriately trained staff.
- We were told that 40% of midwives were qualified in newborn and infant physical examination (NIPE). This meant that babies received timely examination after birth and that women were discharged home without undue wait for a paediatric review.
- Midwives rotated throughout the service which meant that they were competent to work in all areas in times of escalation.
- At the Edgware Birth Centre, staff we spoke with told us that they had training for emergency evacuation of the birth pool but could not tell us when a live drill had been held to practice emergency evacuation of the pool.
- Midwives may delegate tasks to MSWs but an MSW must report findings to the midwife who decides on the management plan, which may include referral. We found that MSWs were working outside of their scope of practice. For example, we were told that a MSW would refer a baby to a paediatrician for review if the baby had lost weight. We raised this with the matron who spoke with the MSW to confirm her responsibilities.
- In response to this situation, staff showed us the Infant Feeding policy which was dated 2009. The trust subsequently commented that an updated policy was available on the intranet, dated December 2014.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The NMC sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:15 which confirmed that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.
- Junior doctors reported very positive feedback on training and the support they received from the obstetrics and gynaecology consultant team.

Multidisciplinary working

- A multidisciplinary handover took place twice a day on the labour ward. The handover used an SBAR (Situation-Background-Assessment-Recommendation) handover sheet and included an overview of all

maternity and gynaecology patients. We observed that the 08.00 hours handover on labour ward was concise and efficient. The Band 7 Labour Ward coordinator attended but did not participate in this handover.

- We saw evidence of good interaction between all team members on duty on labour ward on the day of our visit.
- Communication with community maternity teams was efficient. In the community we were told of effective multidisciplinary team work between community midwives, health visitors, GPs and social services.
- The gynaecology ward informed community midwives and GPs when a woman had suffered a pregnancy loss. They informed the obstetric office so that ongoing appointments could be cancelled.
- We were told of multidisciplinary links with external trusts. For example, the trust was a member of the North Central London Maternity and Newborn Clinical Network which enabled the trust to develop shared polices to ensure consistency of quality across the region.

Seven-day services

- Access to medical support was available seven days a week.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

- Trust intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides, policies and procedures to assist in their specific role. Harmonisation of all policies and guidelines was ongoing and staff could readily see the status of individual guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that the procedure of consent was reviewed prior to surgical procedures which was good practice.
- We spoke with staff who were able to articulate how the Mental Capacity Act and Deprivation of Liberty Safeguards were applied in practice.

Are maternity and gynaecology services caring?

Good

We rated caring as Good because;

- We observed that women were treated with kindness, dignity and respect by nurses, midwives and medical staff.
- Feedback from patients and those close to them was positive. Patients told us that they felt safe. Staff treated patients with dignity, respect and kindness during all interactions and patient-staff relationships were mostly positive.
- Patients were involved and encouraged to be partners in their care and were supported in making decisions. Both maternity and gynaecological patients told us that they felt well informed, understood their care and treatment and were able to ask staff if they were not sure about something.
- Midwifery responded compassionately when patients needed help and supported them and their babies to meet their personal needs. Staff helped patients and those close to them to cope emotionally with their care and treatment.
- Patient's spoke highly of the nursing staff on the gynaecology ward and told us care had been 'really good'.

Compassionate care

- Maternity services were added to the Friends and Family Test (FFT) in October 2013. In December 2015 a high percentage of patients recommended the antenatal services, postnatal ward and birth services. The scores were similar to the England average:
- 91% of women would recommend the antenatal service.
- 95% of women would recommend the labour ward.
- 88% of women would recommend the postnatal.
- 93% of women would recommend the postnatal community service.
- The CQC maternity survey of December 2015 surveyed women who gave birth in February 2015. A total of 23 women, a response rate of 41%, returned a completed questionnaire. It showed that most outcomes were similar to the national average. The trust scored better than other trusts' in two areas:

Maternity and gynaecology

- Women were given a choice about where antenatal check-ups would take place.
- Decisions about how women wanted to feed their babies respected by midwives.
- The trust had significantly worse scores compared to most other NHS trusts in England for four areas:
- Women were not able to move around and choose the position that made them most comfortable during labour.
- Women were not spoken to in a way they could understand when receiving care during labour and birth.
- Women were not able to get a member of staff to help them within a reasonable time if they needed attention while in hospital after the birth.
- Provision of help or advice from a midwife or health visitor in the 6 weeks after the birth.
- Patients told us that the staff were kind, compassionate, respectful and treated them with dignity and that they felt 'nurtured'. One woman told us 'it's been five star treatment'.
- We saw that thank you cards were displayed in ward areas; an indication of appreciation from women and those close to them.
- The trust had significantly worse scores compared to most other NHS trusts in England for four areas:
- 1. Women were not able to move around and choose the position that made them most comfortable during labour
- 2. Women were not spoken to in a way they could understand when receiving care during labour and birth.
- 3. Women were not able to get a member of staff to help them within a reasonable time if they needed attention while in hospital after the birth.
- 4. Provision of help or advice from a midwife or health visitor in the 6 weeks after the birth.
- We saw comments on feedback cards that demonstrated patient's appreciation of the birth centre:' Thorough care, the sense of being listened to and treated as an individual with gentleness and respect'.
- We saw that thank you cards were displayed in ward areas; an indication of appreciation from women and those close to them.

Understanding and involvement of patients and those close to them

- Women told us that they felt included in their care and felt supported to make informed decisions.
- Partners of maternity patients described feeling involved in the care provided.

Emotional support

- Bereavement support was offered a specialist midwife. Memory boxes were provided to parents who had suffered a pregnancy loss. Chaplaincy support was available with access to all religions.
- Patients told us that food was available outside of set meal times if they did not feel like eating or were unable to eat at set meal times.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Patients' individual needs and preferences were mostly considered when planning and delivering services.
- The maternity service was flexible and provided choice and continuity of care; the birth centre was embedded in the low risk pathway for women with straightforward pregnancies.
- The trust offered an ambulatory induction of labour on the Barnet site.
- The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible.
- There were arrangements in place to support people with particular needs.
- Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

However,

- Staff told us that delays in medical review on MDU impacted on timely management and treatment for maternity patients.
- Women could be diverted between sites in times of increased activity.
- The gynaecology ward had outliers (patients who are not being nursed in a specialist area for their particular condition) that impacted on the care provided to women with gynaecological conditions.

- There were high DNA rates for follow up following colposcopy across the trust. This was on the risk register and the trust had an action plan in place.

Service planning and delivery to meet the needs of local people

- Women could access the maternity services via their GP or by contacting the community midwives directly.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.

Access and flow:

Maternity

- The maternity unit had not closed between January 2014 and June 2015.
- Edgware Birth Centre had been closed between January 2014 and June 2015. The impact of closure of the birth centre was that women did not get their choice of place of birth.
- The birth centre was open in the day but closed at nighttime. If a woman went into labour outside of opening hours, the on call community midwives would open the unit and provide care to the woman and her partner.
- Women could access the maternity service via their GP or by direct referral. NICE guidance recommends that women are seen by 10 weeks of pregnancy so that the early screening for Downs Syndrome, which must be completed by the 13 weeks and six days of pregnancy, can be arranged in a timely manner. We saw that 81% of women were seen by a midwife by 12 weeks of pregnancy in September 2015.
- We were told about and saw written documentation which confirmed women were supported to make a choice about the place of birth.
- The MDU had six chairs and provided an assessment service to women over **16** weeks of pregnancy between 8am and 11pm Monday to Friday, 8am and 3pm on Saturdays and 8am and **4**pm on Sundays. Women could be referred to the MDU by community midwives, GPs, or they could self-refer. Up to 50 women per day were seen on MDU. Day care was available for women with concerns such as hyperemesis (excessive sickness in pregnancy) and reduced fetal movements. Outpatient induction of labour was also managed on the MDU. The MDU was staffed by two midwives and a support worker. Medical cover was provided by an obstetric registrar between 8 am and 5pm and by the gynaecology registrar after 5pm from the on call team Staff told us that delay in medical review impacted on timely management and treatment for patients. Women were seen on the triage unit out of hours.
- Women for induction who were considered low risk were given the Propess pessary used to induce labour on MDU and were then sent home to return twenty four hours later for assessment and onward treatment. These women were then contacted by a midwife 12 hours after Propess insertion to ascertain their well-being. Such women could birth on the birth centre.
- One woman and her partner told us that they experienced delays in the induction of labour process because there was a lack of available beds.
- There was a dedicated two bed triage unit where women with urgent complaints could be reviewed and assessed. Women were provided with the telephone number for triage and a senior midwife was always on duty in triage to provide advice.
- A birth centre with five birth rooms and three postnatal rooms was located on the first floor. Three of the rooms had a pool for women to use for pain relief in labour and for birth. We saw that the birth rooms offered specialist equipment such as beans bags and birthing balls to promote the comfort of women in labour.
- The labour ward had 13 delivery rooms, two close observation beds, two obstetric theatres and four recovery beds.
- Consultant-led elective caesarean section lists ran in the main theatres three days a week 8am to 5pm and there were typically 5 operations on each list.
- We were told that women could be diverted between sites in times of increased activity. We saw that four women had been transferred to the Royal Free Hospital in 2015, three for induction of labour and one for augmentation (speeding up) of labour.
- We saw that group talks were provided for women going home from the postnatal ward. This meant that beds were vacated efficiently preventing a back log of women waiting for beds on labour ward.

- We noted that quarterly bed occupancy was 63.2% between June and September2015. This was similar the England average of between 62%. This indicated that women were having similar length of stays in hospital in comparison to the other trusts.
- we saw that community midwives ran clinics at the Edgware Birth Centre which meant that women could access care in their locality.

Access and flow: Gynaecology

- Gynaecology patients were cared for on a female mixed surgical and gynaecology ward.
- The gynaecology ward had outliers (patients who are not being nursed in a specialist area for their particular condition) that impacted on the care provided to women with gynaecological conditions because beds were occupied with patients with medical conditions. Gynaecology patients were admitted to another ward if gynaecology was full. Staff told us that this meant women were nursed by staff without gynaecological experience that would not be competent in conditions such as bleeding.
- We saw that there two outliers on the ward during our visit. Staff told us that this increased during winter pressure and could affect care provided to women with gynaecological conditions.
- We spoke with one patient who had waited for 10 hours in Accident and Emergency before admission to the gynaecology ward.
- A combined early pregnancy assessment unit (EPAU) and Emergency Gynaecology Unit (EGU) offered appointments between 8am and 6pm Monday to Saturday, and alternate Sundays.
- The EPAU service offered care on both the Royal Free and Barnet sites on alternate Sundays which meant that the EPAU service ran seven days per week. Referrals for investigation and treatment into bleeding in early pregnancy were accepted from midwives, GPs and the emergency department. There was access to scans between 9am and 5pm in the unit and medical opinion was accessible from the on call registrar.
- We saw that the numbers of patients that required admission and were admitted within 18 weeks ranged between 91% and 99% from May to December 2015. A total of 19 breaches of the 18 week RTT occurred.
- Consultant led hysteroscopy was offered on an outpatient basis. There was a nurse led colposcopy clinic.
- We were told that there were high DNA rates for follow up following colposcopy across the trust. This was on the risk register and the trust had an action plan in place. It was identified that education was an important factor in follow up but women chose not to attend despite this.

Meeting people's individual needs

- We saw that the antenatal clinic was crowded and did not provide toys or books for young children accompanying patients. A quiet room had been recently created offering space for breaking bad news.
- The consultant midwife held a Birth Choices Clinic for women requesting home birth outside of accepted guidelines or if they were tocophobic (fear of childbirth). Risks were assessed and a birth plan was made in discussion with the woman to support her choices.
- A place of birth workshop was offered to all women which was embedded at Barnet Hospital. This will be rolled out across the trust as part of the community integration plan.
- The trust ran a multidisciplinary diabetic clinic to support women with pre-existing diabetes or those who developed gestational diabetes throughout pregnancy.
- Specialist midwives for diabetes, screening and fetal medicine, safeguarding who, having successfully completed additional training, gave advice and support to women and midwives.
- There was a specialist midwifery team, the Acacia Team, for vulnerable women. The team provided antenatal care for women and were anticipating expanding this to intrapartum and postnatal care as part of the community integration plan. A specialist consultant for mental health ran clinics at the Chase Farm site. Clinics typically offered 10 appointments.
- Telemetry CTG machines were available which meant that women were able to be mobile in labour.
- Privacy and dignity was enabled by the use of privacy screens around beds and on the entrance to rooms on labour ward and in the antenatal clinic.
- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, there was on-site NNU.
- We saw an example of highly responsive care at the Birth Centre. A baby had been transferred from the birth centre to the NNU for treatment with intravenous antibiotics. Following discharge from NNU there was not

a side room on the postnatal ward and the decision was made for the mother and baby to be cared for on the birth centre. Staff from the NNU attended the birth centre to administer medicines. This meant that the mother and baby were not separated.

- We saw that in response to complaints about bed sheets not being changed, the MCAs now asked all women if they needed their beds changed on a daily basis.
- Partners could visit anytime and were encouraged to stay overnight to provide additional support for their partner. Other people could visit at fixed times. This enabled new parents to spend private time with their babies.
- There was a dedicated bereavement suite which although did not have a separate entrance was located at the end of labour ward. This meant that bereaved families had a reduced risk of exposure to labouring women.
- A bereavement specialist midwife provided care and support to women who suffered pregnancy loss at any stage of pregnancy. A cold cot was available which meant that babies could stay longer with parents. Memory boxes were made up for parents who suffered pregnancy loss.
- The bereavement midwife worked with the local Stillbirth and Neonatal Death Society (SANDS) who organised an annual non-denominational memorial service.
- Counselling was provided to gynaecology and maternity patients by the Women's Health Counselling Service.
- Supervisors of Midwives (SoMs) were available to help midwives provide safe care of the mother, baby and her family. SoMs are experienced midwives with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met women's needs.
- We saw that there was an interpreter service available by telephone.
- We saw a variety of patient information leaflets available for both maternity and gynaecology patients.
- Gynaecology patients told us that call bells were answered promptly and that they 'wanted for nothing'.
- We saw that the gynaecology ward use 'Forget me not' stickers to alert staff to patients affected by dementia. They also used a leaflet entitled 'This is me' which meant that women with dementia were treated as individuals.

Learning from complaints and concerns

- A complaints manager was responsible for complaints which were handled in line with trust policy. If a woman or relative wanted to make informal complaints, they would be directed to the midwife or nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns. PALS used a closure form for informal complaints so that themes could be identified. Patients would be advised to make a formal complaint if their concerns were not resolved.
- We saw a trust information leaflet for patients and those close to them informing them of how to raise concerns or make complaints. Complaints were reviewed weekly and distributed to responsible officers for investigation and response within 25 days. A quarterly report was submitted to the Divisional Board.
- We discussed learning from complaints with the management team who told us that care issues and staff attitude were common themes.
- Information from the trust indicated that there had been three maternity and seven gynaecology formal complaints made in September 2015 but no complaints relating to the Edgware Birth Centre, at which site, we saw evidence that duty of candour was observed.

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecology department of The Royal Free Hospital NHS Foundation Trust at the Barnet and Edgware birth centre site was led by a divisional director of midwifery and nursing, a divisional director of operations and divisional medical director, a deputy head of midwifery and a gynaecology matron.

We rated well-led as good because:

- There was strong trust wide and local maternity leadership on the Barnet site. An integrated action plan was approved following the merger with Chase Farm and Barnet Hospitals NHS Trust. A community action plan was in place and progress was being made towards changing the way the birth centres and community midwives worked.
- There was a statement of vision and strategy and staff we spoke with demonstrated an awareness or understanding of it.
- There were good clinical multidisciplinary working relationships. Leaders were described as supportive, visible and approachable.

However,

- We saw that whilst 80 out 125 guidelines had been standardised across the merged sites, 50 guidelines were out of date.
- and at the Edgware Birth Centre:
- the management structure was top heavy with more band seven midwives than band six midwives. Senior management and trust board members were not visible.
- Management had made important changes to the service without consultation.

Vision and strategy for this service

- We saw that the Women's and Children's directorate had a vision and strategy and staff could articulate the content.
- Following the merger with Chase Farm and Barnet NHS Trust in July 2014, the trust commissioned an assessment of the maternity services to seek assurance about the quality and safety of the maternity services.
- Concerns identified at Barnet Hospital included poor clinical governance structure, lack of timely response to SIs and poor embedding of lessons learned from SIs. There was also a lack of action in response to maternity dashboard triggers such as high caesarean section rate and third and fourth degree tears and themes from SIs including issues with antenatal and newborn screening. Concerns were also identified around the leadership structure and midwifery establishment and education and training.
- An integrated maternity and neonatal action plan was approved by the trust to address concerns identified. The action plan was reviewed at the monthly Clinical Governance and Clinical Risk Committee meetings and quarterly by the CQRG which is attended by commissioners. We saw documentary evidence that 108 actions had been completed since July 2015, and 37 actions were in progress and on track to meet their deadline. Actions that were behind schedule were identified and monitored through a dashboard; there were 14 such actions.
- A community integration plan was led by the consultant midwife at Barnet Hospital and the community matron to develop a model of care that met current best practice. Community midwives facilitated 20% of all births at the birth centre and the new model would align the community midwives with the birth centres on all sites in the provision of antenatal, intrapartum and postnatal care. Women and midwives had been consulted and a proposed model designed. Whilst most senior midwives had been involved and know of the plans, band six midwives were unable to articulate them.

Governance and risk management

- A Divisional Director of Midwifery and Nursing managed the maternity and gynaecology service trustwide. The gynaecology services were managed by a matron cross-site. Locally, a Deputy Head of Midwifery managed the maternity services, including Edgware Birth Centre.
- Senior staff told us that the governance structure has improved since the merger and had administrative support.
- A quality manager was in post who led a team with responsibility for patient safety and risk; compliance, audit and guidelines; and complaints.
- The risk and safety manager reviewed all submissions on the electronic incident reporting system. These were discussed at a weekly risk meeting and allocated to an incident manager if it was considered that further investigation was required.
- The NRLS template was used to identify SIs which were reviewed by a multidisciplinary panel and a three day report produced. SIs were uploaded to STEIS twice a week and were reviewed at the trust wide Serious Incident Review Panel (SIRP). A triage process was used to decide whether an internal investigation or an external RCA was required.
- Staff from the Royal Free site who sat on investigation panels or external reviews would be commissioned to undertake investigations.

