Royal Free London NHS Foundation Trust

The Royal Free Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at The Royal Free Hospital

Inspected but not rated

The Royal Free Hospital (RFH) is part of the Royal Free London NHS Foundation Trust. The hospital provides a range of elective (planned) and emergency surgical services to people mainly living in the Hampstead area of the London Borough of Camden. The Royal Free Hospital business unit provides predominately specialist surgery. Surgical specialities are arranged across several divisions alongside medical specialties, where shared care is common.

In most divisions, the surgical services deliver across regional or supra-regional geographies and have similar models of care. In the network services division, individual patients are often cared for by several of the surgical specialities for example, breast and plastic surgery or dermatology and plastic surgery.

The divisions with surgical specialities are as follows:

- Liver and Digestive Health: hepato-pancreato-biliary surgery; liver transplantation; colorectal and general surgery: gastroenterology, endoscopy and hepatology
- Nephrology, Urology and Renal Transplantation: renal surgery; urology; renal transplantation; nephrology
- Cardiovascular: vascular surgery and cardiology
- Network Services: plastic surgery; ophthalmology; breast surgery; dermatology
- Trauma and Orthopaedics managed by Barnet Hospital but ward managed under Royal Free Hospital nursing team
- Anaesthetics, theatres and ICU; including pre-operative assessment; day surgery ward
- Private practice: all surgical specialities

The Royal Free London NHS Foundation Trust has three hospitals. We inspected the Royal Free Hospital only because the majority of the never events happened at this site. The inspection focused on the safe and well-led key questions which enabled the inspection team to assess the safety, quality and the culture of the service.

We carried out a short notice announced focused inspection because we had concerns about the quality of care in surgery. We saw an increase of serious safety incidents meeting the threshold of a never event in comparison to the previous years. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. We were also concerned about the culture within the service.

We did not rate this service at this inspection. The previous rating of requires improvement remains.

We did not inspect other locations or core services provided by the trust as this was a risk-based inspection. We continue to monitor all services as part of our ongoing engagement and will re-inspect when appropriate.

See the surgery section for what we found.

Surgery

Inspected but not rated

Our rating of this service stayed the same.

- The hospital had undertaken detailed investigations into its recent never events to identify the root causes and develop actions plans. The actions plans had been implemented and the risk of future never events had been mitigated.
- Staffing levels were good with a reducing usage of bank and agency staff. Effective systems were in place to keep patients safe.
- Staff reported good access to patient information through EPR. They were complementary about the system and saw benefits of having an instant access to patient information. Most staff reported good support from the EPR support team who they said responded promptly, especially if their request was urgent.
- Staff knew how to deal with Sepsis and other risks to patients. There were clear protocols on recognising signs of Sepsis and how to respond to them. However, the provider had not completed an audit of sepsis compliance since 2019. Currently, the trust's digital systems alert risk of sepsis including high risk attributes which includes vulnerability and systematically provides decision aids for sepsis management. The trust is working on digital audit of compliance with sepsis 6.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- Not all medical staff had completed training in key skills, including safeguarding training. The hospital was not achieving its 90% target for mandatory training.
- One of the paediatric trolleys had not been regularly checked to make sure its contents were present and up to date.
- The clinical risks around the shortage of ketone machines had not been fully recorded in the trust risk register.
- The trust had not been auditing its compliance with sepsis protocols.
- Although incidents were reported and properly investigated, we identified some issues with sharing of learning about never events and serious incidents across the divisions. The frontline staff did not always know about serious incidents that happened within the surgical services or could not remember lessons learned from these incidents.

Is the service safe?

Inspected but not rated

Mandatory training

Although the service provided mandatory training in key skills, compliance with the training for medical staff was not in line with the trust target.

Surgery

Nursing staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The training topics were in line with national guidance and included 18 training modules.

We reviewed compliance data from January 2023 and found nursing staff met the trust's target of 90% for completion of the mandatory training for most of the training modules. For three modules where these were not met, it was just below the target, 83-89%. The lowest completion rates for moving and handling and IRR17 (related to exposure to ionising radiations) were at 79% and 31% respectively.

