Care Quality Commission

Royal Free London NHS Foundation Trust

Chase Farm 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
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 Chase Farm Hospital under the new methodology. We have rated the hospital as Good overall with all core services rated as Good a few areas rated as Requires Improvement.

Chase Farm Hospital is a Good Hospital providing good levels of care and treatment across all of the five 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 five core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, End of life and Outpatients and diagnostic services.

Our key findings were as follows:

- The UCC was a good nurse led service. We found that there was strong and effective clinical leadership. The UCC was well organised and consistently delivered safe and timely care and treatment. Patients outcomes were good.
- The needs of older people and people living with dementia were at the forefront of service developments, including the refurbishment project and reviews of patient pathways.
- There was effective multidisciplinary working, including liaison with community teams, to facilitate timely discharge planning.
- Staff were able to speak openly about issues and serious incidents. However, staff told us they didn't always report an incident as they were too busy and did not always receive feedback.
- There was appropriate medical and nursing staff to cover the work although some medical staff were uncomfortable with the support they needed for more complex post-operative patients.
- We saw the staff use the intranet to access evidence based protocols and care but there were a number of audits either not started or not completed that would demonstrate staff were reviewing their practice in line with national and local standards.
- 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 which was attended, a current EOLC policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.
- The hospital 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 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.
- The trust had consistently not met the referral to treatment time standard or England average since April 2015.
- 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:

- The UCC at Chase Farm Hospital was an outstanding example of a nurse led multi-disciplinary team providing excellent outcomes for patients. Patients were seen promptly and obtained good clinical outcomes. The close working relationship with the Paediatric Assessment Unit significantly enhanced the service provided to children and young people.
- The Matrons in surgery were dynamic, supportive and visible in clinical areas and they inspired others to work together.

Summary of findings

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

Importantly, the trust must:

- Remove the inconsistencies that existed in patient's assessments for DNACPR and the recording of Mental Capacity Act assessments.
- The hospital must reduce the number of outpatients appointments it is cancelling.
- The trust must ensure the 62 day cancer wait times are met in accordance with national standards.
- The trust must ensure all staff interacting with children have the appropriate level of safeguarding training.

In addition the trust should:

- Risk assessment documentation must completed in areas such as falls risk assessments, nutrition charts and fluid balance charts.
- The trust should ensure grading of surgical referrals occurs within acceptable timescales.
- The trust should ensure that RTT is improved in accordance with national standards and England averages.
- The trust should ensure security of prescriptions forms is in line with NHS Protect guidance.
- The trust should ensure the safer surgery policy is implemented and staff awareness on the policy should be enforced.
- The trust should continue with its work around implanting the 5 steps of safer surgery until embedded and audited to ensure full compliance.

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 	Chase Farm UCC was a nurse led service. We found that there was a strong and effective clinical leadership within the UCC. The UCC was well organised and consistently delivered safe and timely care and treatment. There were suitable arrangements for the safe management of medicines. Patients were protected from abuse and avoidable harm and staff were clear about their safeguarding responsibilities. There was a suitable skill mix however we found that there were shortages in nursing and GP vacancies. Agency and bank staff covered these gaps. Staff followed evidence-based national guidelines and best practice to deliver care. Staff were appropriately qualified and trained for their roles. There was strong multidisciplinary working within the UCC and external teams and departments. The UCC consistently achieved their target to see and discharge patients within fours hours. The UCC and PAU had arrangements in place to meet people's individual needs. The UCC staff spoke positively about their work and their team. They were positive about the senior management whom they found supportive, encouraging and approachable.
Medical care (including older people's care)	Good 	
Surgery	Good 	Staff were able to speak openly about issues and serious incidents. However, staff told us they didn't always report an incident as they were too busy and did not always receive feedback. There was appropriate medical and nursing staff to cover the work although some medical staff were uncomfortable with the support they needed for more complex post-operative patients.

Summary of findings

We saw the staff use the intranet to access evidence based protocols and care but there were a number of audits either not started or not completed that would demonstrate staff were reviewing their practice in line with national and local standards.
All patients we spoke with were positive about their care and treatment they had received. Staff treated them with kindness and compassion.
Patients were looked after in a responsive manner and we saw patients having to wait for only short periods prior to their surgery.
Surgical services were well led and driven clinically by the matrons who were visible on the wards and departments. There was an appropriate system of governance in surgical care services and arrangements to monitor performance and quality.

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 which was attended, a current EOLC policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.
The hospital 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 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.

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 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. The trust had consistently not met the referral to treatment time standard or England average since April 2015. 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. Staff felt supported by their managers and stated their managers were visible and provided clear leadership

Chase Farm Hospital

Detailed findings

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

Detailed findings

Contents

Background to Chase Farm Hospital

Chase Farm Hospital is situated in the borough of Enfield which has a population of around 321,000. The hospital has a total of 129 beds. The hospital has a full 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
- End of life care
- Outpatients and diagnostic imaging

Detailed findings

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 Chase Farm Hospital

The hospital provides a full range of adult, elderly and children's services across medical and surgical specialties. There are 36 rehabilitation beds, 25 reablement beds, 39 general surgery beds, 25 orthopaedic surgery beds, and 4 high dependency unit beds. The site does not have provision for non-elective surgery or paediatric inpatients.

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	Requires improvement	Good	Good	Good	Good	Good
Surgery	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

Notes

Urgent and emergency services

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

Information about the service

Chase Farm Urgent Care Centre (UCC) opened on 9 December 2013 following the closure of Chase Farm Emergency Department (ED).

The UCC was commissioned by the Enfield Clinical Commissioning Group (CCG) to provide GP and nurse practitioner led treatment for urgent, but non-life threatening, illnesses and injuries. The UCCs opening hours were initially from 9am to 9pm every day. The operating hours were established based on a review of the ED activity data. Due to increased demand from January 2015 the opening hours were extended from 8am to 10pm.

Outside the UCC's operating hours patients were usually directed to EDs at Barnet Hospital or North Middlesex University Hospital. The UCC had an arrangement with the paediatric assessment unit (PAU) that they would see and treat children who attended the UCC. The two services were located in the same building and they shared the reception but had separate waiting and treatment facilities.

At the time of the inspection, the Chase Farm hospital was undergoing major construction project to redevelopment and modernise the site. As a result, in August 2015 the UCC and PAU were relocated into a temporary accommodation and were to remain there until they move into the new hospital in 2018. During the inspection we were told the future of the PAU was uncertain and there were plans to close the unit however this was not yet decided.

Last year the UCC saw in total 38,723 patients of which 28% were children. The UCC's capacity was 150 attendances per day. In 2014 the UCC saw 29,437 patients, on average 80 attendances per day. The number of patients was steadily increasing and in 2015 the UCC saw on average 106 patients per day.

We used a variety of methods to help us gather evidence in order to assess and judge the UCC against the five domains (safe, effective, caring, responsive and well-led). During our inspection, we spoke to 14 clinical and non-clinical members of staff, six patients and relatives and examined four patient records. We observed the environment and we looked at a wide range of documents, including policies, incident records, audit results, performance data, care pathways, minutes of meetings and action plans.

Urgent and emergency services

Summary of findings

We rated the UCC at Chase Farm Hospital at Good overall because;

Chase Farm UCC was a nurse led service. We found that there was a strong and effective clinical leadership within the UCC. The UCC was well organised and consistently delivered safe and timely care and treatment. The UCC had effective incident reporting and recording process in place and all staff we spoke with knew how to report an incident. Staff discussed incidents at weekly team meetings which allowed them to get an understanding of what happened and share lessons learned. We saw evidence that serious incidents were investigated using a root cause analysis process, and actions identified to prevent recurrence.

During the inspection the UCC and PAU appeared clean in all areas. There were sufficient hand-washing facilities and alcohol gel was available throughout the department. We saw staff following hand hygiene and 'bare below the elbow' guidance and we saw evidence of weekly audits which also showed that staff followed hygiene protocols. If a member of staff failed to reach expected standards they received prompt feedback. There were suitable arrangements for the safe management of medicines. Patients were protected from abuse and avoidable harm and staff were clear about their safeguarding responsibilities. There was a suitable skill mix however we found that there were shortages in nursing and GP vacancies. Agency and bank staff covered these gaps.

Staff followed evidence-based national guidelines and best practice to deliver care. Staff were appropriately qualified and trained for their roles. There was strong multidisciplinary working within the UCC and external teams and departments. The UCC offered seven days service. We saw evidence of staff offering care that was kind, respectful and considerate. The UCC collected feedback from the patients to drive improvement. We saw evidence of changes being implemented following patients' comments.

The UCC saw on average 106 patients per day. Staff told us that on occasions the attendance exceeded the UCC's capacity of 150 patients per day. Staff introduced rapid assessment and treatment (RAT) model to help in managing the workload more efficiently on busy days. The data provided by the trust showed that the UCC consistently achieved their target to see and discharge patients. The UCC and PAU had arrangements in place to meet people's individual needs and they prioritised patient with mental health or complex, cognitive problem. There was complaints process in place and the senior management always tried to deal with individual concerns at the local level.

The UCC staff spoke positively about their work and their team. They were positive about the senior management whom they found supportive, encouraging and approachable.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated safety in the UCC at Chase Farm Hospital as Good because;

The UCC had effective incident recording and reporting system and staff was confident about reporting incidents. There was evidence of the sharing of lessons learnt from incidents reported across the directorate.

We found that the UCC had good infection prevention and control. The areas were clean and well maintained.

Medication was securely stored and there was evidence of daily temperature checks.

There were arrangements in place to protect patients from abuse and avoidable harm and staff were clear about their safeguarding responsibilities. There were systems in place to identify and monitor deteriorating patients.