- Following investigation or RCA the SI was discussed by the SIRP who challenged findings, made a judgement and decided on recommendations and actions.
- Action plans were tracked and kept under review at the monthly local risk management group/clinical governance meetings and reported to the quarterly Divisional Quality and Safety Board. We saw that there were 14 open and overdue maternity actions that related to ongoing guideline development and reflection of or feedback to staff but neither of these related to Edgware Birth Centre. There were two open and overdue maternity actions that related to staff training in dementia awareness and the other to shared learning.
- The monthly multidisciplinary Perinatal Meeting discussed adverse events in order to identify the causes so that steps could be taken to prevent recurrence.
- Staff told us that they recieved feedback in various ways including at weekly meetings, 'lesson of the week' board and a quality and risk newsletter called Risky Business. Medical trainees also had a newsletter. If staff submitted a Datix form, they recieved personal feedback on the incident reported. Performance issues were taken up with the individual staff member. We did not see evidence of a 'lesson of the week' board at Edgeware Birth Centre.
- We reviewed the minutes of the Risk Management meetings for both maternity and gynaecology and the Obstetrics and Gynaecology Governance Group for March 2015 to November 2015 and saw that the meetings followed a standing agenda. Issues were identified and actions were planned and reviewed.
- The maternity and gynaecology risk register was reviewed monthly at the Risk Management meeting. We saw that the risk register contained 35 risks; seven risks related to maternity and one risks related to gynaecology on the Barnet site. We saw that risks were RAG rated, that progress was noted, that the risk register was discussed at the monthly Obstetrics and Gynaecology Governance Group meeting and reported on a quarterly basis to the Divisional Quality and Safety Board. There were no risks relating to Edgware Birth Centre on the risk register.
- The trust used the North Central London Maternity and Newborn maternity dashboard. Quality data was recorded monthly and reviewed at the Obstetrics and Gynaecology Governance Group to identify trends and to aid forward planning. Statistics relating to Edgware Birth Centre were not recorded on the dashboard.
- Guidelines were kept under review by the compliance, audit and guidelines manager. A guideline implementation plan was in progress to harmonise guidelines across the merged services. We saw that 50 guidelines were out of date. When asked, a midwife showed us the Infant Feeding Policy that was dated 2009. The trust subsequently commented that an updated policy was available on the intranet, dated December 2014. The trust informed us that 80 out 125 guidelines had been harmonised across the merged sites. They were discussed at the Women's Health Guidelines group and ratified at the Obstetrics and Gynaecology Governance Group meeting.
- A Labour Ward Forum and Maternity Services Forum met monthly to identify areas of good practice and new evidence based practice.

Leadership of service

- Midwifery staff spoke positively about matrons at departmental level and their support in general. We saw good examples of leadership and teamwork at ward level.
- Staff said that senior managers were visible, approachable and supportive. This meant that they were easily accessible to staff.
- Staff spoke positively about the merger with the Royal Free Hospital. They felt that there were more opportunities for development since the merger and that they had been kept informed of changes. They also felt listened to and gave the example of raising concerns about the disparity in community midwifery models across the trust which were being addresses in the community integration action plan.
- The clinical director (CD) reported a good working relationship with the Divisional Director of Midwifery and the Deputy Head of Midwifery (HOM), the business manager and the medical director. The CD could also go directly to the chief executive officer CEO and felt able to access him as necessary.
- We saw that the Director of Midwifery had direct access to the trust board. This meant that the board could be readily sighted on issues relating to maternity.

- Members of the trust board were not visible at ward level. Staff reported that they were aware that the Chief Executive's weekly newsletter was available on the hospital intranet.
- Staff assimilated into the management structure on merger with Chase Farm and Barnet HNS Trust told us they 'know what a good executive team looks like now'.
- at the Edgware Birth Centre:
- Staff we spoke with told us that there had been a lot of change since the merger and that it was hard to get ownership of the clinical area. We were told that the whole of the Edgware team had been moved to another area with little consultation from management.They felt they 'hadn't got a voice'.
- Staff said that senior managers were not visible. The matron visited weekly and the consultant midwife held a clinic at the birth centre once a week.

Culture within the service

- Midwifery and nursing staff all had a strong commitment to their jobs and displayed loyalty to senior staff. Staff told us that 'everyone is approachable and always smiling'.
- Staff described supportive managers. One midwife told us that following experience with an obstetric emergency, the manager called her the following day on her day off to offer support and debrief before she returned to work.
- From our observations and discussion with staff we saw a strong commitment to meeting the needs and experiences of people using the service.

Public and staff engagement

- The local Maternity Service Liaison Committee (MSLC) focus groups were organised and led by the team of supervisors of midwives. Women were invited to attend this drop in group to share their experience and make suggestions for improvements to the service.
- 'Walk in Your Shoes' boards were visible in the clinical areas which demonstrated that the trust listened to patient's views and acted on them. For example we saw the following comments:
  - You said you would like to mobilise in labour and have a change of birth positions.
  - We purchased birth stools and encourage use of wireless CTG monitoring of babies
- A 'Maternity Star' was peer nominated each month and the successful member of staff was displayed on a notice board along with all nominees.
- At the Edgware Birth Centre:
- We were told that a new leaflet was planned to advertise the birth centre.
- Staff had visited local GPs to promote the birth centre.
- No open days were held for prospective users of the service.

Innovation, improvement and sustainability

- A 'Fetal Pillow' had been designed to reduce the risk of fetal and maternal trauma during emergency LSCS. The fetal pillow was used internally to elevate the baby's head making operative delivery easier.

Services for children and young people

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

Information about the service

Children's services for The Royal Free Hospital NHS Foundation Trust were led by a clinical director, a head of nursing and a divisional manager. In addition there is a neonatal matron who covered both sites and 2 matrons who covered the children's wards on both sites.

It should be noted that certain aspects of the Royal Free Hospital and Barnet Hospital location reports share certain similarities. This is because while services for children and young people operated independently at each site, with both having individual matrons for the children's units, the matron for neonates led both units on each site. The neonatal units were managed as one service between the sites and included a level one unit at the Royal Free Hospital and level two unit at Barnet Hospital. Many consultants worked across both sites. The sites shared common services and the clinical nurse specialists worked across sites. Policies were shared across the sites and data reported usually looked at children's services across the trust as a whole.

Children's services at the Barnet and Chase Farm hospital sites provided care to children and young people between the ages of 0-19 years of age. The children's service based on the Galaxy unit had 30 beds, which included a high dependency area and a paediatric assessment unit. There was an adjacent outpatient department and a separate school room. There was a dedicated paediatric assessment unit at Chase farm Hospital.

The Starlight neonatal unit at Barnet Hospital was a level two neonatal unit, caring for premature and sick babies needing short-term intensive care. The unit could care for up to 30 babies at any one time and is the only unit in the UK to have a special suite of single rooms which enable parents and their babies to interact with the aim or promoting optimal development.

External organisations provided retrieval services for children and neonates.We spoke with eight parents, one child, one day surgical unit co-ordinator, seven consultants, 11 junior doctors, one outpatient nurse, one neonatal occupational therapist, one paediatric occupational therapist, one student nurse, one matron, one head of children's nursing, one community neonatal nurse, one safeguarding advisor, two practice educators, three sisters, two staff nurses, one play specialist, one paediatric pharmacist, one paediatric dietician and two school teachers.

Services for children and young people

Summary of findings

Overall, the children's and young people's service was rated as Good because:

The trust met the Royal College of Paediatrics and Child Health (RCPCH) standards for paediatric consultant staffing levels. Nursing levels were mostly compliant with both Royal College of Nursing (2013) and British Association of Perinatal Medicine standards (2011) for staffing children's wards and neonatal units.

There was good access and flow within the children's service. Patients received evidenced based care and treatment and good multi-disciplinary working existed between the children's services, external providers and the child and adolescent mental health service (CAMHS).

Training provision to staff was good and managers monitored staff training compliance levels using the trust's electronic training compliance system.

Children's service were effectively supported by children's critical care and neonatal retrieval services.

Staff were caring, compassionate and respectful and the staff we spoke with were positive about working in the service and there was a culture of flexibility and commitment.

The service was well led and a clear leadership structure was in place. Individual management of the different areas providing acute children's services were well led. A governance system was in place and clinical risks were identified. Feedback from staff, parents and children and young people was generally good.

However;

Although services provided evidenced based care as identified within evidenced based clinical guidelines, many of these were out of date, posing potential risks to patients.Post-operative recovery facilities were not child-friendly, and some recovery nursing staff were not trained in paediatric immediate life support (PILS).

Are services for children and young people safe?

Good

We rated safe as good because;

- Children's services at the Royal Free Barnet Hospital site had developed reliable incident reporting systems and staff were able to describe the process for incident reporting in significant detail.
- All staff were aware of their responsibilities to report incidents. Lessons were learnt where incidents had taken place and managers cascaded information and learning points to staff of all levels.
- The clinical areas were visibly clean and there were robust systems to ensure that children and their families were protected from the risk of harm associated with hospital-acquired infections.
- Staff undertook regular training to ensure they could recognise and respond to the needs of vulnerable patients. Staffing ratios generally complied with nationally approved standards.

Incidents

- Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incidents and significant events were discussed at ward meetings, mortality and morbidity meetings and governance meetings in association with the risk register.
- We spoke with a range of medical staff, allied health professionals, school teachers, play specialists and nursing staff. All were able to describe the hospital incident reporting system, and were fully able to explain their roles and responsibilities with regard to reporting incidents using the trust's electronic reporting system. The system allowed staff members to report adverse events and near misses, and facilitated initial recording through to investigation and subsequent root cause analysis.
- The nurses and doctors we spoke with explained to us and gave examples of how lessons learnt were identified from reported incidents using the incident reporting system. We examined a serious incident which had

occurred in the trust some weeks prior to our inspection and were assured by the medical and nursing staff we spoke with that all procedures had been followed in dealing appropriately with the incident including applying the 'duty of candour' and being open with the child's guardians. 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. The lessons learned from that incident had been appropriately escalated and cascaded to staff.The outcome of the investigation into this serious incident resulted in new moving and handling procedures. Staff also said that training on the duty of candour was included in their mandatory training.

- A ward manger told us that incident reporting across children's services was robust and positively viewed by all staff as good for learning opportunities and that all staff were trained and confident in its use. The lessons learned from incident reporting were cascaded appropriately. A paediatric consultant we spoke with in the paediatric assessment unit (PAU) at Chase Farm Hospital told us that there was good reporting of incidents involving children.
- The paediatric risk news letter dated December 2015 gave details of all incident reports from May to December 2015. The newsletter also had some incident case studies with key areas of god practice cited.
- Staff told us that training in the use of the electronic incident reporting system was part of the induction process and the student nurses we spoke to on placement at Barnet Hospital children's services unit had also been made aware of the reporting system and had observed their mentors using the process.
- We saw and inspected the children's safety and quality bulletin with hypertext links to more detailed information for readers. The bulletin is emailed to all staff in children's services.
- Junior doctors we spoke with fully understood how to report an incident using the incident reporting system and confirmed that the email response to incident reporting was good.
- Staff we spoke to were able to give examples of how the incident reporting process operated in the trust and we were shown samples of patient notes where incident reporting had been documented. We saw that there was a low level of incidents but all staff we spoke with were confident that they were fully able to use the incident reporting system. Staff we spoke with told us that the trust had rigorous policies and a culture of patient safety.
- We noted that there were regular morbidity and mortality meetings held throughout children's services and we inspected the minutes from the Perinatal meetings dated Monday the 16th December and the 21st December which detailed the management of individual neonates. Doctors we spoke to in the neonatal unit confirmed attending the weekly perinatal meeting.
- We inspected a copy of the risk news letter dated January 2016. The unit had implemented an "improvement of the week" which was discussed at the weekly morbidity meetings.
- Data provided by the trust showed that there had been no never events or serious incidents reported between December 2014 and November 2015. We inspected the outcome of all paediatric incidents dated October to December 2015.There were a total of 87 incidents, 69 of which caused no harm with 5 near misses and 13 where harm had occurred. We also examined the data from trends in paediatric incidents prepared by the trust and saw that the top category of incidents related to documentation, including paper records and drug charts , treatment, procedures and admission and discharge. There had been no neonatal incidents within the 18 months prior to inspection.
- Staff we spoke with confirmed that safety alerts and lessons learned from incident reporting were circulated via email, and were discussed at various meetings appropriately

Safety Thermometer

- There were no incidents of pressure ulcers, falls with harm or catheter acquired urinary tract infections reported between November 2014 and December 2015.
- Clinical performance data was reported monthly and displayed on the children's and young people's safety

thermometer dashboard. During our inspection we examined a range of these dashboards in the various areas we inspected and we saw that the data was prominently displayed.

- We saw at handovers we attended that paediatric early warning scores (PEWS) for the identification of patient acuity were in place. We inspected the PEWS assessment form which had been specially designed for children's services.
- We noted that a protocol for sepsis six was cited within the trust annual report for the assessment of feverish children and senior staff we spoke with told us that aspects of sepsis six would be incorporated within assessment documentation.
- The official launch of the sepsis six pathway in the emergency department at the Royal Free Hospital was in January 2015. The trust reported that the paediatric department had achieved a 100% compliance rate in the first hour of identifying infection in a model infant using the sepsis six pathway.
- We examined the children's emergency pathway designed for the emergency department and the PAU at Chase Farm Hospital and saw the PEWS triage chart and the RAG (red, amber and green) ratings used. This comprehensive document had an integrated PEWS early warning triage chart as part of its design and a multidisciplinary evaluation sheet.
- Staff used PEWs and SBAR (situation, background, assessment and recommendation technique) to monitor deterioration in but no formal acuity tool was used to plan staffing levels at the time of our inspection.
- Junior doctors we spoke with were aware of PEWS, SBAR and sepsis six. They felt the service was safe.
- Staff held safety huddles after completing handovers. Safety huddles were designed to heighten awareness of individual staff and sick children's needs that could be anticipated at the beginning of, or throughout a shift. Safety huddles were held three times per day.

Cleanliness, infection control and hygiene

- Staff who worked within children's and young people's services including the neonatal unit had a good understanding of their roles and responsibilities in relation to cleaning and infection control processes and practices.
- We spoke with an infection control link nurse and we inspected the inspection control procedures and noted that each clinical area had an infection control 'link' staff member.
- Staff told us that they could easily contact the infection control team, which meant appropriate professional advice was available. We saw that the trust intranet contained a range of infection prevention and control (IPC) policies and we inspected a sample of these.
- All staff received IPC training and compliance for attendance was 89% across children's services.
- Parents and staff members we spoke with told us that compliance with IPC procedures such as hand washing and the use of hand sanitisers hand was good across children's services. We observed staff frequently using the hand sanitisers and washing their hands. We noted that all staff carried personal containers of alcohol hand gel. Parents we spoke with told us that they had seen staff members frequently washing their hands and some of them had also been given instructions about hand washing and the use of hand sanitisers.
- We saw that there were helpful and highly visible "six steps of handwashing" poster prompts to encourage handwashing and the use of hand sanitisers.
- We observed that medical and nursing staff adhered to hand washing protocols and procedures. We saw cleaning schedules in place, which identified the tasks and frequency of cleaning in each area. These cleaning schedules were completed with signatures and dates to confirm the respective tasks were completed. Discussions with staff confirmed that nursing and ward assistants had specific roles in relation to cleaning duties.
- We saw that the dirty utility rooms were clean and tidy. Waste management was compliant with national standards and all waste receptacles were colour coded appropriately.

Services for children and young people

- We inspected the neonatal unit and observed that overall cleanliness was good. We examined a parent accommodation room which was also clean and equipped with hand sanitizers. The corridors and clinical areas were all visibly clean.
- The anaesthetic room was visibly clean with well labelled cupboards.
- The clinical areas of children's services had their own regular cleaner and we spoke with one of them who showed us their cleaning schedule and the differing coloured mop heads used for specific cleaning duties which followed the national colour coding for cleaning equipment .We saw that they used the correct colour coded disposable mop heads, disposable cloths and appropriate buckets and mop handles.
- We inspected the sharps bins throughout children's services and all had been dated. We also inspected the linen storage areas and noted that there was sufficient clean linen available.
- We inspected a range of patient equipment such as blood pressure cuffs throughout children's services and these were all clean and had been appropriately labelled with clean stickers. We inspected two commodes and one set of weighing scales and all were visibly clean and had appropriate 'I am clean' stickers applied.
- There were monthly hand washing audits carried out throughout children's services. We inspected some of these, for example the hand hygiene audit in the PAU at Chase Farm Hospital for December 2015, which was 100% compliant. Audit results were communicated to the staff of the children's services by email and were discussed at the meetings. We inspected the cleaning protocols used throughout children's services saw them in place in the sluice areas.
- In the PAU we observed the domestic work schedule and also saw that the premises were visibly clean throughout .
- The trust annual report for 2014/15 showed that patient-led assessments of the care environment (PLACE) audit for Barnet was 90% for cleanliness.
- We saw that staff followed the trust's personal protective equipment (PPE) protocols and the link nurse we spoke to told us that PPE advice was freely available from the trust's central infection control team.
- Play specialists told us that toy cleaning schedules were in place and that they visited the PAU at Chase farm Hospital to undertake weekly toy cleaning.
- The trust annual report for 2014/15 showed that the number of cases of c.difficile infections had fallen by 16% during the year from 69 to 58 cases across the whole trust. The trust reported having the lowest MRSA bacteraemia rate among London hospitals.
- Apart from seasonal respiratory syncytial virus there were no specific infection control issues noted during the inspection. There were notice boards within the staff rooms detailing both infection control bulletins regarding future meetings and issues such as c.difficile rates.
- We inspected the results of the children's services cleaning audit conducted through the independent cleaning service for the hospital and undertaken through the use of an electronic auditing system that uses a touch screen handheld system to perform cleaning audits, and to produce audit reports. The matron of children's services was actively involved in this audit which showed good adherence to national cleaning standards.

Environment and equipment

- Equipment suitable for babies, children and young people was seen in all clinical areas.
- The care environment was noted to be child friendly with appropriate décor. The care rooms within the Starlight neonatal unit allowed parents to stay close to their premature babies 24 hours a day.
- We examined the resuscitation trolleys and resuscitation equipment throughout children's services and the trolleys were clean, secure, updated and had been checked and logged on a daily basis.
- Medical equipment was up to date and the neonatal intensive care equipment managed by one of the equipment companies and all equipment was PAT tested.

Services for children and young people

- We inspected the checking of various clinical refrigerators and freezers for cleaning and temperature monitoring including those for breast milk storage and found them to be up to date.
- Staff told us that there had been lessons learned about breast milk storage and the decision was made to use lids on boxes in the freezers to prevent the mix up of parental breast milk which had happened previously. However, one of the four boxes we inspected did not have a lid in place.
- Breast feeding pumps were plentiful and breast pump hire was available for mothers at a fee.
- Appropriate measures were in place to maintain security throughout children's services. Security cameras were located throughout the building and people either had to ring a bell to enter the clinical environment or use password access. Door security was good although some mothers found the wait to get in quite lengthy. There were posters displayed to prevent tailgating.

Medicines

- Medicines management was in line with trust policy, for example medicines were locked in cupboards. The nurse in charge carried the controlled drug keys. We reviewed three drug charts and saw that al were legible and dated and signed appropriately with all relevant information including allergies, dosage and route of administration.
- Medicines and controlled drugs were secured safely and appropriately accounted for in the records we inspected.
- A paediatric pharmacist we spoke with told us that she was invited to the children's ward huddle to discuss any pharmacy or medicine issues. She confirmed that 24/7 advice was available via on call arrangements. Otherwise dispensary was available 9-5 Monday to Friday and am on Saturdays and Sundays .
- We inspected drug storage facilities across children's services and all aspects were seen to be compliant to recognised standards including fridge temperature monitoring.

Records

- We observed that records were stored securely.
- We reviewed a mixture of three sets of medical and nursing notes of children and found both the storage and completion of the records was exemplary with weight and height recorded, PEWs recorded and the use of pain scales evident.
- We inspected the paediatric anaesthetic care pathway which was very comprehensive and included the WHO surgical safety checklist in patient notes and within the operating theatre we visited.

Safeguarding

- Safeguarding procedures for vulnerable children were in place in Barnet Hospital and the rest of the trust. The safeguarding children's advisor we spoke with in Barnet told us that safeguarding was a whole trust service and that mandatory and statutory training ensured that everyone was up to date with their level three safeguarding training.They said lessons were learned from serious case reviews, and that the trust had supported them to attend courses on sexual exploitation.
- The children's services had a dedicated children's safeguarding team who worked closely with the adult safeguarding team. The named safeguarding nurses were supported by named doctors.
- Mandatory training records showed that compliance for safeguarding training was 87% for the 398 staff who worked in children's services.
- Safeguarding reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide.
- Staff demonstrated knowledge of safeguarding guidance and processes. They knew what to do and who to contact should a concern be raised.
- Staff we spoke with on the neonatal unit told us that they used "red folders" as an alert for children with safeguarding issues.
- The National Institute for Health and Care Excellence (NICE) safeguarding guidance recommends that qualified staff groups be trained to a level three standard in safeguarding and we were told that staff attended child safeguarding training, initially at trust induction and then subsequently during annual mandatory training.