The 90% target was not met for any of the 18 mandatory training modules for which medical staff were eligible. The data showed low compliance rates with some essential training topics such as resuscitation, safeguarding and infection control. The completion rates for most modules were between 60-70%. This has not improved significantly since the last inspection visit despite the trust taking nine actions aimed at addressing the problem. Following the current inspection, the trust told us they were in a process of rolling out a compliance improvement plan to address low response rates for medical staff. This was yet to be implemented and included actions such as building in protected time to complete the training, reviewing compliance at the local faculty group meetings or introducing mandatory training passports.

The service did not provide training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia. From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This means that staff might not have the skills and knowledge to effectively support this patient group. However, during the inspection staff displayed a good knowledge of caring for patients with dementia. They also told us patients living with a learning disability admitted to a ward received a passport which helped staff identify areas where patients may be at risk of harm.

Following the inspection the trust informed CQC that from 1 April 2023, all staff will receive Oliver McGowan Mandatory training added to their MaST requirement. At the time of the inspection, the trust provided training about how to respond to patients with a learning disability as part of the MaST level 2 (eLearning) and level 3 safeguarding adults modules.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had completed training specific for their role on how to recognise and report abuse.

Staff received training specific for their role on how to recognise and report abuse.

Safeguarding training was mandatory to all staff; depending on their role they were required to complete different levels of training.

Data provided by the trust showed that nursing staff met the trust target of 90% for competing safeguarding adults and children training for level 1 and level 2. Medical staff did not meet the trust target with completion rates ranging between 66% and 74%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Surgery

Staff knew how to make a safeguarding referral and who to inform if they had concerns. This was typically the ward sister or nurse in charge. Staff said they could alert the safeguarding lead via the patient electronic system.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, some polices were past their review dates.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The wards had a cleaning schedule which clearly outlined areas or items that required cleaning, frequency and instruction explaining what needed to be done and how.

Staff used records to identify how well the service prevented infections.

Most staff followed infection control principles including the use of personal protective equipment (PPE). PPE was available in all areas. Handwashing and hand sanitising facilities were appropriate and accessible. All staff adhered to being bare below the elbow.

When a patient required an isolation room, this was clearly labelled with a poster which explained the type of infection and the precautions staff should take to avoid further transmission.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Each morning staff were allocated to an area they were responsible for cleaning.

Staff worked effectively to prevent, identify and treat surgical site infections (SSIs). The hospital participated in the national mandatory SSI reporting system for orthopaedic surgery. Due to the small volumes of elective hip and knee replacements, the hospital only participated in the mandate SSI surveillance in the repair neck of femur surgical category. For the period between October 2021 and September 2022, the SSI rate was 0.6% which represents one out of 168 cases.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, two wards did not have their own essential equipment to care for their patients and had to borrow it from other wards.

Staff carried out daily safety checks of specialist equipment. Managers ensured that equipment had been tested and serviced regularly. Any equipment that required servicing was recalled by a designated department.

In all patient areas we visited, staff had access to emergency resuscitation equipment.

Resuscitation trolleys were sealed for security. Records we looked at showed that in most cases staff completed resuscitation trolleys checks twice a day. However, we found a paediatric trolley in the main theatres area, which was not checked since mid-December 2022, and even when it was checked, this was done on three occasions for the entire month.

Surgery

The service did not always have enough suitable equipment to help them to safely care for patients. Two of the three wards we visited did not have their own ketone machines and staff had to borrow these from another ward. This was escalated to the management around a year ago, but staff were told there were difficulties in sourcing the specific type of machines. Elevated levels of ketones in patient's blood or urine can lead to diabetic ketoacidosis which can be life-threatening.

The service had suitable facilities to meet the needs of patients' families.

The service had a suitable recording system that allowed details of specific implants and equipment to be provided rapidly to the health care products regulator if needed.

Staff disposed of clinical waste safely. Clinical and domestic waste bins were clearly marked and easily available, including sharps bins. Staff disposed of clinical waste safely and appropriately. Sharps bins were dated and not overfilled. Dirty utility areas were organised and clear from clutter.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, the service could not evidence that it audited compliance with the national sepsis guidance.