Incidents

- During the inspection we found that there was an effective incident reporting and recording process in place. All clinical and non-clinical staff we spoke with knew how to report an incident and gave us examples of when they had reported one. The examples included issues with patient transport, theft, working late, safeguarding incident and aggression towards staff. Staff explained that if they had concerns about an incident they would speak to the matron or the service manager.
- We looked at an example of a recent incident where learning from the incident had been recorded, along with agreed actions.
- We looked at an example of investigation undertaken by the trust in order to determine the root cause of an incident that happened at the UCC. The investigation looked at the factors linked to the incident. Following the investigation the trust suggested actions and recommendations which they reviewed with all staff involved. The matron also shared learnings from the incident with the rest of the UCC staff during the monthly team meeting.
- A breakdown of all incidents reported through Datix (incident reporting system used by the trust) between June 2015 and September 2015 showed that the most prevalent type of incidents related to security, such as theft or violence. It accounted for 10 out of 27 incidents reported for that period. There were also four incidents linked to the patients flow (access, admission, transfer and discharge) and three incidents related to staffing, facilities and environment. Other incidents such as self-harming behaviour, staff accidents, patient accidents and patient transport had one or two occurrences. One of the incidents that related to security had low severity which meant there was a need for extra observation/minor treatment. The other 26 incidents did not result in any harm.
- There were 14 incidents linked to 'UCC' reported by the trust to the National Reporting and Learning System (NRLS) for the time period 1 January 2015 to 31 December 2015. Five incidents clearly referred to Chase Farm UCC and they resulted in no harm. However, due to limitation of the system we were unable to differentiate whether the remaining nine related to Chase Farm or Barnet Hospital. Of the nine, one resulted in moderate harm and all the others were low or no harm.
- There were no serious incidents related to the UCC reported through the STEIS system (Strategic Executive Information System) from January to December 2015.
- The local security management specialist (LSMS) met and interviewed staff following security related incidents. The LSMS also attended the weekly team meetings. The matron explained this interaction resulted in increased incident reporting. Staff told us they received feedback from the LSMS about incidents.
- Mortality was a standing item of the departmental clinical governance meeting held every quarter. Unexpected deaths which resulted from incidents were discussed at the monthly multidisciplinary ED specialty meetings. The clinical director and clinical governance lead reviewed incidents in with particular reference to any learning or potential changes to policy or process within the department.
- The nursing and administration staff told us they discussed incidents and learnings from them during the weekly team meetings. If a member of staff was not present during the meeting they were encouraged to read the meeting minutes which were readily available in the staff diary. However, we were not assured that learnings from incidents were shared with the middle grade doctors and GP who were not included in the team meetings.

Urgent and emergency services

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.
- We observed a whiteboard near the nursing station explaining the principles of the duty of candour (DoC).
- Staff gave us examples of when they applied DoC by being open and transparent with a patient, or relatives of a patient, about a safety incident.
- A staff member told us they always applied DoC in their practice. They had a good understanding of the DoC requirement and explained the DoC policy applied to certain events which needed to be documented and dealt with within specific timeframes. The staff member also told us they were always honest with patients and apologised for any errors.

Cleanliness, infection control and hygiene

- The UCC and paediatric assessment unit (PAU) appeared clean in all areas. Although there were no cleaning rotas we saw sign-in sheets for a domestic cleaning supervisor who visited the department three times a day to check the cleanliness.
- We looked at the domestic UCC and PAU cleaning audits completed in August, September, November 2015 and January 2016. Scores were consistently over 97% with exception of September 2015 were the UCC scored 92.5%.
- Domestic cleaning staff used colour coded cleaning equipment to avoid cross contamination and they had a good understanding of infection control and hygiene practices.
- There were sufficient hand washing facilities and alcohol gel was available throughout the department.
- The soap dispensers in the toilets had a hand washing technique guidance printed on them.
- Personal protective equipment, such as gloves and aprons, was readily available throughout the clinical areas of the department.
- We saw staff following hand hygiene and 'bare below the elbow' guidance. We observed staff rolling up their sleeves when entering the clinical area.
- Staff informed us PAU toys were regularly cleaned.
- Weekly hand hygiene and 'bare below the elbows' audits demonstrated that the UCC had mostly achieved the trust's target of 95% between June and December 2015with the results ranging from 92% to 100%. In July and December 2015 hand hygiene audit scores were 100%, the lowest score of 94% was in October 2015. In November and December 2015 'bare below the elbows' audit scores were 100%, the lowest score of 92% was recorded in July 2015.
- We also reviewed weekly hand hygiene and 'bare below the elbows' audits at the PAU between August 2015 and January 2016. The results between August and December 2015 were not translated into percentages but we saw that the staff were mostly compliant. If a member of staff failed to reach expected standards they received prompt feedback. In January 2016 a new evaluation tool was used which showed 100% compliance.
- Staff at the department told us the infection control team was responsible for changing fabric curtains in the clinical rooms, Staff were not clear how often they were changed and of the method of cleaning. We observed they were clean. A matron told us the trust was in a process of arranging disposable curtains to improve infection control and hygiene.
- Staff told us they were all responsible for cleaning equipment and that it was a joined effort. If equipment was contaminated with bodily fluids they would send it off for sanitisation.
- We observed green labels on medical equipment and computer keyboards to indicate who by and when then had been cleaned.
- Waste management system was in place for the disposals of clinical and non-clinical waste.

Environment and equipment

- The UCC was well organised, it was bright and clean. The consultation rooms were spacious and well maintained. Clinical staff told us they were happy with the environment and that they had all the necessary equipment to deliver care.
- The PAU offered a secure environment that utilised colour and art with child friendly clinical examination rooms. The doorways which led to the PAU area were secure and not accessible to the public.

- We looked at the resuscitation equipment at the UCC and PAU which was safe and ready for use in emergencies. We saw evidence of daily checks conducted by staff.
- We saw evidence of PAU's monthly health and safety checks between November 2015 and January 2016, with actions taken to reduce any risk.
- The reception desk accommodated between two to three staff members. This area was visibly too small. Staff informed us the receptionists' area were crammed, especially if three people worked at the same time.
- Staff informed us there was adequate seating in the adult waiting area. They said however the area could get noisy and occasionally all the seats were occupied with one or two patients having to stand.

Medicines

- All medications were securely stored. As required by guidance controlled drugs (CDs) were stored in a metal lockable cabinet fixed to the wall. Also, the fridge was lockable with a key, and locked at the time of the inspection. Remaining drugs were stored in a separate storage secured by key code door access.
- Emergency medicines at the PAU were appropriately secured, in date and checked daily. There was awareness that it was important to check they were in-date on a daily basis because staff did not used them frequently.
- We checked controlled drugs register for stock level of all CDs in the UCC and the records showed the correct amount of stock.
- We looked at the records of the fridge temperature checks between December and January 2016. It showed that the temperature was always within the recommended range of 2-8°C. The staff conducted daily checks and there were no omissions.
- Some nursing staff were using 'patient group directions' (PGDs). PGDs are written instructions signed by a doctor and agreed by a pharmacist, which can act as a direction for nurses to supply and/or administer prescription only medicines to patients using their own assessment, without necessarily referring back to a doctor. Staff told us the matron audited and validated the first 10 PGDs for each drug that they were authorised to prescribe.
- The UCC had four nurse prescribers who audited each other's prescriptions every six months.
- There were various information booklets regarding medication available in the UCC and PAU which staff mainly gave to parents of a patient. Adult patients were given medication with already supplied manufacturers' information leaflet in English. There were no information leaflets available in other languages.
- There was one reported medication error since December 2013. This recent error was referred to the matron for further investigation at the time of the inspection.

Records

- Clinical staff from other Royal Free Foundation Trust sites could access patient records electronically.
- We looked at the evidence of weekly patient record audits between September 2015 and January 2016. Each audit looked at one record from each of the three patient groups: adults, children and young people. Most of the records were only partially completed and the combined monthly completion scores were as follows: in September completion rate was 76%, in October the score was 87%, in November 86%, in December 78% and in January 81%. Staff told us if documents were partially completed this was immediately discussed with the staff member.
- All patient records were entered into an electronic patient record system. We noted however that there were inconsistencies in how clinical staff initially completed patient records. Some staff preferred to use paper forms while others entered information directly into the electronic system. The staff who preferred to use paper forms explained the electronic system had limited word count which did not allow them to enter all the details. This meant they had to enter information into the electronic system anyway and leave some details out.
- Staff told us there was no clear direction from the trust as to whether they should use paper or electronic system. The trust informed them they could complete either as long as they used it correctly. However, staff informed us the electronic notes were more important as the discharge summary sent to patient's local GP practice was based on electronic record.

Safeguarding

- Safeguarding refers to the process of protecting people from abuse and harm. The trust had policies and

procedures to support reporting of any concerns and managing risk of abuse. The staff we spoke with were familiar with the processes and knew how to raise concerns about adults and children at risk.

- Adult and children safeguarding training was mandatory and the trust's completion target was 95%. All nurses completed level 1, 2 and 3 children safeguarding training and all doctors completed level 1 and 2 children and adult safeguarding training. The remaining training completion rates were as follow: 91% of nurses completed level 1 and 2 adult safeguarding, 50% of doctors completed level 3 children safeguarding, 85% of administrative staff completed adult and children safeguarding, and 60% of additional clinical services staff completed adult and children safeguarding training.
- A children care record template had a mandatory safeguarding section which prompted staff to assess and record any safeguarding risks and concerns. The adults care record did not have a similar section however staff we spoke with described processes of assessing an adult if they had any concerns and knew how to record and report safeguarding issues.
- One of the UCC nurses was the local lead for child protection and vulnerable adults responsible for liaising with the local safeguarding agencies while the matron was the overall lead. Staff knew whom to contact, in and out of hours, if they needed advice on safeguarding.
- PAU staff were knowledgeable about safeguarding children and told us they were extra careful when it came to safeguarding.
- Each week the matron or the service manager attended a weekly safeguarding psychosocial meeting held at Chase Farm to discuss safeguarding cases.