- Children who failed to attend an outpatient appointment were monitored and were usually sent another appointment, and safeguarding procedures were implemented where necessary.
- We saw that posters on how to deal with issues of female genital mutilation were displayed in staff rooms.

Mandatory training

- The trust's lead practice educator for paediatrics introduced a new electronic system for recording mandatory and statutory training (MAST). Mandatory training is identified as essential learning for people who work in health care environments.
- We inspected the MAST system and saw that it captured all nursing and health care assistant staff training and was linked to appraisals. This system was also being developed to incorporate nurse revalidation, paediatric immediate life support (PILS), equipment and medicine competencies, mentorship and staff development days.
- The practice educator we spoke with told us individual staff were monitored for compliance through the electronic staff record.
- Mandatory training within children's services was at 87% compliance, appraisals 99% and infection control at 100%. Compliance for safeguarding training was 87%. Additional training in female genital mutilation (FGM) and sexual exploitation was being made available to staff.
- We saw that a nurse revalidation quiz for nurses to complete had been developed and we also noted that the trust has invested in post qualifying education.
- We spoke with members of staff of all grades, and confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, paediatric resuscitation, fire safety, manual handling, infection control, and safeguarding. Staff we spoke with in the outpatient department told us that their mandatory training and other training such as FGM and sexual exploitation were up to date.
- Healthcare assistants completed yearly update training in paediatric basic life support.
- Data provided by the trust showed that 50% of staff anaesthetists were PILS trained. The Resuscitation Council (UK) PILS course was launched in 2007 for healthcare professionals who may have to act as first responders and treat seriously ill children or children in cardiac arrest until the arrival of a cardiac arrest team. No staff from the Barnet Hospital theatre were PILS trained, and no recovery staff were PILS trained.
- We spoke with several staff members to test the veracity of the mandatory training records. For example, a staff nurse we spoke with told us that they had recently completed their appraisal and statutory study days and with their consent we examined their electronic training record and saw that their training was fully up to date including level three safeguarding, as was the neonatal occupational therapist we spoke with.
- The community children's nurses we spoke with told us that their mandatory training was 100% up to date.
- Medical and nursing staff confirmed attendance and satisfaction with their corporate and local inductions. Corporate and local inductions were in place for new staff throughout the service.
- Bank and agency nursing staff completed an induction when new to the service.
- The trust provided health care assistants with training known as the five-day fundamentals of care programme from April 2015. This care certificate incorporated both the common induction standards and the national minimum training standards, underpinned by the trust's care values. The care certificate is a national education certificate which aims to provide clear evidence to employers, patients and people who receive care and support that their health care assistants has been trained and developed to a specific set of standards.

Assessing and responding to patient risk

- The service had guidelines and protocols to assess and monitor patient risk.
- The paediatric early warning score (PEWS) and the neonatal early warning score (NEWS) monitoring systems were fully embedded throughout to monitor children and babies who may be at risk of deterioration. We were told that sepsis six information introduced earlier in 2015 to the emergency department was to be integrated into the paediatric documentation.
- Sick children were monitored for signs of deterioration through the use of PEWS and SBAR which is the

situation, background, assessment and recommendation technique. This structured method for communicating critical information contributed to effective escalation and increased child safety. We were told by the matron that both these methods were used for communicating clinical information about sick children.

- Generally the NEWS tool was not used for babies receiving level two care within the neonatal unit as these babies were subject to continuous monitoring. This monitoring process ensured that vital signs, pain levels if any and potential risks were fully identified. Risks to babies on the neonatal unit were identified during their initial assessment and identified within care plans. These risks were reviewed daily or as required and at handover any deterioration in a baby's condition when identified were communicated to the primary care giver.
- Nurses we spoke with told us that there were always nurses on duty with PEWS training. The nurses we spoke with told us that they were fully confident in using PEWs and SBAR to determine the status of a deteriorating child. The student nurses we interviewed told us that they regularly witnessed the trained nurses carrying out patient safety checks using PEWS and SBAR.
- Retrieval services for children and neonates were provided by external organisations whose role it was to transfer sick babies and children to level three tertiary paediatric intensive care or neonatal units. Children and babies requiring intensive care management prior to retrieval were cared for by staff in the neonatal unit or the high dependency unit until the retrieval service team arrived.
- We saw that neonatal care for preterm and sick babies at Barnet Hospital was organised within Neonatal Operational Delivery Network (ODN). ODNs have been established across England and aim to deliver safe and effective services across the patient pathway and help secure the best outcome for patients, in this case neonates. A live patient data management system was used by clinicians, which allowed doctors and nurses to share knowledge and skills. We inspected the perinatal patient data management system on the neonatal unit and found it to be fully compatible with other similar services throughout England.
- The paediatric assessment unit (PAU) at both Barnet and Chase Farm were consultant-led services for the assessment, treatment and observation of children and young people with minor or moderate acute illness, without the need for inpatient admission. Although adult nurses saw sick children out of hours at Chase Farm we were told that all were PILS trained.
- We observed patient safety posters within the operating theatre detailing the five steps to patient safety.

Nursing staffing - Children's service

- Galaxy ward at Barnet Hospital generally met RCN standards for the staffing of children's wards and the matron and ward manager we spoke with told us that they met the 2013 Royal College of Nursing (RCN) staffing guidelines.
- Data from NHS Choices for Galaxy ward showed that for day duty staffing was 96% of the planned level and for night duty 129% of planned level.
- We were told that there was a 10% nurse vacancy rate within children's services at Barnet but that staff retention was good. Vacancies were filled by bank and agency nurses. We were also told that there was an agreement in place for children's nurses in the children's emergency department to provide help on a mutually reciprocal basis in times of staff shortages.
- The high dependency unit was always covered by 2 staff and all staff were PILS trained (The Resuscitation Council Paediatric Immediate Life Support course) with two nurses with APLS (Advanced Paediatric Life Support course). A band six nurse was always on duty.
- Although staff we spoke with told us that a formal patient acuity tool was not used to determine staffing needs they mitigated this potential risk by reviewing patient acuity and staffing at each of the safety huddles and used SBAR to ensure that staff were placed in the most appropriate clinical area.
- The matrons we spoke with told us that the children's service was staffed with appropriately qualified registered nurses in accordance with NMC standards for the care of sick children. For the neonatal unit 50% of nurses had a neonatal advanced life support qualification and with all staff processing the neonatal life support qualification which as updated annually.

Services for children and young people

Neonatal staffing

- Neonatal staffing did not always fully meet the British Association of Perinatal Medicine Guidelines (2011) (BAPM) because they were could not always provide 1:1 and 1:2 care for babies who had required intensive care or high dependency care.
- We examined the nurse staffing board which was very transparent in the way it detailed staffing of the neonatal unit. We examined the patient data management system for recording neonatal data and saw that staffing met the BAPM standards apart from very few occasions. For example in November 2015 the data base showed that the unit was only non-compliant to the BAPM standards for three shifts and in October 2015 for 12 shifts. BAPM produces benchmarked standards that help all those involved in perinatal practice to improve the standards of perinatal care delivery.
- Data from the NHS Choices website dated December 2015 showed that nursing staffing levels were at 89% of the planned level during the day and 91% of planned level at night.
- The neonatal occupational therapist we spoke with told us that there were sufficient staff on the unit to maintain safety and parents we spoke with on the neonatal unit told us that there were always enough staff on duty day and night

Medical staffing

- Children's services at Barnet confirmed that they were compliant against the 'Facing the Future' standards for staffing. Although there was lack of an out of hours consultant within the Chase Farm Hospital PAU, the risk was controlled because of on call cover from Galaxy ward.
- The Royal Free children's service across all sites employed 104 WTE medical staff of which 41% were consultant grade,1% middle grade 54% registrar group and 5% junior grade. Middle grades and junior grades fell short of the English average .This was attributed to the way in which the London deanery allocated junior doctor trainee posts with trainee posts at Barnet but not at the Royal Free Hampstead site.
- Staff told us that there was good medical presence and support throughout the service 24 hours a day. In addition, the out of hours support provided by consultant level staff was described by staff as supportive.
- Anaesthetic consultant and intensivists were available out of hours to provide anaesthetic advice and support for children's services.

Major incident awareness and training

- The trust had a business continuity plan, which ensured critical services could be delivered in exceptional circumstances and we saw evidence of the trust major incident policy.
- The trust major incident policy identified staff specific roles and the measures to be put into place should a major incident take place.

Are services for children and young people effective?

Good

We rated effective as good because:

- The neonatal service provided innovative 'individualised care rooms' which allowed newborn babies to receive care and treatment in a private, family-centred setting. The rooms were designed to support a newborn baby's brain development by limiting extraneous light and noise. Parents could stay in the rooms 24 hours a day.
- Auditing systems informed practice, and the service introduced changes as a result to improve outcomes for children and young people.
- The neonatal service achieved stage one UNICEF Baby Friendly accreditation. Improvements in children's and babies outcomes were observed in the areas we reviewed.
- Multidisciplinary team working within and outside of the children's service resulted in positive outcomes for children.
- Trust appraisal statistics confirmed an improvement in staff yearly appraisal uptake in the last twelve months influenced by the robust structures which had been

implemented to record mandatory training and other training by the practice educators within the service. Staff members told us their training needs were supported and they had received development support appropriate to their needs.

- The children's service had transition arrangements in place for young people entering adult services. These included areas such as diabetes, oncology, and diabetes services. We saw effective working relationships between community staff and neonatal and children's services staff.
- Staff had a good understanding of consent processes and additional assessments were undertaken for children with learning disabilities. The patient records we inspected confirmed that consent procedures were robust.

However;

- We saw that although services provided evidenced based care as identified within evidenced based clinical guidelines, many of the trust guidelines were out of date posing potential risks to patients. This was partly due to the ongoing project of merging guidelines on the trust intranet after the merger of the Royal Free Hospital with Barnet and Chase Farm.

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) were used to inform care. We reviewed a selection of evidenced based guidelines but found many were out of date. During our discussions with senior staff members we were told that this was attributed to the ongoing harmonising project to reconcile clinical guidelines on the trust intranet since the merger.
- Staff told us that they were able to use other sources such as National Institute for Health and Care Excellence (NICE) via the internet and thus mitigate risk.
- A consultant told us that there were no problems in accessing up to date evidence based practice guidelines and that the librarian at Barnet was " absolutely amazing" in being able to retrieve evidence based journal papers.
- We saw good examples of guidelines for the care of children with self-harming behaviours and adolescents who might abscond with good reference to the role of the child and adolescent mental health service.
- We saw that the Starlight neonatal unit had participated in the National Neonatal Audit Programme and the patient data management system showed that data was regularly entered onto the national data collection system.
- There was significant audit activity within children's services at Barnet. We inspected the data boards on Galaxy ward and saw that the results of a bronchiolitis audit were displayed. A meal time audit showed 93.4% compliance rates ,a fluid balance audit 100% compliance rate , an intravenous fluid and complications audit 100% compliance rate , an audit of appraisals completion 100%, a communication audit with families 100%, a PEWs use audit 100%, a Central venous catheter (CVCs) audit 100%,and a patient identification audit 100%.

Pain relief

- Barnet children's services offered a pain service to provide help and advice on pain management issues contactable by bleep.
- We saw that a pathway to theatre for children was in place and we inspected the associated paediatric anaesthetic care pathway which was very comprehensive and included the WHO surgical safety checklist, both of which highlighted pain management.
- We visited the children's recovery area in the operating theatre and saw that children were potentially exposed to upsetting sights and sounds as adults were recovered in opposite bays, some with clinical tubes and drains evident.
- We reviewed a sample of children's pain charts and saw that children's pain scores were escalated as per trust guidance. Staff used a range of pain assessment tools to monitor pain in children. These included the Wong-Baker smiley faces pain rating tool and a 1-10 visual analogue scale tool. Reassessments of children's pain took place following medication given to relieve the child's pain, to ascertain whether the medication

had provided effective relief. The Wong-Baker tool was originally developed to help children more effectively communicate their pain relief needs with health care staff.

- Pain protocols were available for staff to access.
- The play specialists we spoke with told us that they played a large part in offering play activities for children in pain or who might suffer debilitating fears such as needle phobia workers used in pre assessment. We noted that Starlight distraction boxes were available to provide distraction throughout children's services including the paediatric assessment unit (PAU) at Chase Farm Hospital. Starlight Distraction Boxes were filled with toys, games and puzzles to help children cope with various medical procedures. The boxes were used by the nurses and play specialists to provide effective technique's and pain management.

Nutrition and hydration

- The Starlight neonatal unit was supported by a group of specialist midwives from the trust's infant feeding team. The team saw any mothers and babies who were breastfeeding and offered support and advice. We were told that the neonatal unit had been awarded level one UNICEF(United Nations International Children's Emergency Fund) Baby Friendly accreditation. The Baby Friendly Initiative was set up in 1992 by the World Health Organization and UNICEF to recognize hospitals that enable mothers to make an informed choice about infant feeding and to be supported in that choice. Level one accreditation is indicative that Barnet neonatal unit had created policies and procedures to support the implementation of the breast feeding standards and these had been externally assessed by UNICEF UK and found to be adequate.
- We inspected the menu for children and saw that a variety of food choices was available to children and young people. Special diets, for example diabetic, gluten free, renal, textured and allergy diets were available. Specialised milk formulae were provided in the neonatal as required breast feeding advice was seen to be good and non-judgemental.
- Paediatric dietitians were involved in undertaking nutritional assessments in children. We saw dietetic involvement in some children's care had taken place when we reviewed children's medical notes. Nutrition plans were developed and reviewed by the dietician where required.
- We saw that all children were weighed on admission and STAMP assessments to determine malnutrition status were carried out. STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) is a validated nutrition screening tool for use in hospitalised children aged 2-16 years.

Patient outcomes

- Emergency readmission rates for children and babies were less than the England average across the trust. However, multiple admission for children with asthma and diabetes was higher than the national average but not for epilepsy.
- The service had 'individualised care rooms' which were designed to support a newborn baby's brain development by limiting extraneous light and noise. Parents could stay in the rooms 24 hours a day.

Competent staff

- Formal processes were in place to ensure medical and nursing staff received role specific training and an annual appraisal. Nursing staff told us they received annual appraisals and training specific to their needs. Information provided by the trust confirmed that 100% of nursing staff had completed their annual appraisal and the new electronic tracking system introduced by the practice education team for mandatory training and other learning outcomes enabled mangers to easily track rates of compliance.
- Staff told us that training was provided for them and investment in staff training by the trust was perceived by them to be good. For example a play specialist we spoke with told us that she had been enabled to receive training in the use of guided imagery from a specialist children's hospital. This is a non-invasive a method of relaxation which aims to concentrates the child's mind on positive images in an attempt to reduce pain or stress.
- Nursing staff from within the service at Barnet had moved into the PAU at Chase Farm to improve and enhance staff skills in this area.

Services for children and young people

- Nursing staff received frequent training updates from a children's specialist hospital, including tracheostomy care, and comprehensive training days were held for staff every three months.
- Staff on the neonatal unit we spoke with told us that study days they attended were funded by the trust.
- The trust annual report for 2014 showed that it provided all staff with opportunities to support their continuing personal and professional development. The report showed that the education team had commissioned a wide range of courses and projects from local universities and training organisations based on needs identified by ward managers and matrons and which reflected organisational needs and objectives.
- We were shown the mentor database and mentor annual updating and triennial review data for mentors and sign off mentors by one of the practice educators and saw that it was compliant with NMC standards. There were sufficient mentors in post for the student allocation to the clinical areas.
- A student nurse we spoke with told us they felt well supported on their placement by their allocated mentor .The student confirmed to us that they were supervised according to the Nursing and Midwifery Council (NMC) 40% rule, which aims to ensure that whilst giving direct care in the practice setting at least 40% of a student's time must be spent being supervised (directly or indirectly) by a mentor. The student told us they had no reservations in reporting any incidents to their mentor for guidance, but that sometimes their mentor was too busy to give formal teaching.
- An epilepsy nurse specialist was in post covering both Barnet and the Royal Free Hospital.

Multidisciplinary working

- Senior nurses we spoke with told us that team working relationships between children's services at the Royal Free Hampstead site and the Barnet and Chase Farm hospital sites were good.
- Staff we spoke with told us that multidisciplinary team (MDT) working was good. They also said there were effective working relationships between children and adolescent mental health service (CAMHS) professionals and paediatricians.
- Occupational therapists and dieticians told us that they attended a range of MDT meetings and said that MDT working was good.
- The teaching staff we spoke with in the hospital spoke highly of their involvement in MDT working.
- A psychologist was available for MDT working throughout children's services.
- Children's community nursing staff who were based at Barnet within children's services attended the nursing handovers and huddles and were seen a part of the multidisciplinary team.
- The nurses and doctors we spoke with in the PAU at Chase Farm told us that MDT working was good and there were psychosocial meetings held every Friday with the lead for safeguarding.
- The children's diabetes clinic was run by a multidisciplinary team that included paediatric nurses, paediatricians and dietitians.Regular clinics were held at Barnet Hospital and Chase Farm Hospital where children under age 16 years were seen quarterly. Adolescent diabetes clinics, for young people over 16, were also held at Barnet Hospital.
- A family continuing care and outreach team within the neonatal service assisted families during their baby's stay and in discharge preparation. They liaised with allied services in the community to ensure ongoing care and support was provided and assistted parents with planning and advice in the initial period at home.

Seven-day services

- Twenty-four hour paediatric and neonatal consultant support was in place.
- The Royal College of Paediatrics and Child Health standard that at least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent) was being met at Barnet.
- Staff said they could access out-of-hours investigations, for example, urgent laboratory tests. On call pharmacy support, radiology services and pharmacy access was available during specified times at the weekend.
- The Barnet Hospital home care team of paediatric nurses followed up on all children discharged from care.

Services for children and young people

- Children and babies requiring intensive care management and ventilation were stabilised by the resuscitation team within the high dependency unit of Galaxy ward before being retrieved as appropriate by the external retrieval service.

Access to information

- Weekly multi-disciplinary handover meetings took place to discuss children currently receiving support.
- Safe care assurance huddles were held three times per day to discuss individual children.
- Meetings had taken place with CAMHS team to discuss pathways of care especially for self-harming children. The self-harm care pathway confirmed that all CAMHS referrals had to be sent before the 10 am standard.
- Staff had access to evidence based guidance, policies and procedures via the trust intranet.

Consent

- Staff told us they were informed of and understood the consent process. Staff explained the consent process was completed by surgeons for children requiring surgery and that written consent was obtained prior to this.
- Staff members told us that they fully understood Gillick competence in relation to consent processes for children and young people. Gillick competence should be assessed for any child who is under the age of 16 who can consent, to determine if he or she has reached a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring a decision.
- We reviewed children's and babies notes for evidence of consent processes and saw completed consent forms for specific investigations and prior to surgery.

Are services for children and young people caring?