Staff used a nationally recognised tool called National Early Warning Score (NEWS2) to identify deteriorating patients and escalated them appropriately. They recorded patient observations electronically and escalated when a patient's condition deteriorated. The system automatically notified staff if a patient's observations indicated deterioration, such as sepsis or acute kidney injury. These alerts were visible to a ward manager or a nurse in charge. When an alert was triggered, a message would appear with information for staff on how to escalate and prompted them to consider certain conditions, such as sepsis. The system would also display the referral numbers for appropriate staff.

Patients at risk of deterioration for example, with suspected or confirmed sepsis, received prompt assessment when escalated to an outreach team. However, since 2019, the service did not assess compliance with the national guidance in relation to the recognition, diagnosis, and management of sepsis. The last audit was for the period between January and March 2019 and showed 89% compliance with the requirement to screen patients who needed sepsis screening.

Staff completed risk assessments for patients on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service used a sepsis care bundle for the management of patients with suspected or confirmed sepsis. Staff were able to describe the signs of sepsis and knew how to escalate if a patient was at risk.

The trust monitored compliance with the venous thromboembolism (VTE) risk assessments. VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis) and travels in the circulation, lodging in the lungs (known as pulmonary embolism). It is important that VTE assessments are undertaken prior to surgery to reduce the occurrence of an embolism. As part of the national VTE prevention programme, all trusts should have a 95% compliance of VTE risk assessment on admission for all inpatients aged 16 and over. Data from April 2022 to November 2022 shows that the target of 95% was achieved by most of surgical divisions. The day surgery fell just below the target with results between 93-94% in five of the eight months that we reviewed.

Staff shared key information to keep patients safe when handing over their care to others.

Surgery

During a pre-operative safety briefing, staff shared key information about a patient such as any anticipated issues, allergies, concerns relating to surgery, anaesthesia or any additional needs during or post operation. It was an opportunity for the surgical team to discuss the patient, ask questions and raise further issues. However, we noted that on some occasions it was a challenge to get the team together as some staff arrived late for the briefing. Also, many briefing sessions started late which had an impact on the safety huddle that happened after the briefing. Staff said that when doctors were not attending briefings, they did not always know the order of patients on the list. Day surgery staff reported that sometimes briefings did not happen despite this being a recommendation following three serious incidents. This is significant, as an effective briefing can enhance team performance and reduce risk of incidents.

The surgical service carried out monthly audits to check compliance with the surgical safety checklist and adherence with the national safety standards for invasive procedures (NatSSIPS). Compliance with the standards in main theatres was good and for the period between January and December 2022 ranged between 98% and 100%. In addition, staff told us that the WHO checklist (part of the safety standards) was incorporated onto the electronic patient record (EPR) system in a way that the operation could not proceed if this checklist had not been done.

If a patient deteriorated, staff could contact the hospital's patient at risk and resuscitation team (PARRT) to help with interventions to stabilise them and prevent them becoming more ill. Staff said the team was very responsive.

At any given time, there was at least one member of recovery staff who was trained and certified to an appropriate level in life support to support patients in a post-anaesthesia care unit (PACU).

Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients.

The service had reducing vacancy rates which were below trust target.

Since August 2022, the turnover rates had been reducing and in November and December 2022 were below the trust target of 13%.

The long-term sickness rates were slightly above the trust target of 1.95% with rates between 3.15% and 2.68% in the last 12 months.

Managers made sure all bank and agency staff had a full induction and understood the service.

Surgery

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Doctors carried out twice daily ward rounds; a morning ward round and an afternoon round usually being a board round in an office.

The service had low vacancy and turnover rates for medical staff which were below trust target.

Sickness rates for medical staff were low and below the trust target.

The service had low and/or reducing rates of bank and locum staff.

The service had a good skill mix of medical staff on each shift and reviewed this in accordance with the trust's processes. A ward medical team typically consisted of a consultant, registrar, senior house officer or a foundation doctor.

The service always had a consultant on call during evenings and weekends. Surgical divisions had no gaps in the consultant on call covers during evenings and weekends. All medical rotas had internal prospective cross cover built into job planning to accommodate routine leave or sickness absence.

Records

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

Patient notes were comprehensive, and all staff could access them easily.

During the previous inspection, the trust was going through a transition to a fully electronic record system which was resulting in some confusion/duplication of information. This issue was resolved since and despite difficulties posed by the COVID-19 pandemic, the trust managed to successfully complete the roll out of the patient electronic records (EPR) system. The electronic system contained relevant risk assessment bundles such as falls, nutrition, pressure ulcers and sepsis. Majority of notes were electronic with the exception of some documents for example, a consent form which needed to be signed by a patient.