Mandatory training

- Mandatory and statutory training included topics such as moving and handling, conflict resolution, blood transfusion, equality diversity and human rights, fire safety, health and safety, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), infection control, resuscitation, safeguarding adults and children, resuscitation, and waste management.
- All new staff members, including bank staff, had to undergo an induction program. Bank staff were also required to complete mandatory training.
- The trust's mandatory training completion target was 95%. The actual completion rate at the time of the inspection was variable across four staff groups and across the topics. When looking at the staff groups, overall 92% of nurses and doctors, and 90% of administration and clerical staff completed their mandatory training. The group with the lowest completion rate was the additional clinical services staff with 61% completion rate. When considering the individual training, out of 20 topics 17 fell below the trust's 95% completion target. The eight topics with the lowest completion rate were: blood transfusion (75%), fire safety (81%), infection control level 2 (82%), Mental Capacity Act and DOLS (74%), resuscitation level 2 (76%), safeguarding adults level 1 and 2 (81%) and safeguarding children level 3 (82%).
- When mandatory training was up for renewal staff received an email reminding them to complete it.
- Staff told us the management encouraged them to compete the mandatory training and they were allocated time to do so.

Assessing and responding to patient risk

- The UCC aimed to see adult patients within 20 minutes of arrival and child patients within 15 minutes. The reception staff told us if they had concerns about patient's wellbeing they would ask a nurse to see them quicker. Most of the reception staff was also working at Barnet ED therefore they were familiar with the more serious injuries and illnesses. We found that the reception staff had a good understanding of when to raise concerns with the clinical staff they mostly used experience to identify patients who might require urgent clinical involvement. They explained they would prioritise patients with chest pains, severe infections, serious pain or presenting any condition that should go to A&E.
- The UCC and PAU had a system in place to track patient's acuity (level of need for care) and to identify deteriorating patients. They used the 'patient at risk' (PAR) scoring chart for adults and 'paediatric early warning score' (PEWS) chart for children. Staff calculated the score by observing and recording various physiological variables such as blood pressure, respiratory rate, oxygen saturation, and temperature among others. This assisted in identifying the level of risk of deterioration.

- Both, scoring and observation charts, were incorporated into the patient record form. The PEWS had a clear directions for escalation printed next to the observation chart, while PAR was colour coded which helped to indicate if a patient was at risk of deterioration.
- PAU staff told us they used SBAR ('situation background assessment recommendation') as a tool to frame critical conversations requiring a clinician's immediate attention and action.
- We spoke with two staff members about how they would monitor a deteriorating patient. They had a good understanding of how to use the charts and how to identify deteriorating patient.
- Acutely unwell adult and children patients, or those at risk of deterioration, were monitored in a high dependency bay which was located opposite the nursing station at the UCC. There was a system in place to reorganise work so that the patient at risk had a staff member with them at all times.
- We spoke with a staff member about their role in an emergency. They knew the escalation protocol and they felt confident to take charge and direct staff if a more senior staff member was not available.
- According to the Resuscitation Council (UK), Chase Farm UCC was considered to be a prime care service in terms of life support training requirements. This meant staff were not required to have the advance life support (ALS) training although middle grade doctors had completed ALS. Depending on the role, staff completed intermediate life support (nurses and GPs) or basic life support (administration and clerical staff). Also, the PAU consultant was an advanced paediatric life support (APLS) faculty member.
- There was a clear protocol in place concerning ambulance conveyances of patients to the UCC. The protocol incorporated National Early Warning Score (NEWS) to assure appropriate patients were directed towards the UCC.
- Acutely unwell or unstable patients who required hospitalisation were usually assessed, stabilised and transferred to Barnet or North Middlesex ED via 999 ambulance service.

Nursing staffing

- At the time of the inspection the UCC was operating extended hours on request of Enfield Clinical Commissioning Group (CCG). The opening hours were from 8am to 10pm, instead of the originally specified 9am to 9pm. The change had negative impact on the staff and shift patterns. The extended hours were not formally agreed and the trust did not increase staffing levels to reflect this change. Staff told us they often did not finish until 11pm or even 12am. This meant that if a staff member was scheduled to work the next day they could not start until they had the minimum hours of rest as required by the European Working Time Directive. This consequently had adverse impact on staff and their workload the following day.
- We were told that although patients' care was never compromised the system relied on staff generosity, great team spirit and people's good nature to cover late shifts. The matron recognised that this was not a sustainable model and they were trying to address this issue with the trust. However, we were informed the recruitment was put on hold until the trust was able to make a decision on the future of the PAU as this would affect the staffing levels. The future plans for the PAU would depend on what the CCG decided.
- In order to maintain safe staffing levels, bank and agency nurses were used. We were told the UCC tended to use the same agency nurses that were familiar with the site. The matron informed us that they reduced the agency usage since January 2016. During the inspection week the agency nurses covered four shifts while bank nurses covered two and a half shifts.
- The UCC should have had 10 whole time equivalent emergency nurse practitioners (ENPs) in post but there were only six ENPs. At the time of the inspection, a new ENP was undergoing an induction which meant that they would start work in a month time. The matron was working clinical shifts to support the service and cover the staffing gaps.
- The PAU had four senior children nurses and three junior children nurses with students from Middlesex University. We were informed staff rotated between the PAU and Barnet Galaxy children's ward. The matron from Barnet visited the PAU weekly.
- During our visit we found a suitable skill mix, with experienced and senior nurse staff available to support junior nurses.

Medical staffing

- At the time of the inspection, medical cover for PAU and UCC consisted of GPs working between 8am and 11pm. Additionally, the UCC employed two middle grade doctors to support and upskill the ENPs. The middle

grade doctors were available Monday to Wednesday between 10am and 8pm, Thursday 1pm-8pm, Friday 12pm-8pm and weekends 11am-7pm. There was a paediatric consultant working Monday to Friday between 9am and 5pm, outside these hours there was an on call paediatric consultant.

- The middle grade doctors were not covered during annual, study or sick leave. Their work was shared between ENPs and GPs.
- The Clinical director was the consultant for the UCC. Staff could contact him if a problem was not solvable by a medical speciality. In hours staff had access to consultants at Barnet ED and out of hours staff could contact a consultant on call.
- An independent provider employed and provided GPs to the UCC. We were told that there were difficulties with recruiting and retaining UCC GPs. At the time of our inspection, there were issues with GP staffing and the senior management added this to the risk register.

Major incident awareness and training

- The trust had an emergency preparedness response and recovery (EPRR) policy in place which specified the responsibilities and actions of staff and partners in the event of a major incident and special emergencies. Chase Farm Hospital had also its own site specific plans.
- Staff told us there was a recent change to the major incident management in relation to dry contamination. The trust produced a video which was available online for staff to view.
- We spoke with a member of staff about the UCC's role during a major incident. They were aware of the plans and their role in a major incident.
- Staff rehearsed a major incident in September 2015. The senior management explained they agreed with the trust's emergency planning team to practice major incidents scenario every three to four months. At the time of the inspection, the management and emergency planning team were arranging incidents scenarios.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effectiveness in the UCC at Chase Farm Hospital as Good because;

Staff used care pathways for certain conditions in order to standardise the care given. These were accessible through the intranet and staff were able to give us examples of following evidence based national guidelines and best practice.

There were systems in place to assess and give pain relief in a timely manner. The UCC monitored their daily performance against two hours and four hours target which they consistently achieve. However, the UCC was unable to demonstrate that they assessed every patient within 20 minutes of arrival due to the system limitations.

Staff were appropriately qualified and supported to deliver care. There was good multidisciplinary working within the UCC and there was effective collaboration with external departments.

Staff had awareness of mental capacity. The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) were part of the mandatory training.

However;

The completion rate for MCA training of 74.1% was below the trust's 95% target.

At the time of the inspection there were no outcome related audits and the senior management were in the process of reviewing their auditing programme.

Evidence-based care and treatment

- There was a range of trust wide clinical pathways and good practice guidelines which staff told us they could access via the intranet. Clinical pathways have been designed to implement national standards or determine care provision by using the best available evidence.
- The UCC used care pathways in order to standardise the care given. Staff gave us examples of using the following

pathways: feverish illness in child, head injury, headaches, back pain and deep-vein thrombosis. We reviewed patient notes which referenced and were in line with published guidelines.
- The UCC had a clear guidance for critical and non-critical patient transfers. The UCC only dealt with minor illnesses and minor injuries and any seriously ill patient that could not be treated at the UCC or PAU required timely hospital transfer. Staff demonstrated a good understanding of the patient relocation protocols.
- To ensure published guidance was followed staff carried out various local audits including pain audit, hand hygiene, record keeping, medicine, quality of interactions between staff and patients, among others. At the time of our inspection, the senior management was in the process of reviewing auditing processes and deciding what to audit to make it more comprehensive, relevant and suitable for the department.
- The nursing and administration staff held brief daily situation reports meetings (SitReps) three times a day to discuss patients, workload and any issues.