Good

We rated caring as good because:

- Children, young people and their parents received compassionate care with good emotional support. This was especially true of the neonatal Starlight unit, with its innovative individualised care rooms that allowed family centred developmental care where parents could stay throughout the neonatal journey.
- Parents and young people were fully informed and involved in decisions relating to their treatment and care.
- A family centred care philosophy was practiced within all aspects of children's services at Barnet. This approach was based on a belief that health care staff and the family are partners, working together to best meet the needs of the child or baby.
- Support for families was provided by the multidisciplinary team during the child's admission and in preparation for their discharge home.

Compassionate care

- We observed staff providing compassionate and sensitive care that met the needs of babies, children, young people and their parents and carers. Staff had a positive and friendly approach and explained what they were doing to both child and their carers.
- We spoke with eight parents of children using the service who told us they had been happy with the care and support they and their children had received.
- Parents we interviewed on the neonatal unit were highly complementary of the care being received by their babies with one mother describing the staff of the neonatal unit as "a brilliant team".
- It was evident from speaking to the neonatal occupational therapist and other members of the multidisciplinary team that staff were extremely proud of the caring nature of the individualised care rooms. We observed that there was a family centred approach to the care of patients and their relatives.
- Staff we spoke with told us that the philosophy of children's services was family-centred care and that staff tried to adhere to the trust values.
- A nurse we spoke with in the outpatient department told us that the trust was a very caring organisation "where we try to look through the eyes of the child".

- Parents from the neonatal unit and Galaxy ward told us that staff always introduced themselves, and sought their specific needs and level of involvement in the care of their children.
- Satisfaction surveys were carried out and staff told us that parents, adolescents and children had completed satisfaction surveys. We saw good results from the friends and family tests and we examined an email note to staff members praising their contribution to care in the outpatient department.
- The neonatal occupational therapist we spoke with told us that " my role is to add life to days for the baby whereas a doctor adds days to life".

Understanding and involvement of patients and those close to them

- The eight parents and one child we spoke with told us that they had been involved in decisions about their care and treatment, and were happy with the care staff provided. They told us that the doctors and nurses kept them well informed with information about their child or baby.
- We saw one of the doctors interacting with a child and giving the child a full and accurate explanation of their illness in language that the child could understand.
- A parent we spoke with on the neonatal unit told us they were treated "with kindness, compassion, dignity and given the freedom to be a good mother" and said, "as a unit it needs to be given credit for the communication abilities of all staff across the board from the consultants to the nurses, to the receptionist and just being able to create a relationship with myself as a parent and made me feel involved in this process in my daughter's development –it made me feel valued".
- We saw the results of an audit of families experiences of attending an outpatient blood clinic which utilized a Wong-Baker smiley faces scoring system and which was undertaken between January and May 2015.The primary objective of the audit was to elicit if the blood clinic was upholding the trust values of being positively welcoming, actively respectful, clearly communicating and visibly reassuring. The results of the audit showed that 96% of service users from a sample of 189 were strongly positive about the service they received.
- A preadmission clinic was held where children and parents could learn about their forthcoming trip to the operating theatre.
- Parents we spoke with told us that medical cover was available 24/7 and that there were always doctors and nurses who they could ask questions of at any time. One mother described the staff of the neonatal unit as "a brilliant team" who were fully integrated.
- Feedback cards and comment boxes for parents to use were available throughout the service.
- We examined the "you said –we did" board on the neonatal unit and saw that there were many instances of how staff had responded to parent comments. Parent feedback was collated each month.
- Parents were allowed to attend the clinical rounds in the neonatal unit and privacy during these rounds was protected through the use of ear muffs worm by adjacent parents for the duration of the consultation.
- Although the anaesthetic room was not especially child friendly the anaesthetists encouraged parents to come to the anaesthetic room and remain with their child until they had been anaesthetised.
- New parents to the neonatal unit were given a 'baby welcome pack', which contained useful information about aspects of care such as breast feeding support. Similarly a welcome pack was available to families on Galaxy ward and family advice cards were available in the paediatric assessment units.
- Information about the service was displayed throughout the clinical areas children and their parents. Parents from the neonatal unit confirmed that they had been given written information such as information on breast-feeding and baby hearing tests.

Emotional support

- Parents spoke highly of the support given to them by the specialist nurses employed within children's services.
- The needs of new mothers were re-evaluated regularly, demonstrating that appropriate emotional support was available for both mother and baby. Mothers who experienced mental health problems received additional emotional support through the multidisciplinary team. Health visitors and social

workers would be involved in their care and to ensure sufficient support was in place discharge planning for home would commence on admission to the neonatal unit.

- Parents we spoke with on the neonatal unit told us that they were offered high levels of emotional support through for example the "supper club" or through attendance at parents coffee group meetings. Parents were very enthusiastic about the supper club which was introduced by staff to give parents a special homely meal once per week. The supper club facilitated good relationships between staff and parents in a social environment within the parents' sitting room.
- We inspected family feedback comments in the parents sitting room of the neonatal unit all of which were highly complimentary.
- Parents and families could access spiritual support through the multi-faith service provided by the chaplaincy within the hospital and parents told us that folders were provided on spiritual and pastoral care as part of the Galaxy ward information pack.
- Parents described care delivery on the children's unit as "outstanding".
- Parents told us that the charity support group meetings held for parents on the neonatal unit were very helpful in providing them with practical and emotional support .
- We saw nurses giving families information leaflets and using the leaflets to explain elements of care to the family members.
- We noted that the children's survey data showed that the trust scored better than other similar trusts to the question "do you feel that the people looking after you listened to you".
- Despite data from the children's survey showing that food was less well received than in other comparable hospitals across England, children and parents we spoke with told us that the food provision was good. This was confirmed after a discussion with a paediatric dietician who also spoke favourably about food choices for children in the trust.

Are services for children and young people responsive?

Good

We rated the responsiveness of the service as Good because;

- There was good access and flow to services, which met most children's and young people's needs. The 18-week referral to treatment performance data for referral to treatment – incomplete pathway's confirmed that during the 12-month period children's 'weeks waiting' over 18 weeks was from six to 28 weeks.
- The innovative neonatal developmental support service was the first to be launched in England. The 'individualised care rooms' allowed a newborn baby to receive care and treatment in a private, family-centred setting. The rooms were designed to support a newborn baby's brain development by limiting extraneous light and noise. Parents could stay in the rooms 24 hours a day.
- Parents and staff told us that care was delivered in a variety of settings including outpatient clinics at times that generally met their needs.
- The service had developed a Barnet Hospital youth group to advise on the design and layout of the children's services.
- The supper club and coffee mornings held for parents on the neonatal unit were exemplary and the neonatal "little stars " club offered families the opportunity to learn the elements of infant massage and the opportunity to learn from each other.

Service planning and delivery to meet the needs of local people

- Services for babies and children in the trust had been developed to work in conjunction with adjacent larger tertiary children's and neonatal services in other hospitals mainly in London.

Services for children and young people

- The service had a reciprocal agreement with the children's and adolescent mental health service (CAMHS). If there was an immediate concern about a child, an urgent review would be requested within 24 hours, by referral from the child's consultant.
- Additional support was provided in the form of meal vouchers, snack boxes and access to information and associated social care support was provided to families whose child or baby received long-term health care. Parents could access free parking.
- Staff from the neonatal service told us of the success of the recently introduced developmental rooms for the families of premature babies which promoted breast feeding and provided and the provision of free meals .We were also told that the baby massage service was much appreciated by the parents of neonates.
- Care and support was provided through the neonatal outreach team to mothers, babies and their families in the community.
- Care and support for discharged children was provided through the paediatric community nursing service.
- The Barnet Youth group had advised on the design of the children's services departments within the hospital.
- The paediatric dietician we spoke with told us that a five day service was available to children's services each week. No on call service was available. A dietician visited the neonatal unit and the children's ward each day and responded to approximately 35 referrals per month.
- A senior play specialist told us there were four play staff of whom three were qualified hospital play specialists. Play services were available Monday to Friday between 8am and 5pm. The play room was open 24 hours per day with an outside play area for the summer months. Play specialists accompanied children to the anaesthetic room with a nurse to provide play and to support parents.

Access and flow

- Patient flow and bed occupancy was orientated to local demand for paediatric services from local primary care physicians and the dedicated paediatric emergency department, and the paediatric assessment units (PAUs, one of which was located at Chase Farm Hospital). The PAUs offered a service for GPs and health visitors who request a service for children requiring assessment. The children's services division also catered for the needs of the local paediatric population through the provision of outpatient clinics.
- Doctors and nurses told us that discharges were managed effectively with the assistance of the community children's nurses.
- Five nurse specialists were in post for oncology, allergy, diabetes, enuresis and epilepsy. Monthly nurse specialist meetings were held. A mother of a child with diabetes told us that she was so impressed with the organisation of the diabetes service which had arranged for a diabetic nurse specialist to visit her sons school on the Monday following discharge to liaise with the school staff .
- The paediatric community nurses we spoke with told us that they worked closely with the oncology team.
- Information provided to us in advance of our inspection indicated that the median length of stay was in line with the England average on all four indicators for both elective and non-elective admissions where children were under one year of age, and for elective admissions for those aged one to 17.
- Children scheduled for surgical interventions attended a pre-assessment clinic to help them and their families meet with the nursing team, and opportunities were provided for children and their parents or carers to ask any questions.
- There were arrangements in place for the transfer of critically ill children to specialist centres in London via external retrieval services. We were told by doctors and nurses that these arrangements worked well and policies for the transfer of patients could be accessed electronically.
- Children's services did not have access to a dedicated post-operative recovery area for children, this was shared with adults.
- Parents were encouraged to remain with their children whenever possible and were offered accommodation within the ward bays.
- Accommodation for parents within the neonatal unit was freely available.

- Parents we spoke with in the outpatient department who were waiting for appointments told us that they were normally seen in a reasonable amount of time. We did, however, see that there was some overcrowding within the outpatient department.

Meeting people's individual needs

- Translation services were available for children and their parents or carers. The doctors and nurses we interviewed were fully aware of how to organise translation services for families.
- We saw that the Wong-Baker smiley faces pain rating scales had been translated into a variety of languages including Arabic, Polish, Romanian, Somali and Turkish.
- Mothers told us that breast feeding support was very good and that there were good arrangements for expressing breast milk with good privacy arrangements.
- Parents told us when they had required additional support and teaching, such as for breast-feeding appointments with a breast-feeding nurse had taken place.
- The Starlight unit was the first UK neonatal unit to provide 10 individualised care rooms that allowed family centred developmental care where parents could stay throughout the neonatal journey. This allowed parents to learn valuable skills and knowledge while being supported by trained staff including a neonatal occupational therapist. The rooms were designed to support a newborn baby's brain development by limiting extraneous light and noise. The unit had level one UNICEF accreditation for 'baby friendly' initiative with the aim of promoting and improving breastfeeding uptake.
- The hospital school was well-equipped with computers and books. School teachers were able to liaise directly with individual children's own teachers and offer examination support to sick children.
- A parent we spoke with in the outpatient department told us they had received two appointment letters in error resulting in an unnecessary visit to the hospital.
- Parent information boards were located in the corridor of the neonatal unit and other parts of children's services.
- We saw that there were a number of poster and information leaflets for families around the various areas of children's services. We noted a range of specific leaflets for families throughout children's services. For example within the neonatal unit there were a range of specific leaflets for new mothers. Facilities were available to translate leaflets into other languages.
- We saw that the play specialists were very involved with the care of children with learning disabilities. However, there was no learning disability lead nurse.

Learning from complaints and concerns

- Staff told us that part of their complaints quality assurance process included discussions of the complaint's completed actions prior to its closure at the paediatric governance meeting.
- Staff told us that they had been encouraged to be transparent in their communications and that complaints were referred to the matrons or the Patient Advice and Liaison Service (PALS).
- Parents and visitors could raise concerns and complaints locally, through PALS or the trust complaints department. Parents we spoke with said they would feel comfortable raising concerns or complaints. Information on PALS including a contact telephone number was available for parents in the hospital information leaflet.
- We saw that the friends and family tests results were posted on the "how we are doing board".

Are services for children and young people well-led?

Good

Children's services for The Royal Free Hospital NHS Foundation Trust were led by a clinical director, a head of nursing and a divisional manager. In addition there is a neonatal matron who covered both sites and two matrons who covered the children's wards on both sites.

We rated well led as good because:

- A clear leadership structure was in place within the service at trust level and the individual management of the services at Barnet Hospital were well led.

- Service strategies, which were supported by action plans, were in place.
- Governance, risk and quality measurement processes were in place.
- Public and staff engagement processes captured feedback from both groups.
- There was evidence of ongoing innovation and improvement that had taken place within the service which meant that service provision had been focused towards the needs of the child's and the surrounding community's needs.

However;

- Some staff were not aware of the trust vision and values.

Vision and strategy for this service

- Some of the staff we spoke with told us that the chief executive had a strong presence at Barnet and that they were aware of his vison and the trust core values. It was the view of the senior nurses we interviewed that the chief executive was fully in charge and knew what was going on throughout the trust. Nurses we spoke with told us that people in the trust had confidence in the chief executive of the now colloquial "Royal 3" who had useful monthly open meetings for staff which are videoed and sent to all staff via email.
- Staff we spoke with on the neonatal unit identified that the neonatal unit vision and strategy centred on supporting the parent and baby, to promote a safe environment and to identify a parent lead. We were told that the neonatal unit was well managed but without an obvious pecking order
- We identified that there was an all-encompassing vision and strategy, which was attributed to the overall provision of children's services at the trust. This was enhanced by a pan trust lead for nursing and for neonatal medical care and encapsulated neonatal provision, acute care provision, day care, outpatients and the PAU's.
- Some staff were not aware of the trust vision and values.

Governance, risk management and quality measurement

- There were arrangements in place for governance, risk management and quality measurement associated with the care of children and infants across the trust. We found that the arrangements enabled them to measure the quality of the services they provided, as well as having appropriate governance systems in place. Doctors and other health care professionals we spoke with told us that the mortality and morbidity meetings held in children's services were an effective strategy to escalate risks where required. These meetings and the associated quality board meetings facilitated monitoring of action plans and to consider and reflect on situations when the delivery of care had not gone according to plan. These meetings allowed staff to learn from incidents and to consider and implement any actions that may have needed to be taken. Additionally these meetings considered reviews of policies, medical pathways, reviews of existing and new risks, safeguarding concerns and financial and human resource performance.
- Risks were identified and recorded on the risk register, which was monitored regularly and discussed at meetings including governance and mortality and morbidity meetings.There was also a paediatric risk newsletter to keep staff informed of incidents, risks and shared learning.

Leadership of service

- Children's services for The Royal Free Hospital NHS Foundation Trust were led by a clinical director, a head of nursing and a divisional manager. In addition there is a neonatal matron who covered both sites and two matrons who covered the children's wards on both sites.
- There was a clear leadership structure in place for children's services across the trust and at Barnet Hospital. Staff said that managers were visible and approachable.
- We were told by parents we spoke with that they had witnessed student nurses being actively supervised.
- Staff working with children on a daily basis told us that that day-to-day clinical leadership was good and that they received support from their immediate line managers. The staff we interviewed felt well supported by the senior team and they told us that they read or viewed the chief executive bulletin which kept them up to date with events throughout the trust.

- The nurses we spoke to told us how supportive the matrons of children's services were to them.
- Matrons we spoke with told us that they felt supported by the head of nursing.

Culture within the service

- A positive, patient-centred culture was demonstrated among all the teams and staff we met. Staff spoke positively about the service. However, some staff identified concerns in relation to the merger and felt that they had not been integrated properly.
- Staff described positive working relationships including those between the multidisciplinary teams involved in the delivery of children's health services.
- All staff we spoke with told us that should they need to raise a concern they felt confident and supported to do so.
- Several consultants we spoke with at Barnet Hospital told us that they had reservations about the impending closure of the paediatric assessment unit at Chase Farm and several had residual concerns about the success of the merger with the Royal Free Trust. They felt that they were not always listened to by the management at the main trust site. This was not generally shared by the nursing staff who told us that the merger was going well in some areas.
- An occupational therapist told us they had been nominated for an 'Oscar'. The outstanding contributions and rewards scheme Oscars were about celebrating the achievements of Royal Free staff and recognizing the achievements accomplished over the previous year to enhance patient care. Staff perceived these to be useful and they felt that the excellence awards are strong motivators. Nominations for these awards were designed to recognise the clear commitment that staff have to providing excellent care to their patients, by inspiring others.

Public engagement

- Public engagement with children, young people and their families was still at an early stage of development but the service had developed a Barnet young person's forum to advise on the design and layout of children's services including the children's outpatient department.

Staff engagement

- The CEO and his team ran regular staff forums to which all staff were invited to attend, and cascaded information via regular news letters or videos.
- Staff engagement had taken place through a number of forums, for example, ward meetings, via email correspondence, development and training days and at formalised meetings aimed at various staff groups such as senior nurse meetings.
- We were told that staff were concerned about the planned imminent closure of the PAU at Chase Farm hospital. Despite this the staff we spoke to in the Chase Farm PAU told us that they felt well led and the chief executive had visited PAU.

Innovation, improvement and sustainability

- The trust's vision of delivering excellent integrated care for users of children's services when and where it was needed appeared to be fully embedded within the staff culture and the nurses and doctors we spoke with were proud of the key achievements of the trust in recent years especially in the development of the developmental neonatal service and in managing the first trust merger with Chase Farm Hospital.
- The 'individualised care rooms' in the Starlight neonatal unit were an example of innovation.

End of life care

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

Information about the service

The palliative care service of the Royal Free London NHS Foundation Trust was formed in its current configuration in July 2014 with the acquisition of Barnet and Chase Farm Hospitals by the Royal Free Hospital. Each hospital previously having had a well-established palliative care team.

The Royal Free London NHS Foundation Trust and its staff recognised that provision of high quality, compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team, end of life care guidelines and an education programme.

The trust's director of nursing had overall responsibility for the end of life care service. The trust wide palliative care team ensured the service was provided across all three hospitals of the trust Barnet, Royal Free and Chase Farm. The palliative care team worked cohesively and were divided into two teams. This enabled a streamlined service to be provided due to the geographical area to be covered. One team was based at Barnet and covered both Barnet and Chase Farm Hospitals and the other team was based at the Royal Free Hospital.

Barnet hospital reported 985 deaths 2013/14 and 1175 deaths 2014/15. The palliative care team at the hospital received 879 referrals for January to December 2015. Of these 64% (566) were cancer and 36% (313) were non-cancer.

The palliative care team for Barnet Hospital was responsible for end of life care patients at both Barnet and Chase Farm sites. The team provided a service Monday to Friday 8am to 4pm. The team was made up of three palliative care consultants,a consultant nurse, a band 8a lead nurse, clinical nurse specialists (CNS) and administrative support. The palliative team delivered palliative services to all clinical areas across both hospitals and worked cohesively with all areas of the hospitals involved in the care of patients who were on the end of life care plan.

We visited a variety of wards across the hospital including Beech, Juniper, Mulberry, Palm, Quince, Walnut and the Clinical Decision Unit (CDU). We also visited the Patient Advice and Liaison (PALS) office, bereavement office, Macmillan information centre, mortuary, relative's room and hospital chapel and prayer room. We reviewed the medical records and drug charts of six patients at the end of life and seven Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records.

We spoke with 23 clinical staff and 11 other staff. We observed the care provided by medical and nursing staff on the wards. We spoke with two patients receiving end of life care and two of their relatives. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results provided for patient surveys and other performance information about the hospital and trust.