When a patient transferred to a new team, there were no delays in staff accessing their records. Staff said the EPR made it easy for the relevant staff to accessed patient information instantly without a need to wait for the paperwork. This was particularly beneficial when patients were transferred to a different area. Staff could access the EPR system using portable computers. These computers were username and password protected. Staff ensured that computers were locked when not in use.

Most staff reported good and timely support from the EPR and IT support teams who assisted them if they experienced issues with the IT systems.

Records were stored securely.

Surgery

Staff sent care electronic summaries to the patients' GPs on discharge to ensure continuity of care. Patients received a printed discharge summary upon discharge from the hospital. Service leads could monitor how many inpatient and day case discharge summaries were created and processed, and identify any issues that might require training or technical support.

Medicines

The service used systems and processes to safely prescribe, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents safely.

Staff learned from safety alerts and incidents to improve practice. The service carried out a comprehensive medicines management audit once a month. Audit results between July and December 2022 showed variable average compliance with the medicines management process. The majority of the 19 audited surgical areas were compliant each month, with between three to eight areas falling just below the target of 90% and two areas on two occasions scoring between 64-66%. When issues were identified following an audit, managers implemented an action plan to address any areas for improvement.

Incidents

The service did not always managed patient safety incidents well. While staff recognised and reported incidents and near misses and managers investigated incidents, lessons learned where not always effectively shared with the wider service. Patients and their families were not always fully involved in the investigation process. When things went wrong, staff apologised and gave patients honest information and suitable support.

Most staff raised concerns and reported incidents and near misses in line with trust policy.

We reviewed never events that happened in surgical services in the past 12 months. Never events (NE) are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. Surgical services across all trust sites had reported seven never events, five of them occurred at the Royal Free Hospital.

We identified issues with the effectiveness of sharing of learning following NEs and serious incidents with staff and across the divisions. The frontline staff did not always know about the NEs that happened within the surgical services or could not remember lessons learned from these incidents. While we saw the evidence that emails outlining lessons learned were shared with staff following serious incidents, staff could not relay these learnings to us. The process of sharing lessons learned, and feedback post incidents was not effectively and consistently implemented. The service told us about introducing initiatives to improve learnings, but these seemed to have had limited benefit to the learning process. For example, in December 2022 the service organised a safety summit to discuss recent never events, root causes, lessons learned, and the action taken to prevent future occurrences. It was unclear which staff groups attended the summit, however, none of the front-line staff we spoke with mentioned attending the summit. Senior staff told us about a newsletter dedicated to sharing information and learning from incidents with staff. However, no staff member mentioned the newsletter when asked how learnings from incidents was shared.

Surgery

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw evidence that duty of candour was applied appropriately to the never events we reviewed. However, although managers investigated incidents thoroughly, we found that patients and their families were not always involved in these investigations in a way that would allow them to share their thoughts, concerns, or comments to be taken into account. Also, some investigation reports missed the reporting deadline which meant the learning was not timely.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, in dermatology a procedure could not be carried out if a photograph that could clearly identify the site/area to be operated on was not available. Following an incident related to a wrong site surgery, a clarification was sent to staff explaining how to mark a surgical site correctly. The trust also explained that patient and anatomical site checks were to be added as part of the WHO surgical checklist. While many improvements were rolled out by the service following an incident, these were not always followed through or sustained. For example, one of the actions following serious incidents in the outpatients department was for outpatient teams to have a safety huddle at the start of each outpatient day surgery clinic to discuss what safety checks were expected for each patient. Staff told us these did not always happen. This process was to be monitored by the service; however the trust did not share with us an audit data when asked. After declaring three NE in the space of two months, senior staff in each ward and clinical area were asked to complete a NE risk assessment. This was not completed and a month later staff were sent a reminder. A few days later, another NE happened, and a third request was sent to staff asking them to complete the risk assessment. The trust did not provide assurance that there were effective systems in place to ensure learning from incidents was shared with all staff.