Pain relief

- The UCC did not use any formal pain assessment tool to assess pain in adults. However, staff told us that establishing and recording patient's pain intensity was a part of the initial patient assessment. During the initial assessment staff asked patients whether they were in pain, if they had already taken anything and if appropriate they would offer analgesia. Staff recorded this in patient notes.
- The PAU used an appropriate children pain assessment tool which was incorporated into the patient record. The tool was a faces scale which helped to assess the intensity of pain by asking a child to point at a drawing of one of the five faces, from a happy face to a very unhappy face.
- The reception staff informed us if a patient was in significant pain that would alert a nurse who would come and assess the patient quicker.
- We spoke with a patient who was waiting for an x-ray. They informed us during the initial assessment staff asked them if they were in pain and they were offered pain relief.
- Four emergency nurse practitioners (ENPs) could prescribe analgesia and some junior nurses could use patient group directions (PGDs) also to offer pain relief. Staff told us when prescribing pain relief they take into account different factors such as age and occupation.
- Staff told us they offer advice to patients on how to manage pain and they tell them to come back if they feel unwell.

Nutrition and hydration

- Since most of the UCC and PAU patients were treated and discharged within two hours of arrival the department did not have any formal catering arrangements in place.
- Fresh water was available to the patients.
- Vending machines dispensing drinks and snacks were in the waiting area.

Patient outcomes

- We were told that at the time of the inspection the Royal College of Emergency Medicine (CEM) audit cycle did not apply to the UCC therefore the department did not participate in any of the national audits.
- At the time of the inspection there were no outcome related audits. The senior management told us they were in the process of looking at what audits they wanted to carry out so that they had their own audits specific to the UCC.
- The trust monitored the daily performance of each of the emergency departments which included Chase Farm UCC. They checked their performance against the four hours target, and breaches related to delays of treatment and care. We saw evidence that the UCC consistently met the four hour target between January and December 2015.
- Enfield CCG, who commissioned the UCC service, had laid out an aspirational expectation that 80% of patients would be seen, treated and discharged within two hours of arrival. The senior management presented us data between May 2014 and October 2015 which showed that the UCC consistently achieved the two hour target.
- The trust's expectation was that 95% of adult patients would be initially assessed within 20 minutes of arrival. The senior management told us they were unable to provide the data on the 20 minutes target since their

system did not allow them to accurately report on it. Although staff and senior management told us that they consistently achieved this target we were not able to verify it.
- The UCC had a book where staff logged unusual for the UCC cases which they followed up for learning and to inform how to act in similar cases. The examples we were given were heart attacks and a snake bite.

Competent staff

- The skill set within the UCC was appropriate for dealing with minor emergency and primary care conditions.
- GPs were trained to work in the urgent care setting by shadowing UCC GPs. The middle grade trust doctors and ENPs would primarily deal with trauma and minor injuries while GPs were mostly looking after primary, day-to-day healthcare and children.
- The nursing staff had well defined roles and for certain duties they had to undertake additional training. Staff told us their competency was checked before they undertook additional responsibilities and that their work was regularly peer reviewed. For example, the ENPs were responsible for radiology interpretation and prescribing medication. Some junior sisters could use PGDs while emergency department assistants (EDAs) could stream patients with certain conditions and provide treatments as directed, such as plastering, wound care or taking observations.
- At the time of the inspection, the staff appraisals were up to date for all but one person.
- There were weekly consultant training days attended by middle grade doctors. Some teachings were related to the ED work, while others were role specific, such as ultrasound. The middle grade doctors attended a yearly radiology course and they continuously improved their practice through online courses and seminars.
- Clinical supervision for the middle grade doctors was with the clinical director for Barnet and Chase Farm Hospitals. However, the doctors did not have regular meetings with the clinical director and these were only held if there were any issues.

Multidisciplinary working

- The UCC service model was that clinicians would assess all patients attending the department. The initial assessment would decide whether treatment should continue in the UCC, if the patient had to be transferred to the ED or if they should be redirected to their local GP. If the patient was redirected to their GP, the primary care liaison officer (PCLO) would engage with them to assist them in booking a GP appointment.
- There was effective internal multidisciplinary team working within the UCC and cross-site with the PAU. The middle grade doctors, GPs, nurses and administration staff communicated well, and sought each other's advice and expertise to deliver patient care. All staff that we spoke with told us they were a good integrated team and that they always prioritised and shared workload.
- UCC had a clearly defined patient acceptance and exclusion criteria supported by close partnership with external teams and good staff knowledge of referral routs. Staff gave us numerous examples of effective working with other departments and transferring patients to other sites.
- The clinical staff told us they could access specialist advice from medical and trauma consultants and registrars from Barnet Hospital and North Middlesex Hospital (NMUH). They could book patients for follow up appointments with medical and surgical specialities at Barnet and Royal Free Hospital.
- The UCC staff could seek advice from an on-call orthopaedic consultant through a virtual fracture clinic at Barnet Hospital.
- A consultant radiologist reviewed all x-rays for quality assurance.
- The UCC had an arrangement in place to seek advice form Chelsea and Westminster Hospital regarding burns. Staff could take photographs of burns and email them to Chelsea and Westminster Hospital and follow up the email with a phone call to discuss the issue. When appropriate, the staff would arrange a follow up appointment at Chelsea and Westminster Hospital or arrange a patient transfer.
- Deteriorating patients or those with complex conditions who presented themselves at the UCC were transferred to Barnet or NMUH ED. If appropriate, the UCC staff would book a patient to be reviewed by specialities. For mental health assessment patients were also transferred to Barnet or NMUH. Although, there were well defined patient transfer protocols, staff told us there was a trust wide issue with the flow of emergency patients. We were informed delays in patient transfer to Barnet Hospital caused delays in assessment and treatment. This issue was added to the divisional risk register as a high level risk.

Urgent and emergency services

- PAU nurses and doctors told us multidisciplinary working was good. A play specialist attended the unit once a week. They had access to specialist nurses from different Chase Farm departments who advised on various conditions such as nocturnal enuresis, allergy, epilepsy, diabetes, and oncology.
- Staff told us they had a good relationship with the pharmacists who were easy to contact.
- Allied health professionals were not involved in the care at the UCC.
- The UCC and PAU had x-ray room on site and access to radiographer on call. Senior management told us they did not have enough cases to have a radiologist on site at all times, but that they were easily available.

Seven-day services

- The UCC operated seven day service between 8am and 10pm and PAU operated from 9am to 9pm. GPs and the UCC nurses saw children out of PAU's operating hours.
- GPs and middle grade doctors were available seven days a week.
- Paediatric consultants worked Monday to Friday, at weekends there was an on call cover.
- The on call ED consultants were available to provide advice on patient care seven days a week.
- The x-ray room operated every day between 9am and 9:45pm.
- A radiologist was available throughout the week but there was no weekend cover. They reviewed weekend x-rays on Mondays.

Access to information

- Staff could access patient information from computers located at every clinical and assessment room. They could also view the overall status of the UCC to see how many patients were waiting, their age, length of stay, reason for attending, among others.
- Staff told us when a patient was transferred to a different hospital, their printed information was transferred with them. The information was also available electronically at the other trust sites.
- A summary of attendance at the UCC was printed and sent to the patient's GP by post from the Royal Free site. This meant that GPs received patient information with some delay.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA), and Deprivation of Liberty Safeguards (DOLS) were part of the mandatory training. At the time of the inspection, the training records showed that 74.1% of the UCC staff completed MCA and DOLS training against the trust's target of 95%.
- We saw policies on DOLS, MCA, consent for examination and advanced decisions. There were decision flow chart for advanced decision and consent. We also saw a mental health assessment form.
- Staff told us if they required assistance or advice regarding a patient with mental health issues they would contact the mental health team.
- We observed a member of staff asking a patient for consent before carrying out a medical assessment.
- A staff member gave us an example of when a patient had to be restrained. We were told that this was handled appropriately and the staff involved worked well together to control this complex situation. Following the incident there was a debrief meeting with the staff involved were they spoke about dignity and privacy, what they could have done better and lessons learned.
- The UCC staff did not carry out mental health assessments. Staff told us if they had identified during the initial assessment that a patient required a mental capacity assessment they would transferred them to Barnet ED where the assessment would be carried out.
- A member of staff we spoke with had limited knowledge of their responsibilities under the MCA. They told us they knew how to assess patient's capacity but that they did not undertake it because their role was to safely treat people without making any long term plans.
- Another staff member told us patients who attend the UCC usually walked in or were referred by their GPs. If they lack capacity they were usually accompanied by their carer or a family member with whom staff could discuss care.

Are urgent and emergency services caring?

Good

We rated caring in the UCC at Chase Farm Hospital as Good because;

Urgent and emergency services

We observed that staff provided care that was caring and respectful. Patients and their relatives expressed positive views about the care they had received.

Although the NHS Friends and Family Test (FFT) was not formally introduce in the UCC the senior management decided to carry out the survey and explained that patient's feedback was very important in understanding patient experience.

Patients were seen in individual consultation rooms therefore their privacy and dignity was protected at all times.

The UCC did not have a daily contact with the bereavement team however if required staff knew how to access their service. A counselling service and occupational health was available to staff.