End of life care

Summary of findings

Overall we rated the end of life care service at Barnet Hospital as Good because;

- Since the formation of the new trust, the combined palliative care team had worked hard to integrate their processes. Policies and procedures were being developed to harmonise the service with defined action plans for their completion. They were a dedicated team providing holistic care for patients with palliative and end of life care needs in line with national guidance.
- The hospital provided mandatory end of life care training for staff which was attended, a current end of life care policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.
- The palliative care team was highly thought of throughout the hospital and provided support and education to clinical staff. The team worked closely with the practice educators, and link nurses, at the hospital to provide education to nurses and health care assistants. Medical education was led by the medical consultants and all team members contributed to the education of the allied healthcare professionals.
- The majority of end of life care was provided by clinical staff on the wards. The palliative care service worked as an advisory service seeing patients with specialist palliative care needs, including those at the end of life.
- Staff at the hospital provided focused care for dying and deceased patients and their relatives. Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.
- Staff in the mortuary, bereavement office, PALS and chaplaincy supported the palliative care teams and ward staff to provide dignified and compassionate care to end of life care patients and their relatives.
- Medical records and care plans were completed and contained individualised end of life care plans. Most contained discussions with families and recorded cultural assessments. The Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were all completed as per national guidance. However there were inconsistencies in the documentation in the recording of Mental Capacity Act assessments.
- There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. These referrals were seen and acted upon within 24 hours.
- The end of life care service had supportive management and visible and effective board representation. This had resulted in a well led trust wide service that had a clear vision and strategy to provide a streamlined service for end of life care patients.

End of life care

Are end of life care services safe?

Good

We rated safety for end of life care at Barnet Hospital as Good because;

- The service provided safe and effective care for patients who were recognised to be in the last 12 months of their life.
- The trust reviewed incidents relating to end of life care at the hospital with evidence of learning achieved and the resulting changes in practice that took place.
- There were robust systems and processes to ensure that a high standard of infection prevention and control was maintained. The mortuary was visibly clean. Staff in all departments could show appropriate hand hygiene and complied with the trust's policies and guidance on the use of personal protective equipment.
- The trust had a programme of end of life care mandatory training for all staff in line with recommendations by the National Care of the Dying Audit 2014. All clinical staff received training at induction and there were established e-learning modules.

Incidents

- The trust had an incident report writing policy and used an electronic incident reporting system. Permanent nursing and medical staff, porters, mortuary and administrative staff gave us examples of how they reported incidents. Staff told us the trust encouraged them to report incidents to help the whole organisation learn.
- A total of 15 incidents had been logged since October 2014 which were attributed to end of life care at Barnet Hospital. Syringe drivers were the most common occurring key theme mentioned in nine incidents. Faulty syringe drivers in two incidents and the shortage and availability of syringe drivers were the principle incident. We were told by management and clinical staff this had been rectified with the purchase of 40 additional syringe drivers and tighter control maintained by equipment services.
- Eight incidents were logged regarding the mortuary between December 2014 and June 2015. All were classed as no obvious harm. Two regarding transporting the deceased, two about communication failures, two about documentation, one regarding security and one reporting a disagreement with undertakers.
- One incident was logged by the bereavement service in December 2014 regarding the delay in the issue of a death certificate.
- We saw that incidents relevant to palliative patients were discussed in the trust wide palliative care team, speciality group meeting. If there were any recurrent themes these were addressed through changes in the education plan.
- We were also informed that there were regular clinical and business meetings within the palliative care department where clinical incidents and clinical strategies were discussed and actions identified.
- 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. When we spoke to staff they were able to describe the rationale and process of duty of candour.
- Trust wide service users and their families were told when they were affected by something that had gone wrong. The trust apologised and informed people of the actions they had taken.

Cleanliness, infection control and hygiene

- We observed that all areas of the mortuary, including the viewing area were visibly clean. There were cleaning rotas.
- We observed there was personal protective equipment (PPE) for use by staff handling deceased patients in the mortuary.
- We saw ward and departmental staff caring for patients on the end of life care plan complying with the trust's policies and guidance on the use of PPE. We observed staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.
- We saw on all wards visited that there was hand gel available at entrances and notices reminding staff and visitors to use them.

Environment and equipment

- We saw and were provided with the up to date servicing and maintenance records for all the equipment used in the mortuary.
- McKinley T34 syringe drivers were maintained and regulated by the equipment services.

Medicines

- The trust had a Medicines Management Policy. The policy ensured that medicines were prescribed, stored, administered and managed safely according to current best practice.
- There was trust wide guidance for the administration of medication using the McKinley T34 syringe driver. Syringe drivers help reduce symptoms by delivering a steady flow of injected medication continuously under the skin.
- All registered nurses and medical staff received training about the safe use of medication for an end of life care patient and prescribing anticipatory medication. The prescribing of anticipatory medication is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms. A patient discharged with anticipatory medication would allow qualified staff to attend and administer medication which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital. All patients on an end of life care plan were discharged from hospital with anticipatory medication called 'Just In Case' medication which ensured that streamlined care was maintained.
- Across the wards, we reviewed six medication charts for patients who were receiving end of life care. The charts we observed showed that appropriate medications had been prescribed as stated by National Institute for Health and Care Excellence (NICE) Quality Standards guidelines for anticipatory medication. This ensured that end of life care patients received timely and appropriate care.
- The hospital told us that in 2016 they will review the speed of access to medications for both inpatients and outpatients. They aim is that syringe drivers will be started within an hour of prescription and that access to oral medications will be reliable and responsive at all times.
- The trust's 'excellent nursing care in last days of life care bundle' contained clear guidelines for symptom management for patients at the end of their life. The guidelines were comprehensively set out and presented in an easy to follow manner. Practical guidance was provided for the use of McKinley T34 syringe drivers including set up and drug advice. We spoke with medical and nursing staff who were able to show us the guidance which was available on the intranet and in all ward areas.
- In November 2015 the hospital performed an audit of opioids in palliative care and the initiating of drug treatments. The results of this audit were to influence practice trust wide. The aim of the audit was to ensure the safe and effective prescribing of strong opioids for pain in palliative care of adults as set out in NICE guidance. The results of the audit showed that there were variable drug and dose schedules prescribed despite regular teaching sessions and guidance available on the intranet. Specialist advice was not sought in 50% of complex situations. However, where there was evidence of specialist advice, the drug and dose schedules were appropriate. Recommendations were to be presented and an action plan devised at the palliative care business meeting which was to occur after the inspection.

Records

- The mortuary manager told us that effective systems were in place to log patients into the mortuary. They explained the process and showed us the ledger record book that contained the required information. We observed that the book was appropriately completed.
- On visiting the bereavement office we saw there were systems to process death, burial and cremation certificates. An officer showed us the process and explained what the role involved.
- All palliative care records were hand written and managed in line with trust policy.
- Patients receiving care from the palliative team had their documentation updated when reviewed. This gave information around changes in patient care needs and medicines management. Frontline staff on the wards then implemented the changes required, such as applying a syringe driver or changing medication. We observed that the palliative care team provided a holistic assessment on their first visit to a patient and subsequent visits were documented in the patient's medical notes.
- We saw seven DNACPR forms and these were all completed as per national guidance.

End of life care

- Following the withdrawal of the Liverpool Care Pathway and the release of One Chance to Get it Right 2014 by the National Leadership Alliance for the Care of the Dying Person, the trust generated the 'excellent nursing care in last days of life care bundle'. This ensured that patients who were identified as dying experienced transparent and open communication and compassionate care from all health care professionals.
- Staff told us that the 'excellent nursing care in last days of life care bundle' was user friendly with helpful prompts. The guidance and prompts were beneficial for junior staff.
- The 'excellent nursing care in last days of life care bundle' gave clear guidelines that nursing staff should assess the patient at least every four hours and complete a nursing assessment every 12 hour shift. The Royal Free Hospital audited the use of syringe drivers in November 2014 which influenced practice trust wide. The audit showed four hourly checks were completed by staff 70% of the time. All six end of life care patients we saw across the wards had a syringe driver and we saw that their records were completed in a timely manner.
- Across the wards we visited we reviewed six medical records and nursing notes which contained individualised end of life care plans. All the records contained evidence of discussion with family. However, two records did not contain evidence of being assessed for the patient's psycho-spiritual care.

Safeguarding

- Each hospital had a full time safeguarding lead. There was a trust wide safeguarding strategy 2015-2018 and an integrated safeguarding committee that met every quarter and was chaired by the director of nursing. The safeguarding operational groups for adults and children reported directly to the committee.
- Safeguarding was part of mandatory training for all staff and this was monitored by managers. Trust wide data provided showed that training rates for level 1 and 2 safeguarding adults was 78% in May 2015. We were told that this figure was affected as bank staff at Chase Farm and Barnet hospitals were not required to complete mandatory training prior to the acquisition in 2014.
- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable adults. The relevant local authority and social services numbers were available for staff.

Mandatory training

- The National Care of the Dying Audit 2014 recommended that staff received mandatory training in the care of the dying. The trust had a programme of mandatory training for all staff and we saw evidence and records of this training. All staff who had direct contact with patients received training for caring for patients and their relatives at the end of life. This specifically identified the need for staff to communicate well and practice care in line with national and local best practice. This training was received at induction.
- The trust had a trust wide induction programme for permanent and temporary staff with the required mandatory and statutory training plan which involved classroom and e-learning. Education in end of life care was provided by the palliative care team. Significant contributions were also made by the chaplaincy team about spirituality/religion/faith and the bereavement team taught about care after death.
- The trust told us that mandatory and statutory training for all staff trust wide was 83%.
- Mandatory and statutory training for the palliative care team based at Barnet Hospital was 89% up to January 2016. This figure applied to 8 members of staff. Subjects included infection control, information governance, fire safety, Mental Capacity Act and Deprivation of Liberty Safeguards.
- Training for the McKinley T34 syringe drivers was mandatory for permanent nursing staff. We saw that the training records of attendance for staff were held centrally and on individual training records.
- We were shown the mandatory training that the porters received which was stored electronically on a central file. The porters and managers we spoke with told us that their mandatory training was up to date and included adult and child safeguarding, fire, infection control, manual handling and mortuary training.
- The porters told us that they had received training to support the movement of patients to the mortuary after they had died. The training included the use and access of the mortuary 24 hours a day to ensure that mortuary procedures in and out of hours were adhered to. The porters we spoke to were able to describe the process in a knowledgeable manner and were able to demonstrate that all patients were treated with dignity and respect.

End of life care

- The mortuary staff, patient affairs and bereavement officers also provided evidence that they were up to date with their mandatory training.

Assessing and responding to patient risk

- The clinical needs of patients were monitored through regular nursing, medical, therapy and pastoral care reviews.
- The officers in the bereavement office supported all bereaved families with the paperwork and processes for care after death. They ensured all General Practitioners (GPs) were notified within one working day of the death. All doctors when completing the medical certificate of cause of death completed an electronic letter to the GP.

End of life care staffing

- The palliative care team at Barnet Hospital was made up of three palliative care consultants, a consultant nurse, a band 8a lead nurse, four clinical nurse specialists (CNS) and administrative staff.
- We were told that there was a 0.4 Whole Time Equivalent (WTE) psychologist vacancy and 1.0 WTE CNS vacancy at the hospital and they were in the recruitment process. We were told that once these vacancies were filled this would enable a seven day palliative care service to be provided**.**The lead nurse actively managed the staffing daily to ensure a safe service provision.
- The Patient Advice and Liaison (PALS) office was staffed by two WTE officers and an administrator.
- A band 4 mortuary assistant was based at Barnet Hospital with two further band 5 staff who performed a dual bereavement office and mortuary assistant role. The band 7 mortuary manager was based at the Royal Free Hospital.
- There was a comprehensive handover of palliative care patients at the hospital for both Barnet and Chase Farm patients. This was held every Tuesday, Thursday and Friday morning and the palliative care multidisciplinary team meeting was held on a Wednesday afternoon.
- During our inspection we asked ward managers about their staffing levels and whether they felt adequate staff were on the wards when caring for patients on an end of life care plan. Staff on Juniper and Beech wards confirmed that retaining and recruiting staff was a main concern but they were aware of the trust's efforts to manage the situation. Ward managers we spoke with told us that sometimes staff were unable to provide adequate specific end of life care to patients due to availability of staff and workload.

Major incident awareness and training

- There was a trust wide 'emergency, preparedness, resilience and response policy' (2015) which set out a framework for ensuring that the trust had appropriate emergency arrangements which were in line with the Civil Contingencies Act 2004 statutory duties.
- Emergency planning was a mandatory training subject for all staff. An adverse weather policy was implemented to ensure there was palliative care cover in times of emergency.

Are end of life care services effective?

Good

We rated effectiveness for end of life care at Barnet Hospital as Good because;

- Alternative end of life care guidance had been developed in response to the national withdrawal of the Liverpool Care Pathway. The 'excellent nursing care in last days of life care bundle' had been generated. Patients on the bundle were prescribed appropriate medication by medical staff.
- The hospital had implemented standards as set by the National End of Life Care Strategy 2008 published by the Department of Health, the National Institute for Health and Care Excellence's (NICE) End of Life Quality Standard for Adults (QS13) and One chance to Get it Right, 2014 by the National Leadership Alliance for the Care of the Dying Person. The hospital had a regular audit programme.
- The DNACPR forms were completed for appropriate patients.
- The palliative care team provided a service Monday to Friday 9am to 5pm, with out of hours telephone support for palliative medicine provided by a consultant.
- The chapel and prayer room were accessible 24 hours 365 days of the year. The chaplaincy team provided a 24 hour on call service for all faiths via the switchboard.

End of life care

- Patients' pain, nutrition and hydration were monitored in accordance with national guidelines. The palliative care team supported and provided evidence-based advice to health and social care professionals from other wards and departments.

However;

- There were inconsistencies in the documentation in the recording of Mental Capacity Act assessments.

Evidence-based care and treatment

- The hospital had implemented NICE Quality Standards for Improving Supportive and Palliative Care for Adults with the provision of a palliative care team. Following the acquisition of the hospitals, the palliative care teams across the trust were using harmonised policies that included an updated operational policy.
- The National End of Life Care Strategy 2008 published by the Department of Health, sets out the key stages for end of life care, applicable to adults diagnosed with a life limiting condition. NICE End of Life Care Quality Standard for Adults (QS13) sets out what end of life care should look like for adults diagnosed with a life limiting condition. The 16 quality standards define best practice within this topic area. The trust was working towards being compliant with these standards and had a gap analysis and action plan with defined implementation dates.
- The Royal Free London NHS Foundation Trust had responded to the results of the National Care of the Dying Audit for Hospitals (NCDAH). Also the withdrawal of the Liverpool Care Pathway (LCP) and the publication of One Chance to Get it Right. A group was set up by the trust wide palliative care team. Its objectives were to agree a trust response to the audit, the withdrawal of the LCP and to consider how best to take forward the wider end of life care agenda. The group designed and launched the 'excellent nursing care in last days of life care bundle', achieved the action plan for the NCDAH and set up an end of life care steering group. The group was chaired by the director of nursing to oversee the provision and development of end of life care throughout the trust.
- The trust told us that they were committed to continuing to embed best practice in care of the dying patient. This was to be achieved with a comprehensive education programme, modelling of a gold standard of care by senior clinicians, monitoring performance with a regular internal audit programme and benchmarking themselves against national standards by participating in the bi-annual NCDAH audits.
- We saw that trust wide there was a regular audit programme for end of life care embedded in the hospital. This included the NCDAH 2015, NICE guidance 140 on opioid prescribing standard 13 for end of life care, response to referral times and syringe driver prescribing and monitoring. The audit start dates, anticipated completion dates and the date of presentation of results to the service business meeting had been decided and recorded.
- In November 2015 the palliative care team audited their response to referral times. The trust wide operational policy stated that urgent referrals would be seen within 24 hours and non-urgent within 48 hours. The stated standards were minimum standards. The team told us that they aimed to see the majority of urgent patients within four hours of triage and non-urgent patients within one working day. The results of the audit were to be presented to the team business meeting in February 2016. We were not shown the results.
- The early warning system used by Barnet and Chase Farm Hospital's was a cumulative system. It had six physiological parameters that were closely aligned to the National Early Warning System (NEWS). It had a three stage graded response: refer to nurse in charge, ward medical teams, Patient at Risk and Resuscitation Team (PARRT) and then ITU, dependant on severity of score.
- An audit performed by the PARRT team in 2015 reviewed patients' observation charts and notes to ascertain if a patient was triggering the early warning system in a timely manner. The results of the audit showed that all of the patients had been escalated and reviewed in a timely manner. Appropriate plans were in place and ward based staff were able to identify the triggers and describe the escalation process. The audit also showed that there were many examples of excellent recognition and anticipation of an end of life care patient. There was multidisciplinary team and patient involvement in planning further treatment with the focus on patient choice and symptom relief.

End of life care

- We saw evidence across the wards we visited that the palliative team supported and provided evidence based advice when caring for patients reaching the end of life. Guidance and instruction was given regarding complex symptom control and individualised care of the patient.
- During our visits to the wards, staff demonstrated how they were able to access end of life care information on the intranet and knew how to refer to the palliative care team.

Pain relief

- Effective pain control was an integral part of the delivery of effective end of life care and was supported by the palliative care team and the inpatient pain service.
- The 'excellent nursing care in last days of life care bundle' supported the effective management of pain in the dying patient. Guidelines included prescribing anticipatory pain relief alongside guidance for other common symptoms.
- We reviewed six patients' medical records and drug charts and saw that patients had regular assessments for pain and appropriate medication was given frequently and as required.

Nutrition and hydration

- Risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a nutritional screen assessment tool which identified patients who were at risk of poor nutrition, dehydration and who experienced swallowing difficulties. It included actions to be taken following the nutrition assessment scoring and weight recording. The six care plans we observed across the wards contained the nutritional screening assessment and showed where patients had been referred to the dietitian.
- The 'excellent nursing care in last days of life care bundle' had clear guidelines for the assessment of mouth care, hydration and nutrition. The end of life care records we observed showed that these were being completed and updated by staff.
- The personalised care plan included prompts to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.

Patient outcomes

- Trust wide there was 2319 deaths in 2013/14 and 1742 were referrals to the palliative care team. In 2014/15 2172 deaths trust wide and 1787 were referrals to the palliative care team.
- Barnet hospital reported 985 deaths 2013/14 and 1175 deaths 2014/15.
- The palliative care team at the hospital received 879 referrals for January to December 2015. Of these 64% (566) were cancer and 36% (313) were non-cancer.
- The palliative care team also received 63 referrals for Chase Farm Hospital patients January to December 2015. Of these 63% (40) were cancer and 37% (23) were non-cancer.
- The PARRT team received on average 140 referrals a month for Barnet and Chase Farm Hospital patients.
- The SHMI (summary hospital-level mortality indicator and HSMR (hospital standardised mortality ratio) for the trust were 85% and 88% respectively for the period April 2014 to March 2015.
- Comprehensive mortality reports were taken to the clinical performance committee, a non-executive chaired board committee.
- Results of the NCDAH 2014 showed that jointly Barnet and Chase Farm Hospitals achieved five of the seven organisational indicators and was worse than the England average for eight of the ten clinical indicators. The hospital was worse than the England average for access to specialist support, formal feedback processes regarding capturing bereaved relatives views of care of delivery, multidisciplinary recognition that the patient is dying, discussions with the patient and their relatives, communication, spiritual needs, review of interventions during dying phase, nutrition and hydration requirements, and review of care after death.
- The results of the national audit were acknowledged by the trust and the recommendations reflected the trust's view that they needed to completely overhaul clinical guidelines on the care of dying patients within all three hospitals. They also acknowledged a new education programme for staff was needed to support this.
- Since the audit the hospital had implemented a bereavement survey, there was multidisciplinary recognition of an end of life care patient and recording of relevant discussions in the medical notes. Also the spiritual needs were acknowledged, and patient's nutrition and hydration needs were met within the personalised care plan.