Managers debriefed and supported staff after any serious incident and staff confirmed this was done in a supportive and fair way without attributing blame.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They actively supported staff to develop their skills and take on more senior roles.

Clinical governance is delivered through each divisional quality and safety board with sharing of learning across divisions. The divisions are clinically lead, often by a doctor but always a clinician. The divisions reported to the hospital CEO, Medical Director and Director of Nursing. In turn, this team reported to the trust board.

Staff understood the reporting structures of the service and told us they were well supported by their managers. Managers told us they felt supported by the senior leadership of the organisation and that they were approachable and contactable.

Leaders we spoke with were clear and competent in their roles, with a clear vision of what needed to be done.

Surgery

The trust in some clinical areas had introduced a 'consultant of the week' and a 'Hot consultant of the day'. This consultant was free from any set commitments which allowed them to provide leadership and support to staff dealing with spontaneous issues in the hospital.

Vision and Strategy

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

The Trust vision was; 'We aspire to become one of the top 5 global academic health science centres and be the leaders in providing the highest quality patients care through technological achievement and research'. The trust described its mission as: ' To improve the health of communities we serve through world-class medical research, education and patient care'.

Staff we spoke with were committed and passionate about providing the best possible service to patients.

The trust had plans and was active at national, regional and local levels. The trust was often the lead for regional services, such as renal care and cancer screening.

Culture

Staff usually felt respected, supported and valued. They were highly focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had a very open reporting culture where patients, their families and staff could raise concerns without fear.

Although there had been improvements, some staff reported that a few consultants still exhibited poor culture in theatres with incidents of shouting and aggressive behaviour. The trust was able to give examples where it had investigated these concerns when reported by staff. In most cases, consultants had been spoken to and had made immediate apologies to the staff member concerned. Most staff other than a number of health care assistants we spoke with said they felt able to challenge other staff including senior staff if they were rude. Continuing to improve the culture has been a key part of the theatres improvement programme.

The trust is using its own 'What Matters to You' programme to improve culture. The programme of activity started in February 2022, which the trust believes has made significant improvements in staff data that reflect culture.

We reviewed staff data for the 'theatres' area and found; The use of bank and agency staff had reduced in the last 12 months. Since September 2022, no agency staff had been used in the Scrubs area. For the last 12 months, staff appraisal rates had been above the trust target of 90%. The staff turnover rate had moved from above 15% to below 10%. The staff sickness rate had rescued from 8% to 6.5%.

Governance

Surgery

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

Although incidents were reported and properly investigated, we identified some issues with sharing of learning about never events and serious incidents with staff and across the divisions. The frontline staff did not always know about serious incidents that happened within the surgical services or could not remember lessons learned from these incidents. It seemed that the process of sharing lessons learned and feedback post incidents was not effectively and consistently implemented.

In November 2022, an independent business consultancy reviewed the design and operating effectiveness of controls in place regarding serious incidents (SIs) and how learning from incidents is implemented and shared across the trust. The review provided an assurance rating of 'Significant assurance with minor improvement opportunities'. Concluding that overall, the controls in place in relation to managing SI actions and learning from SIs is well designed. However, the monitoring of action implementation could be strengthened.

LocSSIPs compliance should be audited by using the Tendable system. However, it was not clear if this was being done and we were told that there was little or no peer review taking place. We asked the trust to provide data showing LocSSIPs compliance. The data provided showed that some evidence of LocSSIPs auditing was taking place, but there was no independent or peer review taking place.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They usually identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Governance and risk management processes and meetings were effective. Risks were mitigated for patients and improvements identified and actioned.

The service had strong performance management and governance processes in place. There were regular and effective meetings that were supported by good management information. Divisional Quality and Safety Boards are held monthly by the divisional leadership teams. The Clinical Performance and Patient Safety Committee meets monthly by the site executive team. There is a weekly Serious Incident review panel. We reviewed this process in more detail and found it to be effective in its role of conducting an initial review of incident, taking immediate mitigation action and starting the investigation process if appropriate.

Quality and improvement are driven in the trust by the Clinical Standards and Innovation Committee (CSIC). The committee is chaired by a non-executive director. We examined the most recent minutes of this meeting and found that all relevant issues were discussed in detail with appropriate actions being identified.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Surgery

The trust had an appointed Data Protection Officer who was responsible for overseeing the proper care and use of patient's information. There had been no reported data protection incidents in the last 12 months.