Compassionate care

- We spoke with six patients and relatives during our inspection. Feedback about staff was positive. One patient told us they had "found nurses and doctors excellent. Could not fault them" and that "care is very good and I am shown lots of respect." Another patient stated "the staff is great. I am very happy."
- We observed a patient being cared for in the high dependency bay and another patient being admitted to the PAU. The interaction we observed was very positive. The nurses introduced themselves, they were respectful and caring.
- The UCC used the NHS Friends and Family Test (FFT) to obtain feedback from patients. The FFT is a single question survey which asks patients whether they would recommend the NHS service they had received to friends and family who needed similar care or treatment. The UCC used a combination of electronic responses and paper forms where people could also add their comments. The FFT results were displayed on a board in the main UCC corridor; this included positive and negative comments.
- The FFT results between October 2015 and January 2016 showed that 88% of respondents had stated they were extremely likely or likely to recommend Chase Farm UCC to their friends and family. This was similar to England average FFT results of 87% for A&E between October and December 2015. However, we recognise that the response rate was very low and was based on 75 responses out of over 6,500 patients who attended the UCC in the three months period.
- The respondents stated the UCC staff were friendly, reassuring and knowledgeable, they were happy with the quick and efficient service and short waiting times. One patient stated "lovely staff and doctors. Fabulous care and treatment", another patient commented "stay as you are. Exceptionally outstanding care. So impressed. Thorough examination with knowledgeable diagnosis. Thank you." Patients also stated that certain things could be improved such as hospital signage of the UCC which was difficult to find, or not being informed about waiting times.
- The PAU carried out a pilot FFT in January 2016. The results were based on 18 responses and were largely positive. All respondents stated they would recommend the service to friends and family. The respondents complimented staff for being friendly, knowledgeable and kind. One patient commented "after 10 weeks of health visitors, regular GP and two other GPs, I finally got taken seriously here!", another patient stated "we were seen very quickly and my concerns about my son's health were taken seriously". Patients appreciated short waiting times, attentive staff who took time to listen, and being "treated with respect". On the other hand, some patients stated the PAU was difficult to find and the waiting area was not comfortable.

Understanding and involvement of patients and those close to them

- Although the trust used the FFT to obtain feedback from patients, they did not formally introduce it in the UCC. The senior management decided to carry out the survey and explained that patient's feedback was very important in understanding patient experience. They were especially interested in the narrative information provided in the feedback so that they could improve the service.
- We have spoken with a patient who was waiting for an x-ray. They told us they were very happy with the staff who explained them what was happening and how long they would have to wait.
- We observed reception staff positively responding to a partially sighted patient by requesting a nurse to chaperone them to the clinical area.

Urgent and emergency services

Emotional support

- Since the UCC mainly dealt with minor conditions they did not have a daily contact with the bereavement services but staff knew how to contact them. Staff told they would contact a senior manager if they needed help or advice.
- There was no counselling available to patients and if required staff would refer them to their local GP or a mental health charity such as Mind.
- A staff member gave us an example of when they had to break bad news to a patient. They demonstrated a sensitive and professional approach. They also explained that since they saw patients in the individual rooms their privacy and dignity was protected at all times.
- A counselling service and occupational health was available to staff.

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

Good

We rated responsiveness in the UCC at Chase Farm Hospital as Good because;

Since the opening, the UCC saw a steady increase in patients' attendance. The UCC consistently achieved the trust's standard that 95% of patients should be discharged, admitted or transferred within 4 hours.

The UCC introduced rapid assessment and treatment (RAT) model to help in managing the workload more efficiently.

The UCC and PAU had various arrangements in place to meet people's individual needs such as access to a play specialist, distraction box for children and dementia box for people living with dementia. Staff told us they prioritised patient with mental health or complex, cognitive problems.

Staff had a list of organisations who offered support to the victims of domestic violence. There was access to a telephone translation services should these be required.

However;

Since the closure of Chase Farm ED many patients did not know about the UCC and what their function was. The senior management was trying to promote the UCC through local advertising campaigns.

Service planning and delivery to meet the needs of local people

- The UCC's function was to deliver urgent care to adults and children with minor, non-life threatening and short-term illnesses which required prompt treatment or advice. Patients who attended the UCC or PAU were usually referred by their GP, 111 call or walked in. Staff told us since the Chase Farm ED was closed many people did not know that the UCC existed. Staff told us quite often people did not know what the function of the UCC was. Two out of four patients we spoke with told us they did not know about the UCC before they were referred there from a different hospital or clinic. One patient told us "there has been lack of communication but now I will use it when needed", and later added "this service is ideal".
- A senior manager told us in the past they tried to promote the UCC which brought great results. They had a local bus advertising campaign and they distributed leaflets in the local areas. They explained that at the time of the inspection there were no plans in place to distribute leaflets or another bus campaign due to financial restrains. However, they asked trust's communications team to send emails to the local schools to increase their knowledge and understanding of the UCC.
- The UCC had an agreement with the PAU that they would deliver care to children attending the UCC. The two units were in the same building and they shared the entrance and reception but had separate waiting areas. Outside the PAU's operating hours the UCC GPs and nurses saw children.
- The UCC was designed to deal with 150 patients per day. Daily performance data between August 2015 and January 2016 showed the UCC saw between 71 and 136 patients per day and on average 100 patients. The day before the inspection the UCC saw 160 patients. Staff told us such busy days were becoming more frequent and they reported it as safety incidents. In response the trust suggested introduction of rapid assessment and treatment (RAT) model which helped to manage the workload more efficiently. All staff we spoke with talked about team work and sharing responsibilities and tasks

to assess and treat patients in order to stop work from building up. Staff told us although the work at times was very busy it was not stressful and they liked the fact they had the time to speak with patients and build rapport.

- If a patient was not registered with their local GP the primary care liaison officer (PCLO) advised them on how to register and if required assisted with the paperwork. The PCLO also dealt with the patients who were not entitled to the NHS free care. If patient's first language was not English the PCLO could use a telephone language service.
- The PCLO also assisted patients with booking GP appointments and sent information to GPs regarding patient's dressing change requirements. The PCLO had a list of surgeries that did not offer dressings change in which case a patient was informed they could bring their own dressing which the UCC staff would change.

Meeting people's individual needs

- The PAU could arrange for a play specialist to support children and make their visits more enjoyable. They also had a distraction box to help children relax and keep them entertained.
- The staff we spoke with had a good understanding of caring for people living with dementia and their needs. There was a dementia box that staff could use to divert or occupy people with dementia. The dementia lead nurse for Barnet and ED delivered training and staff that we spoke with gave a very positive feedback regarding this session. One of the UCC nurses was a dementia champion. Dementia champions are trained volunteers who act as a point of contact for staff and encouraged others to learn about dementia. There were resources available online to help staff support people and understand dementia.
- Staff told us they usually triage patients in a time order however they would prioritise a patient with mental health or complex, cognitive problems. Staff told us they supported patients in that manner as they knew the hospital setting could exacerbate their condition.
- The UCC had a folder with contact details of charities and organisations who offered support to the victims of domestic violence. There was a domestic violence helpline poster inside the patients' toilet.
- The UCC staff could refer elderly patients to the Older Persons Assessment Unit (OPAU) which was another primary care unit opened during week between 9am and 7pm. OPAU offered a range of treatments and diagnostic tests, such as blood tests, blood transfusions x-rays and ECGs. They could also refer patients to a physiotherapist or an occupational therapist who would assess and help to maintain patient's independence.
- Staff told us they had training on female genital mutilation which was covered during child safeguarding course.
- To improve patients' interaction with the reception and to preserver privacy the glass panel which separated the reception from patients was removed. The trust risk assessed the area and consulted staff who largely supported this plan.
- There was access to a telephone translation services should these be required although staff told us patients were usually accompanied by a relative who could translate.
- There was a range of leaflets available for patients such as information on hand injury, ankle injury, sex health, 24h dental care, strain and sprains, and eye injury. However, these were only available in English.
- Staff told us they were aware the UCC was not very dementia-friendly environment and they asked the trust for the new building to address this issue.
- If a patient was unwell and was waiting to be transported, or was under observation staff could offer them tea, biscuits or toast. They could also arrange a meal by calling the canteen.

Access and flow

- The UCC used a nurse led approach to triaging patients. After registering at the reception usually a junior sister or emergency department assistant (EDA) assessed patients within 20 minutes of arrival (15 minutes if it was a child).
- Between January and December 2015 the UCC saw 38,723 patients. In that period the UCC had eight cases of four hour breaches which meant that they met the target in 99.98% of cases (trust's target was 95%). The England average for that period was 93%.
- Data from January 2016 showed that 81% of patients were discharged within two hours of arrival (trust's target was 80%).
- We checked the patients list during our visit and at the time there were 15 patients (six of them were children). The patients list showed that the average length of stay was 55 minutes however the list did not show if patients were assessed within the 15-20 minutes target.

Urgent and emergency services

- The data provided by the trust between November 2014 and October 2015 showed that there were no ambulance handover delays at the UCC.
- The trust's target for unplanned re-attendance rate within seven days was set at 5%. The UCC provided us with the data between May 2014 and April 2015 which showed the rate was between 0.6% and 2.25%. This was below the trust's 5% target and much below England ED average for that period of approximately 7%. Staff told us that patient re-attendance was mostly for changing dressing.
- The admission rate was below the England average. The PAU admission data between June and December 2015 showed that no PAU patient was admitted to hospital in that period. The admission rate at the UCC was very low. The data between April and August 2015 showed the admission rate was 0.6% (England average for ED was 21%).
- For non-urgent transfers reception staff could arrange patient transport and book an appointment with the relevant specialist team. Nurses were responsible for arranging transfers of patients who needed urgent care in ED.

Learning from complaints and concerns

- Data provided by the Trust between December 2014 and November 2015 showed that the UCC had received six complaints. These accounted for 3% of all complaints received by the trust in that period. Of the six complaints, four related to clinical treatment and the remaining two related to insufficient communication.
- Senior management told us they tried to deal with the individual concerns at the UCC level, before they escalated into more serious complaints. The senior management explained they always tried to invite a patient to discuss their concerns. They gave us an example of when they positively dealt with and resolved patients complaint by meeting them and discussing the issue.
- Patient experience and complaints was a standing item on the clinical governance and risk committee agenda which was held once a month.
- The senior management told us they sent the FFT results to staff and discussed patients' comments at the team meetings.
- Leaflets explaining complaint process were available in the waiting area.
- We observed 'you said, we did' board in the main corridor which showed that the UCC encouraged patients to give feedback and that services responded to complaints that were made. For example, after receiving feedback from patients about not being informed about the waiting times staff put a board up in the waiting area which displayed average waiting time. The senior management also asked the trust to improve the signage around the hospital after patients stated they had difficulties in finding the UCC.