End of life care

- Trust wide the hospital had implemented a system to obtain feedback from bereaved relatives. A feedback card was enclosed in the information wallet which was given to all bereaved relatives advising them of the formal processes after death and access to bereavement support. We were told that this was a new process and the results had not been collated yet. This survey was trust wide and not specific to the palliative care team.
- The trust had an advance care planning policy which explained staff's role and the importance of healthcare professionals involving patients and their families in decisions about care and respecting decisions that had been made and documented earlier. The policy related to the information leaflet given to patients who were recognised to be end of life and gave guidance on the reason and process of advance care planning.

Competent staff

- In line with the NICE end of life care quality standards (2011) and Ambitions for Palliative and End of Life Care (2015) the trust recognised the need for a workforce skilled to provide end of life care and care after death. Also, for staff to have the ability to have honest and sensitive conversations with patients and their families.
- The palliative care team based at Barnet Hospital were all trained in specialist palliative care to at least degree level education and some were pursuing masters' level qualifications. The team leader had a post graduate qualification in education. We were told that the team were to receive psychology level 2 training.
- The palliative medicine consultants demonstrated continued professional development in line with the requirements of revalidation.
- All junior medical staff working at the trust received at least two teaching sessions a year from palliative care consultants. These covered symptom management, decision making and care of the dying. Additional sessions were provided on ethics and communication skills pertinent to this area.
- Education in palliative and end of life care for staff working in the trust included symptom control, care of the dying patient, communication skills (both advanced and Sage and Thyme), ethical issues at the end of life and leadership. End of life care education was provided by members of the trust wide palliative care team.
- The palliative care team at Barnet Hospital provided teaching for all hospital staff on 'the priorities for care of the dying person'. This consisted of 12 one hour sessions between September 2015 and February 2016. This was well attended.
- The hospital told us that trust wide the appraisal rate was 71%. The appraisal rate for the palliative care team based at the Barnet Hospital was 75%.
- We saw evidence that nursing staff, mortuary staff, porters, patient affairs and bereavement officers participated in annual appraisals and had personal development plans.

Multidisciplinary working

- The Royal Free London NHS Foundation Trust and two local hospices' were all members of the organisations PallE8, the palliative care network for North Central and North East London.
- The hospital told us that the majority of patients in the trust's palliative care service were in the catchment area for the local hospices. In addition, some patients lived in the catchment area for other hospices in Hertfordshire. All of the medical consultants based at Barnet Hospital had joint contracts with a local hospice.
- The hospital palliative care team had formed close and mutually helpful working relationships with the clinical teams in the local hospices. The lead nurses for the hospital team and the hospices met regularly. This meant they could support each other and discuss cross organisational operational issues.
- Members of the palliative care team were members of local end of life care steering groups for each borough that covered the local hospices. The steering group enabled cross organisational discussion of the end of life care strategy for each area.
- Weekly multidisciplinary meetings were held at the hospital on Wednesday afternoons to discuss Barnet and Chase Farm patients. Doctors, nurses and members of the extended team were present. The meeting covered all aspects of patient's medical and palliative care needs. The outcomes of the meeting were recorded and shared with the extended team. We saw that the team administrator coordinated the meetings ensuring an accurate list was kept of patients discussed and a record of attendance.

End of life care

- The palliative care team had a close working relationship with the PARRT team around the work of the deteriorating patient. This meant that there was joint leadership and ownership around significant conversations, especially setting ceilings of treatment.
- The palliative care clinical nurse specialists were allocated to wards where end of life care link nurses had been developed. This enabled the team to deliver localised training as needed which depended on local requirements. For example new staff, incidents or complaints.
- The hospital supported palliative medicine registrars in their training programme from a London university. The director of medical education at Barnet Hospital was a palliative medicine consultant and ensured that all post registration medical training programmes delivered within the trust contained appropriate end of life care training as stipulated by their curricula. This had led to the development of multi professional communication skills training to all junior doctors within the trust alongside other healthcare professionals.
- We saw a letter from a medical student who contacted the team and said "this has been one of my favourite placements at medical school. Thank you for making me feel like part of the team and letting me get involved. You guys are the best example of team work and a properly functioning multidisciplinary team I've seen in the six years at medical school".
- The palliative care team attended matron meetings trust wide to represent end of life care and highlight concerns and areas of good practice.
- We saw the palliative care team handover where all patients on the caseload were reviewed. Each patient was allocated a clinical nurse specialist (CNS) and this was defined with the use of colour coding. If a CNS was unavailable the caseload was divided between remaining nurses. The handover was a well-managed business like session with clear priorities and work plans agreed.

Seven-day services

- The palliative care team provided a service Monday to Friday 8am to 4pm for both Barnet and Chase Farm Hospitals. The team told us that a business case had been secured to provide a seven day service and this would be implemented once posts were recruited. There was 24 hour consultant telephone advice.
- The mortuary was staffed 8am to 4pm Monday to Friday. Within these hours collections were possible from 8.30am until 3.30pm and 30 minute viewing appointments were available to families between 10am and 3pm. Out of hours arrangements meant exceptional requests could be met for both collections and viewings outside of normal hours.
- The chapel, Muslim prayer room and Jewish Shabbat room were accessible 24 hours a day every day of the year. The chaplaincy team provided 24 hour on call service and were contactable via the switchboard.
- The Patient Advice and Liaison (PALS) office was open Monday to Friday 10am to 4pm. The office also covered enquiries from Chase Farm Hospital.
- The bereavement office at the hospital also covered enquiries from Chase Farm Hospital and was open Monday to Friday 9am to 4pm.
- The Macmillan office was open Monday to Friday 10am to 4pm.

Access to information

- NICE QS13 guidance states: "Provider organisations should ensure that patients and carers have easy access to a range of high quality information materials about cancer and cancer services".
- The hospital had a Macmillan cancer information and support centre where patients, their family and friends could ask questions and talk through their concerns with a cancer specialist.
- The 'excellent nursing care in last days of life care bundle' contained a leaflet for patients and their relatives to explain the end of life care plan, facilities and contact details. They were provided with the leaflet when their relative was started on the bundle.
- The hospital provided a trust wide leaflet 'Planning your discharge booklet: information for patients, relatives and carers'". The booklet was designed to help the hospital plan a patient's discharge. It explained the different services a patient may need and arrangements that can be made to support them when they leave. It also contained a list of useful telephone numbers.
- A person collecting a death certificate from the bereavement office was provided with a trust wide information wallet. This contained contact details for bereavement support, hospital contact details and a feedback card.

End of life care

- The chaplaincy team provided a leaflet which explained its services, contact details and special events. Details were advertised on the chaplaincy centre notice boards and available on the hospital's web page.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical staff we spoke with understood the DNACPR decision making process and described decisions with patients and families. They told us they provided clear explanations to ensure that the decision making was understood. There was a trust wide guideline for DNACPR.
- While visiting ward areas we checked medical records and we viewed seven DNACPR forms. We saw that all decisions were recorded on a standard form, signed by an appropriately senior clinician. All the forms were kept in the front of the patients' notes and had evidence that there had been discussion with relatives. All seven forms had been counter signed by a senior health professional.
- An audit performed by the Patient at Risk and Resuscitation Team (PARRT) in December 2015 looked at trust wide decisions for the use of DNACPR. The audit found that the DNACPR decisions were made based on clinical considerations. The audit observed that DNACPR discussions were well documented, especially by the respiratory teams.
- We were told that DNACPR remains a high priority in teaching. Focus remains on the documentation of the communication of the decisions with the patient and their relatives.
- The trust had a consent policy which was based on the model developed by the Department of Health. The policy included the process for consent, documentation, responsibilities for the consent process, consent training and use of information leaflets to describe the risks and benefits. The policy also included consent for advanced decisions, guidance for lasting power of attorneys and mental capacity.
- There was a trust wide Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS) Policy 2014.
- Two of the DNACPR forms we observed had recorded that the patient did not have mental capacity. However we did not observe documentation of the Mental Capacity Act assessment in the medical notes.
- We did not observe any DoLS assessments. However, staff explained to us the process and demonstrated a good understanding of completion of DoLS for patients if they had been assessed as lacking capacity to give consent.

Are end of life care services caring?

Good

We rated caring for end of life care at Barnet Hospital as Good because;

- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life. There was collaborative working across the teams to provide exceptional care for end of life care patients.
- We observed compassionate and caring staff that provided dignified care to patients who were at the end of their lives.
- Patients and relatives were complimentary about the care they had received.
- Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support and patience from staff.
- Emotional support was provided by the hospital. Staff knew who to signpost relatives to for bereavement care. There was an on call service with access to chaplaincy staff and other multi faith leaders who supported families in times of loss and grief.

Compassionate care

- Staff on all wards we visited said that end of life care was a vital part of their role and they enjoyed the relationships they formed with patients and their relatives.
- A relative of a patient on Juniper ward told us that the nursing staff were "wonderful".
- During our inspection we observed end of life care that was sensitive and caring by all staff. The palliative care team provided the inspectors with a sample of 10 cards and letters thanking the team for their support and care. Comments included "thank you for your support during

my stay in hospital", "thank you for your support, understanding and kindness" and "the team were on the case to ensure that dad was so well cared for in his final days".
- Trust wide the hospital received four responses for the mortuary and bereavement service survey for the period October 2015 to December 2015. All responses were positive except one response stated that they felt they were not dealt with in a timely and sympathetic manner and was not given enough time.
- Positive comments on the survey included "the bereavement officer was very sympathetic and also very helpful with regard to registering the death. Thank you for your kindness".
- Quince ward told us about an incident where exceptional care was provided for an end of life care patient. The cohesive and collaborative working between the palliative team, district nurses, ward staff, equipment and care services. A dying patient wished to go home and owing to joint multidisciplinary working this was achieved within four hours. Staff told us it was "an amazing experience to witness".
- Juniper ward showed us the thank you cards and letters they had received from relatives. One had included a cheque for a large sum of money which had been collected at the funeral of the patient.

Understanding and involvement of patients and those close to them

- We spoke with two patients and two of their relatives. They told us staff providing end of life care were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. They felt they had time to ask questions and that their questions were answered in a way they could understand.
- We observed staff introducing themselves to patients and their relatives.
- Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting with mouth care and personal care.

Emotional support

- Staff provided emotional support for end of life care patients. We observed on the wards occasions when this occurred.
- Bereavement support was not specifically provided by the hospital. Relatives were signposted to the relevant agencies that could support them. A relative on Juniper ward told us they had been provided with information on who to contact if they required emotional support.
- All GPs were informed within one working day of a patient's death so they could provide appropriate community centred bereavement support if required.
- The chaplaincy service offered access to multi faith worship 24 hours a day. There was an on call service with access to chaplaincy staff and other multi faith leaders. The chapel was a space for patients and families to have a quiet time.

Are end of life care services responsive?

Good

We rated the responsiveness of end of life care service at Barnet Hospital as Good because;

- The palliative care team was embedded in all clinical areas of the hospital. They were professional, responsive and supportive to patients, relatives and other members of the multidisciplinary team. This was demonstrated with their specialised advice and knowledge.
- The palliative care team responded promptly to referrals to assess patients and plan care. The team achieved face to face assessments within 24 hours for all urgent referrals and within 48 hours for non-urgent.
- The mortuary viewing area was visibly clean and appropriate for relatives.
- The chapel accommodated all faiths as well as those with no faith. Staff respected the individual cultural, religious and spiritual needs of patients. The palliative care team identified the cultural, religious and spiritual needs of patients and this was recorded as part of the holistic assessment, and supported by the chaplaincy team.
- The palliative care team was involved with all discharges for end of life care patients. The response time for discharge depended on the patients preferred place of care and what area the patient lived in.

However;

- The hospital did not collect data regarding patients dying in their preferred place of death. The hospital

acknowledged that they did not have a clear rapid discharge at end of life protocol or strategy as expected by national guidelines. They were reviewing their collection tools to correct this.

Service planning and delivery to meet the needs of local people

- During the inspection we observed that the palliative care team was embedded in all clinical areas of the hospital. Staff on the wards told us that the team was professional, responsive and supportive with specialised advice and knowledge. Where a patient was referred to the team they were prompt in responding, assessing the patient and planning care and other required referrals, for example, therapists. Staff on the wards confirmed that the referral criteria was clear and patients were seen within 24 hours if not sooner.
- End of life care link nurses on the wards had organised an anticipatory box that contained the necessary equipment for setting up a syringe driver. This ensured streamlined care could be given and there was not a delay in controlling symptoms for an end of life care patient. The box did not contain the syringe driver but these could be obtained from the equipment services with ease.
- We observed across the wards we visited that staff supported relatives to stay with patients when it was thought that the person may die within the next few days or hours. A relative on Juniper ward told us they had been encouraged to stay overnight by the ward staff. We were told and observed that when a patient was recognised to be in the dying phase all wards would offer patients and their families side rooms dependant on availability and suitability.
- The hospital had provided concessions for visitors of patients who were end of life. Parking permits were provided to assist with the cost of parking.
- The mortuary had a viewing suite where families could visit their relatives. They were escorted by the mortuary attendant who would stay with the relatives in the waiting area during the viewing for as long as they required.
- The bereavement office advised relatives on the process around the death of a patient. The officer issued death, burial and cremation certificates and arranged viewing of the deceased with the mortuary.
- The bereavement officers told us that they aimed to issue the death certificate on the day of death but were unable to provide any data to confirm this. They also told us that there were clear systems in place to support faiths that required a funeral within 24 hours.
- Guidance and support was offered immediately after death from the bereavement office. Contact numbers were provided to relatives within a trust wide information wallet. The staff in the bereavement office told us they were aware of whom to signpost relatives to if they required additional support.
- The Patient Advice and Liaison (PALS) office was a spacious office located off the main corridor and contained a separate seating area to accommodate confidential and private conversations.
- The hospital acknowledged that patients who were dying and those at the end of life may require rapid discharge home. The hospital told us that their aim for a dying patient was to discharge them within one working day. The aim for a patient at the end of life was to discharge them within 24-72 hours.
- The care needs of end of life care patients can be complex and likely to be provided by multiple provider services. The majority of patients were entitled to provision of care funded by continuing healthcare. Most end of life care patients discharged from the hospital were discharged to the five main boroughs and a few to many others. All of the boroughs had varying protocols for approving and providing care and there was wide variation in the speed of both.
- The hospital told us that they were aware of the varying practices of discharge protocols across the hospital and the trust. Staff outside of the palliative care team had poor knowledge of the discharge procedures for patients who were at the end of life.
- The hospital was unable to provide data for patients dying in their preferred place of death. The hospital acknowledged that they did not have clear rapid discharge at end of life protocols and strategies as expected by national guidelines. They were reviewing their collection tools to correct this. A proposal has been accepted for a work stream that would look at the discharge of patients specifically focused on the end of life and dying patient.

Meeting people's individual needs

- The hospital told us that there was a trust wide initiative to review their facilities for families of dying patients,

ensuring that the facilities were fit for purpose and that there was clear information for families/carers as to what was available for them to use. They made 'care packs' available to families who wished to stay overnight with dying relatives.

- The hospital ensured that dying patients were moved to side rooms, when they were available and not needed for infection control purposes. This was enshrined in policy to match current practice.
- Facilities for relatives provided by the hospital included a garden room. This was a restful place for family members, friends or carers of patients with a life threatening illness. The room was the winner of the Barnet and Chase Farm Hospital NHS Trust End of Life Care award winner 2011. The room was visibly clean, a bright spacious area and had access to the garden. The room contained a seating area, drink making facilities and children's toys. Access was via a key code which was obtained from the palliative team and main reception.
- The garden room had a comment book for user's feedback. Comments included "it was a welcome relief to have somewhere to rest at a time of great sadness", "a welcome space that provided comfort through a difficult time", "thank you for making the difference for us" and "whoever came up with the concept and designed it will be held in gratitude by many people looking for some respite".
- The mortuary had a viewing suite which was divided into a waiting and viewing room. The suite was visibly clean and provided facilities for relatives such as seating, tissues and information booklets about bereavement. The suite was neutral without religious symbols which allowed the suite to accommodate all religions.
- The mortuary was able to facilitate the transportation and storage of bariatric patients. Additionally they had separate baskets for the transportation of babies.
- The hospital ensured that the faith needs of the community were met. The chaplaincy team offered spiritual, religious or pastoral support to people of all faiths and beliefs, religious and non-religious. The chaplaincy team was assisted by a group of volunteer visitors. They were able to contact community faith leaders who represented the major world religions and the Humanist Association.
- Relatives of end of life care patients told us that they had been offered chaplaincy support and a member of the team had visited them promptly.
- The hospital chapel was multi faith. A Christian service was provided weekly on Wednesdays and Sundays and Muslim services were held on Fridays. Jewish festival celebrations were also held in the chapel.
- The hospital had a Muslim prayer room with separate washing facilities and Jewish Shabbat room which met the needs of the local community.
- We observed in four of the six care plans and medical notes that staff respected the cultural, religious and spiritual needs of patients. This was part of the initial holistic assessment and was supported by the chaplaincy team.
- The hospital had access to translation services via telephone or could be booked through a centralised booking system.
- Patients living with learning disabilities or dementia were supported by the hospital. A blue butterfly flagging system on the notes identified the patients who required extra assistance. Patients living with learning disabilities were also issued with passports which recorded their individual needs.

Access and flow

- The hospital told us that trust wide they do not have a process for identifying patients on an end of life care plan on admission. Discussions with primary care services, particularly GP's, have resulted in the plan to use an electronic system that can be used across all systems. The trust told us they plan to have this within the next three years. Additionally the trust was working to introduce a paper free notes system. They told us this will mean the patients who are thought likely to be end of life care will trigger appropriate management and will be flagged. The trust was working with the project team to build a pilot module which included the 'excellent nursing care in the last days of life care bundle', and the questions to trigger its use.
- The trust wide 'Patient at risk internal and external transfer guideline' 2013 advised on the transfer of deteriorating patients who were recognised as end of life. Staff were advised that the appropriate transfer to the patient's preferred place of discharge relied on good communication and a robust management plan being in place.
- The trust wide patient safety programme included the deteriorating patient and work stream progress report November 2015.

End of life care

- The trust's policy for the administration of medication using the McKinley T34 syringe driver had clear guidelines for discharge planning for a patient being discharged home with a syringe driver. At the Royal Free Hospital the patient and/or the carer were provided with a pre stamped and addressed padded envelope. This innovative system ensured the safe return of the syringe driver once community services had replaced with their own. We were told that there were plans to shortly introduce this system at Barnet Hospital.
- The trust told us that rapid discharge protocols had not yet been harmonised. The work stream to develop harmonised protocols with the standard that dying patients should be discharged to their preferred place of care within 24 hours had started and would be completed in 2016. We were told that one of the aims of the discharge at the end of life work stream was to develop robust data collection systems that ensured that they followed and responded to the data appropriately in the future.
- In anticipation of this, an audit of fast track continuing health care funded discharges was carried out for a five week period in November to December 2015. Out of the 159 patients assessed within this period 24 (10%) patients were fast tracked and these patients were deemed to have a prognosis of less than six weeks. The audit showed that use of fast track funding sometimes delayed the discharge of patients which was caused by where the patient lived. Applications for one clinical commissioning group (CCG) averaged 3.3 days for time from application to funding being granted and average 4.5 days to discharge. Another CCG granted funding on average 1.5 days and discharge average 3.2 days. A third CCG granted funding average 1.75 days and discharge average 3.3 days. In comparison the local boroughs for The Royal Free Hospital had a response time of approving continuing care applications of 0-1 day and the provision of care within 0-4 days.