Staff understood the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. General Data Protection Regulations (GDPR) had been reviewed to ensure the service was operating within regulations. Most staff had completed training about information governance and data protection.

Staff had access to trust policies and resource material through the internal intranet. Staff could locate and access relevant and key records, this enabled them to carry out their day to day roles. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The trust had completed a successful migration to the new Electronic Patients Record system.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients in numerous ways.

Overall for the RFH business unit, 35% of staff completed the 2021 annual staff survey. A key piece of feedback was staff wanted to be listened to more frequently at a local level and for actions to be taken forward. In most clinical specialties other than Ophthalmology, the staff survey responses were significantly worse that the trust or national averages. This had been one of the main drivers for developing the What Matters to You programme within the hospital.

Following the poor staff survey results in 2021 for surgery, the Hospital Quality Improvement Team undertook a 'what matters' to staff in Theatres survey. A bespoke survey was completed to measure how included, safe and supported staff felt at work. 115 staff members completed the survey. The 'what matter' survey took place in February 2022 and, also included the overarching themes of kindness, fairness and respect. The survey identified three major themes that mattered to staff; 1) 'Please keep us better informed' 2) 'I'd like my voice to be heard' 3) 'I feel excluded when I don't understand the language others are using.'

The management team responded positively to the points raised by staff. They set out a planning detailing what they had already done and what was planned. The success of the plan will be measured against solid indicators, such as sickness and turnover rates for staff.

For the 2022 staff survey, the Royal Free Hospital achieved 45% (a 10% increase in comparison to 2021). The results from this survey are under embargo currently and were not available to CQC during the inspection.

It was not clear that patients and their families were fully involved in the investigation and writing of investigation reports. They do not have the opportunity to comment on draft reports and are not informed of any improvements made following report recommendations.

Following the inspection the trust informed us that they write to patients and families to inform them of the investigation process and are asked to agree the terms of reference and key lines of enquiry. They are sent a leaflet explaining the process and are offered the opportunity to contribute towards the investigation process by informing the trust of their experience and key facts relating to the event. The trust receive information by email/telephone or face to face; whichever is best for the family. Where a patient or family member makes a point of factual accuracy on the report following publication, this is amended and re-sent.

Surgery

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The trust had used its 'What Matters to You, initiative to identify important areas for improvement. It had been implemented and supported by senior management who wanted to know what the issues were and showed a willingness to address them. Numerous departments were utilising QI to improve efficiency.

Following a cluster of never events in dermatology, the trust held a never events safety summit in December 2022. The summit agreed a number of key themes in the events around; correctly identifying patients, including the use of wristbands. Completion of LocSSIP entries. Correctly identifying the site of lesions and the use of medical photography. The summit has agreed with staff a set of actions to form a detailed improvement plan. During our inspection, we found that most of the improvements had been completed and the risk of a new never event reduced.

The trust were implementing changes to the urology pathway to increase theatre utilisation for nephrectomies. The hospital had conducted an audit of barriers to maximising theatre utilisation, for which they are recording all reasons for delay live on a daily basis with a plan to review all themes and devise action plans with relevant teams.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The trust must ensure that all consultants meet the trust target for training in modules relating to resuscitation and immediate life support. Regulation 12(2)(c).
- The trust must ensure that all paediatric resuscitation trolleys have consistent regular checks. Regulation 12(2)(e).
- The trust must ensure that there is regular audit of compliance of staff with processes for managing sepsis. Regulation 17(2)(a).
- The trust must ensure that the risk register entry relating to the purchase of new ketone machines, covers the clinical risk and mitigations around the shortage of the machines. Regulation 17(2)(b).

Action the service SHOULD take to improve:

- The trust should ensure that as many staff as possible are aware of the learning from incidents.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and an Inspection Manager. The inspection team was overseen off site by Nicola Wise, Deputy Director.

During the inspection, we spoke with 21 staff members, including the surgery service leadership team, governance team, doctors, nurses, operating department practitioners, allied health professionals, and health care support workers. We visited three wards: 9 North, 7 East, 7 West, the main theatres, a day surgery unit and a recovery area. We attended three briefing meetings and a safety huddle.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.