Are urgent and emergency services well-led?

Good

The emergency department for The Royal Free Hospital NHS Foundation Trust at the Chase Farm site was led by a clinical director, a service manager and one matron. This management structure reported to the urgent care divisional board and had joint governance meetings with the Barnet site.We rated leadership in the UCC at Chase Farm Hospital as Good because;

- There was a strong clinical leadership team within the UCC. We found the UCC to be well organised and managed. The UCC team consistently delivered safe and timely care and treatment.
- All staff spoke positively about working at the UCC. Staff told us the matron and service manager were supportive and approachable. Staff supported each other and worked collaboratively to ensure they delivered safe and effective care.
- Staff told us they were encouraged to contribute ideas towards quality improvement and said they had opportunities to develop their career.

However;

- We found there were gaps in the UCC's medical leadership. The doctors did not have any regular meetings with other UCC staff and had no formal meetings to express their concerns and raise issues.

Vision and strategy for this service

- The trust stated that one of their first commitments following the acquisition of Barnet and Chase Farm Hospitals NHS Trust was to redevelop and modernise

Chase Farm Hospital. Plans of what the future hospital building would look like were displayed at Chase Farm site. Staff told us the redevelopment was exciting and stated the executive team showed a great deal of interest and support for the UCC. Staff told us they were involved and consulted on plans for the new UCC.

- There was no separate strategy for the UCC services within the trust. However, the trust had a clear strategic direction which was to provide world class expertise and local care. We asked a staff member about the vision but they did not remember it.
- Staff felt Barnet ED received more attention and support from the divisional management team and their involvement in the UCC was reactive rather than proactive.
- Staff told us there was a division between the three Royal Free London NHS Foundation Trust hospitals. We were told that Barnet and Chase Farm were not working together with the Royal Free site. Some staff told us they did not notice any change since the acquisition.
- We were told staff were concerned about uncertain future of the PAU and its possible closure.

Governance, risk management and quality measurement

- The clinical governance and risk board meetings for Barnet and Chase Farm sites were held every month. We reviewed the minutes of the meetings between July and November 2015 and we saw that discussions about safety incidents, duty of candour, risk register, audits and NICE guidance took place. The meetings were usually attended by operations managers, clinical directors, consultants, and matrons.
- The UCC senior management also attended monthly urgent care operations meeting for Barnet and Chase Farm sites. There was no operational meeting for all three trust hospitals.
- At the time of the inspection, the UCC had one risk against the divisional risk register which related to ENP staffing levels. The risk was mitigated by the use of bank and agency staff. The UCC was waiting for authorisation of business case to change staffing establishment. Also, during the inspection we were told another risk was going to be added to the register which related to the gaps in the out of hours GP cover. There were no risks against PAU at the time of the inspection.
- Assigned staff members conducted regular audits. Staff told us that if someone felt short of the expected standards they would address it immediately with the staff member to drive improvement.

Leadership of service

- Chase Farm UCC was a nurse led service. We found there was a strong and effective clinical leadership within the UCC. We saw evidence that the UCC was well organised and consistently delivered safe and timely care and treatment.
- Staff told us the matron and service manager were supportive and approachable. They had a good control over the UCCs operational activities and we saw evidence that they responded well to changing demands and work pressures.
- The matron had protected time dedicated to work a clinical shift once a week. They stated it was important for them to work clinical shifts so that they could be part of the team and lead by example.
- Staff spoke highly of the head of nursing and chief executive who were supportive and frequently visited the UCC and PAU.
- However, we found that UCC middle grade doctors and GPs did not have any regular meetings with other UCC staff.
- We found that there were gaps in the UCC's medical leadership. Middle grade doctors met with their clinical supervisor infrequently and they had no formal meeting to voice their concerns and raise issues.
- An independent company employed the GPs however they worked to the trust policies. Although the medical director of the independent company carried out clinical audits of GPs practice, there were no other arrangements with the trust to support and oversee their work.

Culture within the service

- All staff spoke positively about working at Chase Farm UCC. They said they enjoyed their work and told us about "superb" staff, "great comradery", feeling valued and supported.
- Staff told us the trust encouraged them to take regular breaks.
- The UCC had an arrangement in place to meet the religious and spiritual needs of staff.

- All nurses and doctors we spoke with valued the working arrangements which allowed them to take time to build rapport with their patients.
- Administration staff, nurses and doctors supported each other and worked collaboratively to ensure they delivered safe and effective care. However, some staff acknowledged that the lack of sufficient staffing levels and working late hours had a negative effect of them.
- The matron recognised that problems with staffing levels and workload, in particular having to work late, affected staff. They stated the team had a great spirit and at times they had to rely on their good nature but were aware that this was not a sustainable solution. The matron often covered gaps in clinical shifts to support the team. The matron presented a business case to the trust to increase the staff levels. Staff told us they were given time off for hours worked beyond the normal working day.

Public and staff engagement

- The UCC captured patients and families' views through FFT questionnaire and patient feedback forms.
- Patients, members of the public and staff who want to know more about the Chase Farm redevelopment could visit redevelopment hub, located in front of the Clocktower building at Chase Farm Hospital. They could read the planning documents, ask questions and leave feedback.
- The administration and nursing staff had regular monthly meetings where they discussed complaints, positive feedback, learnings from incidents and training opportunity. This was also their opportunity to bring any concerns and ideas up. PAU nurses attend the monthly sisters meetings at Barnet site.

Innovation, improvement and sustainability

- Staff told us they were encouraged to contribute ideas towards quality improvement within the department and they could approach the senior management at any time.
- We saw evidence of innovation and service improvement projects led by staff. A staff member told us about a patient flow chart that they introduced which improved reporting of a patient flow during SitReps. Another staff member was in a process of developing and introducing a tool to improve the QUIS (Quality of Interaction Schedule) observational audit which, in its original form, was not fit for the UCC setting.
- Staff told us they had opportunities to develop their career. The matron wanted to promote their own staff so they over-recruited junior nurses. The matron planned to send two nurses on an emergency nurse practitioner course. One of them was already booked on the course while the other was waiting to receive founding from the trust.

Medical care (including older people's care)

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

Information about the service

Capetown ward had 16 beds allocated to stroke rehabilitation and 20 beds for general rehabilitation patients. Adelaide ward had25 beds for reablement patients who required support for sub-acute or social issues in hospital prior to discharge to their usual place of residence. Napier ward was an escalation ward for times when bed capacity in the trust reached critical levels. This was closed leading up to and during our inspection. A new endoscopy suite was opened in December 2015 and there were 13 patient rooms available within this unit. Approximately 1000 patients each year were admitted to Chase Farm Hospital under the medical services.

We visited the medical service at Chase Farm Hospital for one announced inspection day. During our inspection we inspected all wards and the endoscopy suite, spoke with 23 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the medical leadership team, 11 patients and three relatives. We checked 11 patient records and many pieces of equipment.

Summary of findings

Overall we rated medical services at Chase Farm Hospital as Good because;

The needs of older people and people living with dementia were at the forefront of service developments, including the refurbishment project and reviews of patient pathways.

Few patients had to move between wards and when they did, it was usually in the daytime.

There was effective multidisciplinary working, including liaison with community teams, to facilitate timely discharge planning.

Patients and their relatives were involved in decisions about their care, such as setting specific, individualised rehabilitation goals. There was a positive culture on the medical wards and staff were engaged with developments in the service.

Staff showed good understanding of consent and mental capacity act principles and knew how to raise safeguarding concerns. We saw evidence that Deprivation of Liberty Safeguards (DoLS) were used correctly. There were good rehabilitation facilities and ward activities available for patients.

However;

Documentation was not always fully completed such as falls risk assessments, nutrition charts and fluid balance charts which could place patients at risk.

Medical care (including older people's care)

Some safety data had not been fully reported and staff were not entirely aware of duty of candour principles. There were some areas of poor practice in relation to infection prevention and control.

Patient length of stay was longer than in other units and privacy and dignity was not always fully maintained. Audit activity and risks recorded by the service were unclear.

Are medical care services safe?

Requires improvement

We rated the safety of medical services at Chase Farm Hospital as Requires Improvement because;

The number of reported incidents was low and staff told us the new computer-based forms took too long to complete and so some issues were no longer reported.

We observed some poor infection control practice in relation to use and disposal of personal protective equipment and staff did not always clean their hands after performing patient care tasks.

There were some gaps and inaccuracies in falls risk assessments which could place patients at risk. There were also gaps in safety thermometer reporting, although data which was reported showed no concerns.

Mandatory training rates were below the trust target and staffing numbers relied upon unqualified nursing assistants to support the gaps left by vacant posts.

However;

Staff understood safeguarding principles but not all staff were familiar with duty of candour.

The environment was visibly clean and mainly fit for purpose, although the treatment room on Adelaide ward which stored medicines was hot and the temperature was not monitored.

Patient at risk scores were completed accurately and staff knew escalation procedures for deteriorating patients.