Learning from complaints and concerns

- The trust's chief executive had overall responsibility for the trust's complaints procedure. However, the role of executive lead for end of life care complaints in the trust was delegated to the director of nursing and there was regular dialogue between the two about complaints received. A non-executive director chaired the patient and staff experience committee where complaints and PALS reports were discussed quarterly. Corporately, the head of complaints and PALS had responsibility for the day to day running of complaints and were supported by a central complaints administrative team.
- The central complaints team oversaw the registration and administration surrounding complaints and the divisional complaints managers led on the investigations for the complaints involving the specialities within their division.
- Patient information that advised patients how to make a complaint or raise a concern with PALS was available on the trust website. There was an easy to read leaflet 'comments, concerns and complaints' which was available throughout the trust and was available in other languages upon request. A poster 'Have you got a concern or complaint and don't know where to turn' was displayed throughout the hospital.
- The end of life care steering group was responsible for monitoring complaints, incidents and user surveys for learning to be shared. Data provided by the hospital informed us that trust wide there had been five complaints relevant to end of life care reported during the period December 2014 to November 2015. We saw that these had all been actioned appropriately and in a timely manner.
- Staff on the wards we visited explained to us the process should a query or concern be raised. The person would be directed to the PALS office if the query could not be resolved at ward level. The PALS officer explained to us they would liaise with the ward, nursing staff or consultant as appropriate and all efforts were then made to resolve issues as quickly as possible for patients and their relatives.
- During our visit we observed the PALS officer manage enquiries and these were all processed in a professional and efficient manner.

Are end of life care services well-led?

Good

Leadership of the end of life care service was trust wide. There was a non-executive director, executive director and a clinical lead. The trust wide medical director had overall responsibility for the palliative care service.

End of life care

The palliative care team based at the Barnet Hospital cared for inpatients at Barnet and Chase Farm Hospitals. The team was led by three consultants, a nurse consultant and a lead nurse.

We rated leadership for end of life care at Barnet Hospital as Good because;

- The end of life care service had trust wide board representation. The leadership of the service was made up of a non-executive director, director of nursing (who was the executive director for end of life care) and a clinical lead
- The palliative care team had a vision to ensure that end of life care was consistent with a trust wide approach. This was to be delivered in a timely, sensitively, spiritually and culturally aware manner, with appropriate patient and relatives focused care of the dying and deceased patients..
- We saw that the trust wide end of life care three year strategy was underpinned by a clear action plan. The vision, values and strategy were being developed in line with all who were involved in the end of life care steering group.
- The trust culture encouraged candour, openness and honesty.
- The end of life care service had a risk register, governance meetings and a strategy and steering group. The hospital and trust were committed to delivering excellent end of life care for all patients. The leadership of the hospital and the team working within the palliative care team delivered care of a high standard and were proud of the service they provided.

Vision and strategy for this service

- The aim of the trust wide palliative care service was to continue to provide a high standard of specialist palliative care to patients. We were told that in 2016 there will be a review of staffing across the service in the context of work load and planned future developments. The London Palliative Care mapping data from PallE8 and London Cancer Alliance will allow them to benchmark their service against similar services across the capital.
- The trust aimed to build a team which provided excellent clinical care as well as being a learning team that provided and encouraged training to non-palliative care colleagues. It contributed robustly to research and policy development and was innovative in palliative and end of life care.
- The trust wide palliative care service told us that they were proud of the higher than national average proportion of referrals of patients with a non-cancer diagnosis. They will continue to build on work previously done with the renal, liver and frailty teams to develop joint working clinics, wards and multidisciplinary teams. In 2016 they aim to start discussions with leads for end stage cardiac and respiratory disease and look at ways of developing shared care for appropriate patients. They told us they would develop this service for these patients over 2017/18.
- The trust wide palliative care service told us that over the next three years they aim to expand the education programme, particularly the training of senior clinical and education staff who will roll out training to other staff. They aim to work with colleagues to embed training in palliative and end of life care throughout undergraduate and post graduate training as well as continuous professional development. They told us that by the end of February 2016 they will have in conjunction with the end of life care steering group mapped education in palliative and end of life care throughout the trust. By October 2016 they will have a plan to expand educators in end of life care to senior members of the clinical staff in all appropriate teams.
- The vision of the service was to streamline the discharge process by educating ward staff and ensuring adequate support services in the community. This would enable patients to return home in a timely manner.
- The leadership of the end of life care service recognised that they needed to identify the dying patient earlier and keep end of life care as the focus.
- The head of the mortuary and bereavement team told us the vision was for a trust wide single team streamlined service that would cover all three hospitals. At the time of inspection a consultation was in process that would ensure that both mortuary and bereavement offices would be operated by two dedicated members of staff in each office.

Governance, risk management and quality measurement

End of life care

- The end of life care steering group was established in 2015 and was responsible for the overall monitoring of the provision of end of life care across the trust. This was a multi professional group that was accountable to trust staff and the patient experience group. We were told that the group will produce an annual report.
- Trust wide there was a palliative care leadership meeting which met bi-monthly. The purpose of the meeting was to lead the provision and development of specialist palliative care in line with the trust's strategic direction, professional direction and centrally driven initiatives. Its objective was to agree and develop service design to meet the changing needs of patients.
- There was a trust wide palliative care service business meeting which was held three times a year. Membership was all staff working in the palliative care service. The role of the meeting was to provide a forum for the service to discuss issues which affected the service as a whole and to make decisions regarding them.
- The hospital had a bi-monthly palliative care team business meeting where all members of staff working in the palliative care service including chaplaincy discussed the day to day running of the palliative care service. This included the monitoring of all aspects of clinical governance including the risk register and audits.
- We saw the end of life care risk register. This had an action plan, risk levels and review dates documented. At the time of inspection the register contained three risks relevant to Barnet and Chase Farm Hospitals. The risks identified had an action plan, level of risk and review dates.
- One identified risk related to the identification of patients who may be end of life care as opposed to patients who are in the last days of life. This ongoing risk had been improved with a comprehensive education programme and guidance provided in the 'excellent nursing care in last days of life care bundle'.
- The second risk identified that there was no psychological level 3 support for end of life care patients. The palliative team were to receive level 2 training and had developed links with level 4 psychiatric liaison services. A business case had also been approved for a 0.4 WTE clinical psychologist post.
- The final risk identified that there was not an out of hours and weekend palliative service which had led to poor patient care and complaints. A business case had been implemented for additional staff to provide a seven day service.

Leadership of service

- We saw that the trust was committed to delivering excellent end of life care for all patients. Since the formation of the trust the service had a named board lead trust wide and a clinical lead. The executive director with overall responsibility for the service was the director of nursing.
- Trust wide leadership for the palliative care service consisted of a medical director who had overall responsibility. There were three divisional directors: director of nursing, director of operations and a divisional medical director. The divisional medical director was responsible for a clinical director and a palliative care service line lead, who was the clinical lead for end of life care.
- The director of nursing chaired the end of life care steering group which reported to the patient experience committee. The patient experience committee was chaired by a non-executive director who was also the non-executive director for end of life care. The patient experience committee reported to the full trust board.
- The palliative care leadership and clinical team were of a high standard and this was confirmed by all staff we spoke with.
- The palliative care leadership told us they were proud of the palliative care team who worked very hard to perform exceptional care for end of life care patients. They were also proud of the professionalism and attitude of staff adjusting to the transition when the hospital was acquisitioned with Royal Free Hospital.

Culture within the service

- We were told by staff and the senior team that the trust culture encouraged candour, openness and honesty.
- Staff told us they were positive about the amalgamation of the hospitals and felt confident about the future. They were aware of the changes and acknowledged that it was a slow process.

Public engagement

- The hospital performed a bi-annual audit that surveyed the patient experience of palliative care for patients at

Royal Free and Barnet hospitals. The last audit was over a three month period in 2015. The survey consisted of 12 questions with an additional four questions for carers. The Royal Free Hospital gave out 41 surveys and 12 were returned. Barnet hospital gave out 30 surveys and four were returned. The overall response rate was 22.5% for the service.

- The palliative care team acknowledged that although overall the survey achieved some positive feedback it was too a small a sample from which to draw conclusions. They told us that consideration needed to be given to future audits on the best way to capture patients' experiences of their service.
- A bereavement survey was started at the end of 2015 which would enable the trust to capture feedback from bereaved relatives. Results of this survey would be fed back to wards and services.
- At the time of inspection the trust did not have a working end of life care patient satisfaction survey. We were told that this was due to start in February 2016 and completed in March 2016. The results of this would be presented to the service business meeting in June 2016 and an action plan devised.

Staff engagement

- Staff told us that they were actively encouraged to express their views which could help to develop services.
- The palliative care team told us they were actively encouraged to report any concerns regarding wards that may affect the care of an end of life care patient. For example, staff shortages that could affect the care of end of life care patients and identified training issues.

Innovation, improvement and sustainability

- The trust told us that in May 2015 the palliative care team launched the 'excellent nursing care in last days of life care bundle'. This was developed with other local acute trusts. It consisted of a nursing care plan; a medical plan that guides individualised care planning and the conversations to have with the patient and their relatives; guidelines for the practical management of the patient; and a patient information leaflet.
- The trust told us that they were currently going through a quality improvement plan (QIP) cycle for a lanyard guideline for anticipatory prescribing at the end of life for junior doctors. Previous results of the National Care of the Dying Audit for Hospitals and staff survey identified that the junior doctors did not feel confident in prescribing at the end of life. In addition to the new longer guidelines a lanyard was designed that was a quick reference guideline, which was being trialled.
- The trust told us that a joint working group commenced in October 2015, looking at recognising the deteriorating patient and acting on their needs appropriately. We were told they were building a 'recognising the patient at the end of life' stream into this work. This would be an innovative way to approach the difficult task of recognising the end of life patient and piloting the tools needed (such as advance care planning protocols).
- In 2014 the palliative care teams on all sites were nominated for the 'team of the year' award in the Royal Free London NHS Foundation Trust Oscars 2014.

Outpatients and diagnostic imaging

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

Information about the service

Barnet Hospital offers outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up are required. The hospital had medical and surgical specialty clinics, as well as paediatric or obstetric clinics. There were 256,648 outpatient attendances at the hospital in the last year.

The diagnostic imaging department carries out routine x-rays, magnetic-resonance imaging (MRI), computerised tomography (CT), mammography and ultrasound. On average 16,973 patients attended the diagnostic imaging departments each month.

During the inspection, we spoke with 67 members of staff, which included managers, nurses, administrative staff and allied health professionals. We spoke with 10 patients and their relatives.

We visited outpatient areas, the booking centre and areas of the diagnostic imaging department.

Summary of findings

Overall we rated outpatients and diagnostic imaging as Good because;

The areas we visited were clean and tidy. Staff on the whole demonstrated good infection control practices.

Staff reported incidents and there were good systems of incident feedback to staff and to governance committees.

Records management was good and over a 12 month period almost 100% of complete medical records were available for clinics.

The outpatient and radiology departments followed best practise guidelines and there were regular audits taking place to maintain quality.

Staff contributed positively to patient care and worked hard to deliver improvements in their departments.

Staff felt supported by their managers and stated their managers were visible and provided clear leadership.

However;

The trust had consistently not met the referral to treatment time standard or England average since April 2015.

There had been a deterioration in the 62 cancer wait times compared with the national standard.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as Good because;

- The areas we visited were clean and tidy. Staff on the whole demonstrated good infection control practices.
- Staff reported incidents and there were good systems of incident feedback to staff and to governance committees.
- Records management was good and over a 12 month period almost 100% of complete medical records were available for clinics.
- Medicines management was good on the whole, but there was no system of monitoring how many prescriptions had been issued.

Incidents

- Staff reported incidents using an electronic reporting system. Staff received feedback automatically from this system via their trust email accounts. Staff gave us examples of incidents they had reported. Clinic overruns were also reported as incidents, which allowed service managers to monitor performance.
- Outpatient staff discussed incidents at communication meetings each morning. Senior staff reviewed information about reported incidents at the governance meetings. Managers passed on any lessons learned at governance meetings back to their teams.
- In the last calendar year, the radiology department reported 3 incidents to the Care Quality Commission in line with ionising radiation (medical exposure) regulations (IR(ME)R 2000). Staff dealt with the incidents in an appropriate manner and gave patients an explanation of what had happened.

Cleanliness, infection control and hygiene

- Overall, we found that the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (2015) was complied with in outpatient and diagnostic imaging services. There were systems in place to reduce the risk and spread of infection.
- Staff participated in infection control training as part of their mandatory training. 100% of staff had attended training in the last year which was greater than the target score of 95%.
- All areas we visited were tidy, clean and uncluttered. Daily cleaning checklists were on display in each clinic rooms we entered. All checklists we saw were legibly completed and indicated rooms were cleaned at least daily. Domestic cleaning was carried out by an external cleaning company. The outpatients' sister did a walk round with the cleaning supervisor each week.
- Equipment was labelled with green 'I am clean' stickers which indicated equipment was clean and ready for use.
- Disposable curtains hung around examination beds. They were clean, free of dust, and labelled and dated. The dates were within six months of the inspection.
- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health and Health and Safety at work regulations
- We saw sharps bins available in treatment areas. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) d. which requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. The sharps bins we examined had labels affixed showing which member of staff had prepared the bin.
- Hand gel was available at all outpatient waiting areas. There was a hand washing basin in every room we saw and guidance on the five steps to hand hygiene displayed above soap dispensers. This was in line with World Health Organisation advice.
- The hand hygiene audit score for the last month was 100%, which was greater than the target score of 87%.
- Personal protective equipment was available in a variety of sizes in all areas we visited.
- The endoscopes used in the ear, nose and throat (ENT) clinics were cleaned between each use with a triple cleaning system. At each stage of cleaning, a label was affixed into a record book, demonstrating staff were following the correct procedure. The records showed each time an endoscope was clean with the three stages completed. This process was audited and we saw copies of these audits which indicated compliance with the cleaning process.
- In the diagnostic imaging department we saw cleaning checklists in rooms were complete.

- If an infectious patient requires an examination, they were booked on the end of the list and the room was deep cleaned afterwards, which is line with best practice.

Environment and equipment

- The outpatient department had separate clinic areas, with dedicated waiting areas for each clinic. Seating was made of wipe clean fabric with some higher chairs available. Waiting areas suitable for children had a good selection of toys available.
- An environmental audit of the outpatient department in August 2015 scored on average 92%, which was above the target score of 85%.
- The breast clinic and mammography waiting rooms were small and cramped.
- A consulting room in the breast clinic had a single alarm system for medical emergencies and safety. The alarm button was situated by the examination couch. This was not easily accessible to staff sitting at the desk. A patient chair was situated between the desk and the door. This is not in line with Hospital Building Note (HBN12) 5.88, which recommends staff call points should be provided in all spaces where staff consult, examine and treat patients.
- We saw stickers on equipment which indicated it had been serviced recently.
- The resuscitation trolleys in outpatients and diagnostic imaging were checked by members of staff. All trolleys had both adult and paediatric equipment. We saw regular checks were occurring.
- An x-ray room was located within the fracture clinic providing easy access for patients. This was in line with HBN 12 (3.6b) which recommends that an orthopaedic clinic should be conveniently located to an imaging room.
- In clinic two there was no separate area for physical measurements to be taken. Patients had their weight and had blood pressure measurements performed in the corridor. This was not in line with HBN 12 (4.18) which recommends a space for physical measures be provided so this can be done in privacy.

Medicines

- Doctors' hand wrote hospital prescriptions that could only be dispensed in the hospital pharmacy. Each prescription had a serial number on it and a scan of the prescription was stored in the patients' electronic medical record. A registered nurse gave a pad to each doctor at the start of clinic who kept the pad in an unlocked clinic room. The pads were stored in a locked room at the end of clinic. No record was kept of how many prescriptions were issued each day. This is not in line with NHS Protect security of prescription forms guidance (2013).
- We saw medicines kept in outpatients were stored in a locked cupboard and a registered health professional held the keys. This was in line with standards for medicines management.
- Medicines requiring refrigeration were stored in locked fridges. We saw the temperature of medicine fridges was monitored regularly and the fridge temperature remained within range. Individual thermometers provided additional checks of the temperature of the fridges.
- Patient group directives (PGD's) provide a legal framework that allows the supply and/or administration of a specified medicine, by a named, authorised, registered health professional. We saw up to date PGD's in the outpatient department.

Records

- In the last year the medical records department pulled 174,465 for outpatient clinics. On average 100% of full medical records were available for clinics last year.
- We saw medical records stored in unlocked trolleys outside clinic rooms and on a consulting room desk with the door open. This did not give assurance that records were being stored securely.

Safeguarding

- 100% of nursing staff had attended level one and two vulnerable adult safeguarding training and level one and two children's' safeguarding training. 81% of additional clinical staff had attended level one and two vulnerable adult safeguarding training.

Mandatory training

- 91% of staff had completed mandatory training in the last year, which was lower than the trust target of 95%.

Assessing and responding to patient risk

- The booking centre booked all outpatient appointments. They had good processes and practices

in place to ensure patients could not be lost in the system. Paper referrals received into centre were scanned onto a computer system. The referral was entered onto the administrative system the same day.

- The referral to treatment (RTT) clinical harm group met weekly to provide clinical oversight of patients waiting longer than 18 weeks. We saw minutes of these meetings which gave assurance this process was on-going.
- Clinic cancellations should be done with less than six weeks' notice and with clinical oversight. We saw the policy stated where possible patients were rebooked in the next available appointment. If this was not possible, the information about the cancellation would be entered on the patient tracking list, indicating there was clinic oversight of cancelled patients.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in all areas we visited and signed by all members of staff. Diagnostic imaging staff had a clear understanding of protocols and policies. Protocols and policies were stored in folders in each room.
- We observed good radiation compliance as per policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. We saw radiographers referring to the ionising radiation (medical exposure) IR (ME) R regulations for a patient's examinations. A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required. This was in line with ionising regulations 1999 and regulations IR (ME) R 2000).
- The Radiation Protection Advisor performed an annual quality assurance (QA) check on equipment in the diagnostic imaging department. Departmental staff also carried out regular QA checks. This indicated equipment was working as it should. These mandatory checks are in line with ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R 2000). We saw electronic records of QA checks
- Patient identification check reminders were visible on the walls of diagnostic imaging rooms. Staff used a pause and check system to ensure patient identification checks occurred.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging departments in line with best practice. Staff offered pregnancy tests for all women for whom pregnancy was a possibility.
- The diagnostic imaging department used the five steps to safer surgery checklist for all interventional procedures. We saw two audits of these checklists and they were 100% compliant on both.
- Lead aprons limit exposure to radiation. Lead aprons were available in all areas of diagnostic imaging for children and adults.
- Warning signs were displayed on clinic room doors when LASER's were in use. This was in line with the local rules which were kept with the machine. The keys to the LASER were kept in a locked cupboard in accordance with the policy.

Staffing

- A matron worked across the four hospital sites for outpatients and provided monitoring for staffing levels across all sites.At each site there was a dedicated nurse in charge at either band 7 or 6 level. The nurse in charge acted as the point of contact for all other nursing staff.Each clinic area had at least one band five nurse to provide medication or complex procedure support. In addition to this each clinic had band three and two nursing staff to provide support for preparation, procedure support and chaperoning.
- There are no set guidelines on safe staffing levels in the outpatient department. Nursing cover was calculated depending on the number of clinics running and the numbers of patients attending clinic. We saw electronic rostering for nurse staffing which indicated forward planning of nurse staffing.
- The radiology consultants were on site seven days a week to cover emergency work and the reporting requirements for the hospital. They provided emergency reporting from 5pm to 8pm and emergency CT and ultrasound scans from 8pm to 8am.
- The consultants provided cover on Saturdays and Sundays from 8am to 8pm for emergency ultrasound scans and reporting scans.
- At the time of inspection, 50% of ultrasound staff were agency to cover vacancies. This is in line with national sonographer shortages. Agency staff completed a local

induction checklist and would be buddied up with a permanent member of staff. The trust had recruited more trainee sonographers than required to assist with future recruitment.