Incidents

- There were 222 incidents reported under the medicine directorate at Chase Farm Hospital between October 2014 and September 2015. Incidents were reported across all three wards; on Capetown ward there were 90 incidents reports, 108 on Napier ward and 109 on Adelaide ward. Staff knew how to report incidents and were able to fully explain the types of situations that should be reported, including near-misses.
- There were two serious incidents reported which related to a patient fall resulting in a fractured neck of femur and a medically unstable patient

inappropriately transferred to Chase Farm Hospital. We saw learning had been identified from these incidents and steps were in place to reduce the risk of reoccurrence, for example a new patient transfer checklist was introduced to ensure patients were suitably stable prior to being transferred.

- Incidents were recorded on computer-based forms and staff told us the form was considerably longer and took more time to complete since the acquisition. They told us this meant some issues like delayed investigations were no longer reported as incidents.
- Patient slip, trips and falls and pressure ulcers were the predominant types of incident reported. These themes were consistent across all wards.
- Medical staff told us lessons learnt from incidents were disseminated during meetings or by consultants prior to ward rounds however feedback from nursing staff was variable about when this took place. Some staff told us they received no feedback or learning points from incidents whereas others told us they were given feedback during team meetings or handovers. Meeting minutes we reviewed showed feedback was provided.

Duty of Candour.

- Senior staff were aware of duty of candour and were able to accurately describe the requirements of this, such as being honest about mistakes and apologising to patients and their families when something went wrong.
- Most junior ward staff and doctors we spoke with on Adelaide and Capetown wards were not familiar with the term duty of candour or the principles which underpin this. They told us the senior staff would deal with anything to do with incidents once the incidents had been reported.

Safety Thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. Data was collected as a 'snapshot' of care on the wards on one day in the month.
- Safety thermometer data detailed below covered the period January 2015 to January 2016, however data for Capetown ward was not reported in five months and Adelaide ward had two months with no reporting.
- Safety thermometer performance data was clearly displayed on the safety noticeboards at the ward entrances. This meant patients and their visitors could easily identify how well the ward was performing.
- There were three new pressure ulcers across the medical wards recorded by the safety thermometer, all of which were reported on Adelaide ward. We saw evidence that the SKIN care bundle or 'Waterlow Pressure Ulcer Prevention Score' were used to assess patient pressure areas and respond to patients with increased risk of pressure areas. For example we saw evidence pressure relieving mattresses and seat cushions were used.
- One catheter related UTI was recorded via the safety thermometer and this was reported by Adelaide ward. A urinary catheter daily assessment sheet was used to encourage staff to review whether the catheter was still required. The HOUDINI programme was introduced trust-wide in 2015 to reduce the number of urinary catheters left in place without clinical need, in line with NICE guidance. Audit data from November 2015 showed that all urinary catheters in use on Capetown and Adelaide wards had an ongoing clinical need.
- There was one fall with harm recorded by the safety thermometer and this was reported by Adelaide ward.
- There were no new VTEs recorded by the safety thermometer in the reporting period.
- Records we reviewed showed all patients some been assessed for VTE risk on admission and at appropriate intervals after this. We noted there was no documentation regarding VTE assessments for some patients. Data provided for Barnet and Chase Farm Hospitals showed VTE assessments were completed for 55.6% of rehabilitation patients in December 2015.This was worse than the previous month where 64.3% of rehab patients had completed VTE assessments. VTE assessments had been completed for 40% of stoke rehabilitation patients which was better than the previous month (33.3%).

Medical care (including older people's care)

Mandatory training

- Staff were required to complete mandatory training at various intervals to ensure they remained competent in specific core areas. Mandatory training included topics such as moving and handling, conflict resolution, fire safety, blood transfusion and equality, diversity and human rights. Some mandatory training was delivered on a face-to-face basis for example moving and handling and resuscitation, whereas other topics were covered through an e-learning package.
- Staff told us new starters were allocated protected time to ensure their mandatory training was completed soon after they started. Staff completed refresher mandatory training courses on an ad hoc basis rather than having specific time put aside for completion. They told us the nurse in charge would allocate time during "less busy shifts" to help get the training completed.
- On line spreadsheet systems were used to record when training had been completed and when updates were needed or nearly needed.
- The trust target for mandatory training was for 95% of staff to have completed the relevant training on each ward. Mandatory training completion on Capetown ward was 82% and 89% on Adelaide ward, which did not meet the trust target.

Safeguarding

- Staff across the wards were aware there was a safeguarding lead nurse within the trust. Staff were able to identify the types of situations which may trigger a safeguarding referral.
- Most staff, including doctors, told us they would escalate safeguarding concerns via the nurse in charge. Staff should raise concerns formally themselves rather than relying upon others to do this, as there is a risk a referral for an 'at risk' patient might not be completed.
- We saw evidence of safeguarding referrals appropriately completed on Capetown and Adelaide wards for patients considered to be at risk.

Cleanliness, infection control and hygiene

- All patient areas we inspected including bays and spaces for rehabilitation were visibly clean. We observed domestics staff working throughout the course of the day in a logical pattern, according to a schedule of work.
- A colour-coded cleaning system was used throughout the medicine wards to prevent cross contamination between areas such as the patient bathrooms and pantry. We noted that cleaning equipment was disposable and we observed staff using this correctly.
- Once a patient had been discharged from the wards, domestics staff cleaned the bed space and nursing staff restocked necessary equipment. A cleanliness and equipment checklist form was completed and left on the clean bed to identify it was ready to receive a new patient.
- Disposable curtains were used to separate patients in bay areas and we saw almost all curtains checked had been marked with the date they were put up. Staff told us the curtains were changed on a six monthly basis or sooner if they became soiled or had accommodated a barrier nursed patient.
- Patients who required barrier-nursing, such as those with MRSA colonisation, were usually accommodated in side rooms. Isolation signs indicated which patients required barrier nursing and gave guidance about what types of precautions were needed. Staff told us there was a hierarchy of use policy for the ward side rooms and this policy identified which infections were prioritised for side room accommodation and which patients could be safely cohorted in a bay with other patients.
- Basic personal protective equipment (PPE) such as gloves and aprons were available on the wards at the entrance to each patient bay, adjacent to the side rooms and at the foot of the bed for barrier nursed patients in open bay areas. On Adelaide ward, we noted the clinical waste bin nearest to the barrier nursed patients was across the other side of the bay in one area. This placed patients at risk of cross contamination as staff walked through the bay with used PPE items. Additionally, the waste bin was located within the bed space of a non-barrier nursed patient which meant staff were incorrectly taking contaminated items into a 'clean' area.

Medical care (including older people's care)

- We observed staff using PPE correctly to perform patient care tasks and most staff removed their PPE appropriately, however some staff were observed leaving patient bedsides and going into storage areas still wearing PPE which is incorrect.
- There was one case of Clostridium Difficile (C. Diff) identified on the medical wards between April and October 2015. Root cause analysis was completed and no lapse in care was identified by the investigating team.
- Patients were swabbed for methicillin-resistant staphylococcus aureusis (MRSA) on admission and treatment was commenced if indicated. No cases of MRSA bacteraemia were identified across the medical wards.
- Clean endoscopy equipment was stored in the designated 'clean' area and was in airtight, labelled plastic covers. When equipment was used, it was placed into sealed red plastic covers and transported to a storage area designated for used equipment. Used equipment was removed for cleaning out of the back door to the endoscopy suite to prevent the risk of cross contamination by moving it through the main unit.
- There were plenty of clinical, general and recyclable waste bins throughout the wards. These were appropriately located by handwashing facilities within bays, side rooms, treatment rooms and dirty utility rooms.
- Sharps bins were available in treatment room areas and side rooms. Staff used small, portable sharps bins if patient bays if required. All sharps bins we checked were appropriately labelled and none were filled above the maximum fill line.
- We observed staff usually cleaned their hands at appropriate intervals when working on the ward, including prior to and after patient contact, however we noticed some members of staff left patients after performing care tasks without cleaning their hands with soap and water or alcohol gel. Staff adhered to the bare below the elbow policy.
- Weekly audits conducted by the hospital between August and October 2015 showed staff on Capetown and Adelaide wards were consistently 100% compliant with hand hygiene protocols. No audit data was available for Napier ward or endoscopy.

Environment and equipment

- Chase Farm Hospital participated in the 'Patient Led Assessments of the Care Environment' (PLACE) 2015 audit and scored in line with the England average for cleanliness and overall appearance and maintenance of facilities.
- A full time housekeeper was allocated to each ward to ensure equipment was available and clean as well to maintain a suitable provision of stock on each ward. Consumables were stored in labelled drawers within storage cupboards, alongside spare items in boxes.
- Resuscitation trolleys were available on each ward as well as in endoscopy and contained all relevant equipment, including emergency medicines. We saw evidence of regular documented checks on this equipment, although there were some gaps in checking evident such as eight gaps during January 2016 in endoscopy.
- Commodes were available for patients who were unable to use the patient bathrooms and we all commodes we inspected were visibly clean.
- Armchairs with removable armrests were available for patients who required physical assistance or special equipment such as sliding boards to transfer onto the chairs. This reduced the risk of patient falls as appropriate help was able to be provided without trying to manoeuvre the patient over an armrest.
- We saw evidence of sufficient rehabilitation and mobility equipment including walking frames and sticks. Staff told us equipment was readily available and different equipment could be ordered quickly if needed, for example a very small walking frame for a petite patient.
- The purpose-built endoscopy unit was opened in December 2015. There were 14 single patient rooms and three endoscopy theatres, as well as dedicated

storage for clean equipment and storage in a separate room for used equipment. The pathway of the patients and equipment through the unit limited the risk of cross contamination.

- We saw all electrical equipment had a registration label affixed and was maintained and serviced in accordance with manufacturer recommendations. We also saw Portable Appliance Testing (PAT) labels were attached to electrical systems showing they had been inspected and were safe to use.