- Assistant practitioners were trained to be radiographers in house to help with staff retention and the radiographer vacancies present at the time of inspection.

Major incident awareness and training

- Staff in the diagnostic imaging department had a clear understanding of the process should a major incident occur. Staff showed us a box with cards detailing what each diagnostic lead should do.

Are outpatient and diagnostic imaging services effective?

There was evidence of good team working in clinics, within the diagnostic imaging department and across the specialities.

The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care.

We saw that staff had a good awareness of National Institute for Health and Care Excellence (NICE) guidelines and this was demonstrated in their practise.

Evidence-based care and treatment

- Staff followed NICE clinical guidelines in the speciality clinics we visited. We saw audits which demonstrated staff monitored their compliance with these guidelines.
- We saw a variety of local audits were undertaken on a regular basis in outpatients and diagnostic imaging departments. They included environmental, hand washing and infection control audits. The results of these were shared amongst staff and displayed in waiting areas and we saw examples of both.
- In diagnostic imaging guidelines were followed for providing imaging for acute adult emergency services 24 hours a day, seven days a week. NICE guidelines were followed for the management of all referrals from the emergency department.

Pain relief

- The outpatient clinics had stocks of pain relieving medication, which they could give to patients as required. If anything stronger was needed the doctor in clinic wrote a prescription.

Patient outcomes

- Staff inputted a patient outcome on the computer system. It indicated if a patient, had another appointment, or had been discharged. Staff could not close a clinic without inputting an outcome. This indicated all patients had an outcome.

Competent staff

- We saw certificates which indicated staff were competent to give out drugs.
- Staff completed medical devices competencies to give assurance they could use certain pieces of equipment safely. We saw certificates of these competencies.
- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the nursing and midwifery council (NMC).
- Appraisal rates in the outpatient department were 91% which was below the trust target of 95%.
- Some staff in diagnostic imaging can give medicine to patients for certain diagnostic tests. We saw certificates which confirmed staff were competent to do so.
- Staff kept cannulation records for those staff able to put a cannula in patients. We saw certificates which indicated staff were competent to do so.
- In diagnostic imaging, we saw training records and competency certificates.

Multidisciplinary working

- Staff ran one stop clinics for a variety of clinical specialities at the hospital. They offered access to a specialist doctor, nurse and allied health professionals. Patients were able to meet with staff, have diagnostic tests and get results and have treatment on the same day.
- Staff told us they felt well supported by other staff groups and there was good communication within the teams.

Seven-day services

- The hospital provided 24 hour a day, seven day a week access to emergency diagnostic tests.

Outpatients and diagnostic imaging

Access to information

- The implementation of a new patient archiving communication system had resulted in 209,000 appointments having to be put on the system manually.
- Staff felt the installation of this new system occurred too quickly. They had not received training in the use of the system and had difficulty using it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In medical records we looked at, consent was documented. There were consent forms available in all ENT rooms, for consenting patients to procedures.
- Nursing staff did not have a clear understanding of how the Mental Capacity Act (MCA) related to their practise, although they were aware of who to contact if they required guidance and where to find referral forms on the intranet.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as Good because;

- Staff treated patients with kindness, respect and staff they interacted with and behaved in a professional manner.
- Patients and their carers were involved in the planning of their care.
- Privacy was respected in the department with staff making sure that all patients' consultations could not be overheard

However:

- Staff did not always wait before entering a room after they knocked.
- There was little privacy for patients who waited on trollies in the diagnostic imaging department.

Compassionate care

- In the most recent Friends and family test (October 2015), 86% of patients would recommend the outpatients department, which is lower than the national average of 92%.
- Signs offering patients a chaperone were clearly visible in clinic rooms we visited in the outpatient and diagnostic imaging departments.
- Patients told us they were given the time to have full explanations about their care. They never felt like they were being hurried.
- Clinic doors were shut during consultations to maintain patients' privacy and dignity. We saw one member of staff knock and enter a clinic room three times during a patient's consultation without waiting.
- We received information from a patient who had an examination in a cubicle which required her to be undressed. They told us a member of staff repeatedly stuck their head round the curtain without first seeking their consent.
- In the diagnostic imaging department patients waited on trollies in an open area without any privacy.

Understanding and involvement of patients and those close to them

- We saw there were a variety of health-education literature and leaflets produced by national bodies. Some of this information was general in nature while some was specific to certain conditions. This literature was available in all waiting areas of the outpatient and diagnostic imaging departments.
- In the breast clinic staff put a pack of patient information leaflets together for patients. This ensured each patient had personalised information available to them.

Emotional support

- A cancer charity helped to provide emotional support to patients in the breast clinic along with the specialist staff. Volunteers for the charity had experience of living with breast cancer.

Are outpatient and diagnostic imaging services responsive?

Good

We rated the responsiveness of the service as Good because;

- A variety of clinics were available at evenings and weekends. This gave patients a wider choice of appointment days and times. In addition to this, the pharmacy opened on a Saturday to provide a service to patients attending clinic at the weekend.
- There was a consistent reduction in 52 week waiters from 195 patients in May 2015 to 15 patients in November 2015.
- A mobile MRI scanner was being used to provide extra capacity, so patients could get their scans on time.
- The trust had not met the referral to treatment time standard or England average since April 2015, but had a comprehensive strategy in place to deal with the backlog. It was on track to meet the standard.
- The trust met the two week and the 31 day cancer targets and there was capacity to over book clinics to ensure these targets were met. In addition to this there were 18 different one stop clinics across to the trust to ensure patients had access to a variety of clinicians, examinations and their results at one clinic.

However;

- Patients were waiting a long time on the telephone to get through to the appointments office.

Service planning and delivery to meet the needs of local people

- In the last year the trust offered 64 outpatient clinics during the evening and weekends. The diagnostic imaging department had implemented weekend lists. This provided patients with a choice of appointment times more convenient for them.
- Outpatient pharmacy was open from 9:00am to 5:00pm Monday to Friday and on Saturday from 9:00am to 13:00 to provide a service to patients attending ad hoc clinics.
- The Physiotherapy department was open from 7:30 am every day and until 8:00pm two nights a week. This provided a choice of appointment times for patients.
- The phlebotomy department opened from 9:00am to 4:45 from Monday to Friday.
- Electronic self-check in was available in the outpatient department. Patients told us they used these desks but then had to queue for their appointment letter to be checked by reception staff. They felt this was a waste of time. We saw this process happening.
- Patients told us they experienced long waits on the phone to the central call centre whilst trying to change their appointment.
- A mobile MRI was used to provide additional capacity for the diagnostic imaging department.

Access and flow

- Since January 2009 every citizen of this country has the binding NHS constitutional right to be treated within 18 weeks. Where a hospital is unable to offer patients treatment within 18 weeks the patient has the right to be treated elsewhere. In June 2015, the incomplete pathway standard became the sole measure of a patient's constitutional right to start treatment in 18 weeks.
- The trust had been below the below the England standard of 92% for incomplete pathways for referral to treatment time (RTT) within 18 weeks since April 2015.
- At the time of inspection, 90% of patients were waiting within 18 weeks and 12 out of 19 specialities were better than the England standard. The trust had a system in place to clear the backlog with an RTT group which met regularly.
- There was a consistent reduction in 52 week waiters from 195 patients in May 2015 to 15 patients in November 2015. A merger of computer systems in November 2015 had a significant impact on the ability to maintain the RTT recovery trajectory.
- The trust met the two week and 31 day cancer wait time targets but there was a deterioration of performance in the 62-day cancer wait time performing worse than the standard and England average from September 2014.
- Staff at the outpatient appointment centre booked first appointments for patients on a two week pathway. Patients on this pathway were then tracked and monitored by individual speciality teams.
- The trust was unable to access reliable cancellation data from their computer system. The cancellation team kept a spread sheet of all clinics they cancelled and the reasons for cancellation. The data provided to us indicated that 34 clinics had been cancelled within six weeks at the hospital in the 5 months prior to the inspection. 22% of those clinics at Barnet and Chase Farm were cancelled because of annual leave. This indicated the trusts policy was not always followed when cancelling clinics due to annual leave
- Paper referrals were received into the outpatient appointment centre. Staff scanned them onto the computer system. Referrals were triaged electronically. The target time for this process was 48 hours. We saw data which indicated from October to January the

average time taken to triage referrals was 5 days. On average 27% of referrals were triaged in the target time. The longest time taken was 28 days. This indicated the target time was not being met.
- An audit of 454 patients waiting times in December at Barnet and Chase Farm Hospitals showed; 32% were seen on time, 82% were seen within half an hour and 97% were seen within one hour.
- The outpatients' pharmacy operated a ticketing system. On average there was a 30 minute wait. We saw very few people waiting.
- Physiotherapy waiting time was two weeks, which indicated patients could access treatment and advice rapidly.
- A virtual clinic had recently been introduced in the fracture clinic, which involved giving patients telephone advice. It was anticipated this would reduce the number of patients in the clinic by 30%, but there was no data to support this at the time of inspection.
- One-stop clinics enabled patients to access a variety of health professionals, examinations and treatment during a single visit.
- The diagnostic imaging department had won a national award for the lung biopsy same day service. It provided a CT scanning service, with a report on the scan in one hour.
- In diagnostic imaging urgent patients and those on a two week pathway waited no longer than one week for an MRI, CT or ultrasound scan. Routine patients waited up to four weeks for an MRI scan, five weeks for a CT scan. Sixty-one patients had waited longer than seven weeks for a routine ultrasound scan.

Meeting people's individual needs

- A specialist nurse in the fracture clinic provided a service for older patients following a fall. The nurse was able to carry out a variety of blood tests and refer patients on to a specialist for further assessment and management.
- We saw patient information leaflets were available in languages other than English and specific to children.
- In several outpatient areas we saw quiet rooms dedicated to counselling or breaking bad news.
- There was no flagging system at the hospital for identifying patients with learning disabilities, those living with dementia or any with safeguarding concerns.
- Patients with learning disabilities or on transport would be seen as a priority on arriving in the outpatient departments.
- In the diagnostic imaging department there was a learning disabilities champion.
- Patients told us they had difficulty accessing wheelchairs in the hospital.
- Several patients told us they were unhappy with the expense and poor availability of car parking.
- There was clear signage in the eye clinic and patients, including some with limited vision, told us there appointment letters were very clear.

Learning from complaints and concerns

- In the last year there were 46 complaints about the outpatient department. The average time to respond to complaints had reduced over the past 12 months from 75 days to one day in November 2015.
- The two most common causes for complaint to outpatients were verbal and written communication, appointments being cancelled or delayed.
- The numbers of complaints received was included in the monthly communication email to all nursing staff. We saw action plans arising from complaints made.
- Staff gave us examples of changes made as a result of complaints. For example, patients had commented on experiencing difficulties with the voice recognition software for confirming appointments. Managers were planning to change from voice recognition to text alert.
- Information for patients on how to complain about the service was visible in all the areas we visited.

Are outpatient and diagnostic imaging services well-led?

Good

The outpatients directorate for The Royal Free Hospital NHS Foundation Trust, within the transplant and specialist services (TASS) division,was led by a clinical director for outpatients and had a tripartite model across all sites of the clinical director, senior operations manager and head of nursing.

Theclinical directorreported to the divisional director, the senior operations manager reported to the divisional director of operations and the head of nursing reported to the divisional director of nursing.

Outpatients and diagnostic imaging

A senior matron worked across all sites. Each site had a band 7 senior sister who reported to the senior matron who reported to the head of nursing.

The senior operations manager was supported by an operations manager, assistant operations manager and 4 service managers.

We rated the leadership of the service as Good because;

- The leadership, governance and culture ensured the delivery of person-centred care. Staff were supported by their local and divisional managers.
- Staff felt their line managers were approachable, supportive and open to receiving ideas or concerns. Most staff knew and understood the vision of the hospital and were able to demonstrate how this was implemented in practice.
- Staff enjoyed their work and felt that it made a difference to how patients felt about the hospital.
- Clinical staff in all the outpatients and diagnostic imaging areas stated their managers were visible and provided clear leadership.
- There was an open culture amongst staff and managers. Staff said they felt empowered to express their opinions and felt they were listened to by management staff.

Vision and strategy for this service

- The trust had a five year strategy in place to improve the outpatient department performance across each site. The strategy has five high level objectives to be delivered by four different work streams. Each work stream had representatives from a number of staff groups.
- The work streams reported in to an outpatient steering group and had clear key performance indicators to achieve in order to deliver each objective.
- A lot of work had been already done in validating pathways and dealing with a backlog of waiting patients. Managers were looking to planning for the future in order to anticipate and plan for changes in capacity demand.
- Staff we spoke with were aware of the outpatient strategy and the future planning.
- Barnet and Chase farm hospitals diagnostic imaging departments had a variety of quality improvement projects on-going. They had training available for staff to extend their practical and managerial skills. They had developed a variety of direct access and care pathways.

Governance, risk management and quality measurement

- The outpatient directorate had its own risk register which identified and monitored risk within the directorate. Risk was discussed at monthly governance meetings and we saw minutes of these meetings which indicated this was occurring. Risk was also discussed at the divisional board meeting, of which we saw the minutes.
- There were a number of audits being undertaken regularly in the outpatient and diagnostic imaging departments. They provided assurance delivery of services were in line with national guidelines.
- The radiology department followed policies and procedures in accordance with ionising radiation (medical exposure) regulations (IR (ME) R) regulations, 2000. This gave assurance risk to patients was managed in line with national recommendations.
- Clinical governance was embedded at local level with structured standard monthly emails to staff detailing complaints, incidents and audit results.
- The local groups reported to the board via the trust's clinical governance meetings. Minutes from these meetings were available for inspection and we noted that all risks, incidents and complaints were discussed.
- The trust had set up an RTT project and steering group in order to manage the delays in patients receiving treatment. The steering group reported to the RTT board who in turn reported to the trust board. We saw minutes of meetings of these groups.
- A part of this project provided clinical oversight and review of patients on the waiting list to minimise risk to these patients.

Leadership of service

- Four senior sisters reported to the matron, who reported to head of nursing. Five service managers reported to one assistant operations manager and an operations manager. The operations managers reported to the senior operations manager. The senior operations manager and director of nursing reported to the clinical director.
- Staff in the outpatient and diagnostic imaging department felt managers were approachable and they could discuss any issues with them. They were aware of

who the senior managers and the changes on-going in the department. The senior management team were visible to staff on the floor and could be easily contacted if issues arose.
- Staff felt change was on-going in the hospital and the leadership team handled it well.

Culture within the service

- We found passionate staff who were dedicated to a patient centred approach. There was pride in individual teams and the services they provided.
- We noted staff within outpatients and diagnostic imaging were proud of the team dynamics and the willingness to change and develop their service, to meet changing needs.
- The majority of staff felt well supported by manager but some told us they did not get acknowledged for the good work they did.

Staff and public engagement

- Staff spoke positively about working in their department and demonstrated excellent understanding of their respective roles
- Staff told us they felt that appraisals were a useful process and personal development was positively encouraged by their managers.
- Nurse managers supported staff and made staff feel valued, although some staff told us they did not always feel valued for the work they did.
- We saw letters of positive feedback sent to the outpatients department.

Innovation, improvement and sustainability

- The referral management, booking, cancellation and call centre teams had recently been relocated to one area in Enfield, which we were told was a good working environment. The teams were in the process of bringing two different systems of work together. They planned to take the most efficient processes from each to establish one efficient system moving forward.
- A patient experience working group was established to look at patient experience trust wide. The outpatient improvement programme was a key part of this and focus was on building the trust's capability for the future. This included updating computer systems, changing the physical environment and changing patient pathways. We saw evidence of on-going progress in the minutes of these meetings.
- The RTT project was working through the backlog of patients waiting for appointments and were looking to future planning for capacity and demand.
- The diagnostic imaging department had won an NHS innovation award for the development of an ambulatory lung biopsy. This service had increased the number of lung biopsies carried out each year and reduced costs by 90%. It freed beds because patients had the examination as an outpatient, with the majority discharged 30 minutes following the procedure.
- A virtual fracture clinic had just been set up. This would reduce the number of attendances at the hospital and enable patients to begin treatment in their own home.

Outstanding practice and areas for improvement

Outstanding practice

- We observed dynamic nursing leaders who supported clinical environments are were essential in the development and achievement of best practice models.
- The neonatal unit at Barnet hospital was very well equipped and offered outstanding levels of compassionate care delivered by all grades of staff from across the whole of the multidisciplinary team .
- The neonatal unit had level 2 UNICEF accredited baby friendly status where breast feeding was actively encouraged and mothers are given every opportunity to breast feed their babies.
- The diagnostic imaging department had won an NHS innovation award for the development on an ambulatory lung biopsy. This service had increased the number of lung biopsies carried out each year and reduced costs by 90%. It freed beds as patients had the examination as an outpatient, a majority being discharged 30 minutes following the procedure.

Areas for improvement

Action the hospital MUST take to improve

The trust must take action to ensure compliance with The National Patient Safety Agency (NPSA) alert PSA001 issued 31st January 2011.

The trust data base of clinical guidelines and procedures hosted via “freenet” should be updated as soon as possible.

The recovery area ambiance of theatre must be altered to protect children from witnessing upsetting sights and hearing frightening sounds.

Theatre recovery staff must receive PILS training.

The trust must address the issue of the day surgery unit being used to accommodate patients overnight.

The trust must ensure the 62 day cancer wait times are met in accordance with national standards.

Embedding of fresh eyes for review of CTGs

Ensure that emergency drugs such as Sodium Bicarbonate and Adrenaline are removed from the Rescusitaires.

Complete the harmonising of all relevant national guidelines.

Implement individual appointments for booking interviews.

Action the hospital SHOULD take to improve

The trust should ensure the swab, needle and instrument policy is ratified and new practices are embedded in all relevant departments across all sites.

The trust should ensure a safer surgery policy is produced and ratified.

The trust should ensure that there is an electronic system in place to flag patients who may require additional support.

The trust should ensure fridges are replaced on Damson ward.

The trust should ensure appropriate storage of medicines in the day surgery unit.

The trust should introduce the use of POSSUM scoring.

The trust should ensure the call bells in theatres are improved to be louder.

The trust should ensure that RTT is met in accordance with national standards and England averages.

The trust should ensure all staff interacting with children have the appropriate level of safeguarding training.

The trust should ensure security of prescription forms is in line with NHS Protect guidance.

The trust should review its process of triaging referral to ensure they are done within the target time.

Outstanding practice and areas for improvement

Ensure emergency medication is stored safely and access to these drugs is controlled.

The hospital should ensure that all staff undertake mental capacity assessments and record best interest meetings to ensure that they can evidence that staff are working the legal framework of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training.

Ensure that good standards hygiene practices are followed in clinical areas such as hand hygiene and bare below area.

The trust performance in the National Safety performance improves to meet the England average.

The trust ensures that staff mandatory training on the medicine wards meets the trust target of 95%.

Arrangements around equipment storage should be reviewed so that shower rooms are not used.

The ward environments for individuals living with dementia should be improved.

Improve antenatal risk assessments.

Undertake a maternity acuity staffing assessment to identify staffing requirements for the merged service.