Medicines

- Prescription charts we reviewed were suitably signed, dated and legible. Patient allergies had been documented and medicines were prescribed correctly.
- We saw evidence that pharmacy staff reviewed prescription charts and annotated prescriptions where necessary, such as to add administering instructions like "must be taken with food". We notes pharmacists wrote on prescriptions in red ink to highlight their notes.
- Nurses had to complete medicines administration competencies to be signed off for giving oral and intra-venous (IV) medicines to patients. A senior nurse signed staff off once their competency had been established as consistent.
- Medicines were stored in lockable cupboards within keypad locked treatment rooms. The treatment room containing medicines on Adelaide ward was hot and the temperature of the room was not monitored which meant medicines could be stored above their recommended maximum storage temperature. This was raised with staff who told us they were aware of the issue but there was little more they could do about it. Staff had placed an electric fan in the room in an attempt to reduce the temperature but it remained hot.
- Controlled drugs (CDs) and the CD stock book were stored in lockable wall-mounted units which were accessible via the key held by the nurse in charge. Two members of nursing staff checked stocks of controlled drugs together twice per day. We reviewed the contents of the CD cupboards against the stock book and found the contents were accurate.
- We observed staff administering oral and IV medicines correctly. We also observed staff preparing and administering controlled drugs correctly, including checks of the prescription and patient by two members of staff.
- We saw evidence that oxygen was correctly prescribed for patients receiving oxygen therapy, including a target oxygen saturations range. Staff told us they asked doctors to review oxygen prescriptions if patients' requirements changed.
- Doctors were encouraged to complete tablets to takeaway (TTAs) requests the day before patient discharge to limit the delays caused by TTA preparation. Staff told us doctors were usually good at doing this however there were still discharge delays while patients waited for their TTAs.
- Staff told us dosette boxes could be prepared by the pharmacy team to help patients administer their own medicines after discharge home or in preparation for discharge. The pharmacy team required 48 hours' notice to prepare dosette boxes for patients.

Records

- Patient records were securely stored in keypad locked trolleys which were located adjacent to the main reception desk. We observed staff ensure that the trolleys were secure after removing or replacing the relevant notes.
- There were clear sections for different entries by the various staff members, for example therapy notes were completed within the grey divider section. Staff told us this system worked well but were not sure if other colleagues would look at their notes specifically.
- Most notes were legible and it was possible to identify who had written each entry. We noted there were gaps in several care plans and risk assessments, such as falls risk assessments.
- Monthly notes audits were completed and results from January 2016 showed Capetown ward scored 78% (which was a 12% improvement of their previous results) and Adelaide ward scored 86% (which was a 2% improvement).

Assessing and responding to patient risk

Medical care (including older people's care)

- In line with NICE guidance, patient at risk (PAR) scoring was used on the medicine wards to track patient observations and trigger escalation processes. The first stage was to escalate to the nurse in charge and to escalate further to the allocated medical or on call team.
- A hospital audit across three wards (including Capetown ward) and 51 patients was completed in December 2015. Audit results showed correct PAR scoring and that staff were aware of escalation procedures.
- During our inspection we observed that patient observations were fully completed at the required intervals and PAR scores were correctly calculated. None of the records we reviewed demonstrated that escalation to the nurse in charge was necessary however staff were able to describe when this should occur.
- Patients who deteriorated and required additional support could be transferred to the high dependency unit which was able to accept level two patients (patients requiring more detailed observation or support of a single failing organ system).
- The patient 'status at a glance' boards had a column dedicated to safety. This was where safety risks such as falls or infections were highlighted to staff looking at patient details.
- We saw evidence that falls assessments were completed with patients across the medical wards, however these assessments were not always fully or accurately completed. For example we noted one patient's falls assessment had nothing documented in response to a question about their level of confusion and also staff had ticked the box stating the patient's admission was not related to a previous fall, when it actually was. These inaccuracies could place patients at additional risk of falls during their admission, as appropriate steps may not be put in place to prevent this. In January 2016 a falls screening audit was completed cross-site with Barnet Hospital and results showed 90% of falls screening was fully completed.

Nursing staffing

- Twice per year (in March and September) the Safer Nursing Care tool was used to determine the appropriate staffing levels for each medical ward. Other considerations such as professional judgement and service development plans were also taken into account when planning staffing.
- Each ward was overseen by a nurse in charge, who was supernumerary to the planned nursing numbers.
- Capetown ward was staffed by five nurses and five nursing assistants during day and night shifts. Adelaide ward was staffed by four registered nurses during the daytime, with support from three nursing assistant. There were three nurses with one nursing assistant overnight. Student nurses were supernumerary and always worked with supervision.
- We saw evidence of three 'specials' being used for patients who required one to one nursing, such as those with confusion or other mental health needs. 'Specials' were usually nursing assistants who were supernumerary to ward staffing and were dedicated to the care of one particular patient throughout their shift.
- Staff told us specialist mental health nurses could be requested if there was a patient with a specific mental health need.
- Planned vs actual staffing data provided by the trust for Capetown ward in October 2015 showed there were frequently less registered nurses on shift than planned (83.7% in the daytime and 83.9% over night). Staff told us this was due to ongoing vacancies and difficulties in recruiting. To accommodate the shortfall in registered nursing staff, additional nursing assistants were allocated to work (143.9% in the daytime, 150% overnight). Actual vs planned staffing data was not provided for Adelaide ward or endoscopy.
- As of 31 October 2015 vacancy rates on Capetown ward were 18.3% and on Adelaide ward they were 18%. These vacancy rates were slightly worse than in other areas of the trust which reported an average of 16.9% vacancies. No vacancy data was available for endoscopy.

Medical care (including older people's care)

- Staff on each ward were also supported by an allocated ward clerk who was responsible for various administrative duties including tracing medical notes, typing discharge letters and general day to day ward administration.

Medical staffing

- There were two planned sessions of stroke consultant cover and two planned sessions of geriatrician cover per week for patients on Capetown ward. Two SHOs worked on Capetown ward from Monday to Friday, each allocated to work with either stroke or general medical rehabilitation patients.
- There were five planned sessions of geriatrician cover for patients on Adelaide ward. The consultant was supported by an SHO who worked on Adelaide ward from Monday to Friday.
- Daytime on call medical support was provided by a registrar and an SHO who worked on the wards in addition to being the on call contact. An on call registrar with advanced airway skills provided overnight medical cover.
- When Napier ward was open, staff told us patients were allocated to one of the geriatrician consultants or to the stroke consultant, depending upon the cause of their admission. Staff told us the daytime on call SHO would be mainly based on Napier ward to provide generic medical support.
- There were no vacancies for doctors on the medical wards at Chase Farm Hospital in data relating to 31 October 2015.

Major incident awareness and training

- There was a trust-wide major incident policy that was available to all staff via the hospital intranet. Staff were aware that the hospital would be used to redistribute more stable patients in the event of a major incident, leaving more acute beds free at the larger sites.
- Staff were also aware of the role the hospital might play if bed occupancy levels reached critical levels. They knew that patients may be transferred to Chase Farm Hospital and additional beds may be opened to address the situation.

Are medical care services effective?

Good

We rated the effectiveness of medical care at Chase Farm Hospital as Good because;

Embedded multidisciplinary working involved community teams and discharge planning began on admission to hospital.

Due to an effective discharge planning processes the risk of patient re-admission to hospital was lower than the national average.

We saw examples of evidence-based outcome monitoring and some evidence-based practice.

Staff were aware of consent principles including the mental capacity act and we saw evidence of appropriate use of Deprivation of Liberty Safeguards (DoLS) on the wards.

Patient pain was frequently assessed and suitably managed.

Patient mealtimes were well organised and audit data showed they exceeded the trust target for the identified mealtime standards.

However;

There were limited seven day services of allied healthcare professionals.

Some nutritional and fluid balance charts were incomplete or incorrect.

There were good opportunities for learning and development of nursing staff however long termtrust grade doctorsreceived no study leave or formal teaching to assist their development.

Evidence-based care and treatment

- We saw evidence of policies in use on the medical wards which had been developed in line with evidence-based practice and NICE guidelines, for example the slips, trips and falls policy was based on NICE guidelines.
- Evidence-based assessments such as the 'MoCa' (Montreal Cognitive Assessment) screening test were

used to identify patient needs, such as referral to a memory clinic. We saw evidence this was used with patients where memory was considered to be a concern.

- The HOUDINI programme was introduced trust-wide in 2015 to reduce the number of urinary catheters left in place without clinical need, in line with NICE guidance. Audit data from November 2015 showed that all urinary catheters in use on the medical wards had an ongoing clinical need.
- Evidence-based rehabilitation outcomes measures were used in accordance to NICE guidance to identify patient progress, for example the 'timed up and go' test for elderly patients.
- The endoscopy unit was not 'Joint Advisory Group' (JAG) accredited at the time of our inspection. An analysis of the service provided showed several areas of non-compliance with JAG requirements, such as waiting list times. Some areas of non-compliance would be difficult to evidence due to the short timeframe the service had been open for, as JAG standards required information over three months.

Nutrition and hydration

- Nutritional risk assessments were completed with patients thought to be at risk malnutrition. We saw evidence this was completed with some patients and considered for most patients.
- Protected mealtimes were used on Capetown and Adelaide wards and we observed staff placing appropriate signage at the ward entrance to discourage visitors and health professionals from visiting the ward between the specified times. Protected mealtimes were designed to ensure patients had sufficient time without interruptions to eat their meals.
- Each patient had an allocated tray with sealed hand wipes and individual salt and pepper. We saw staff encouraging patients to use the hand wipes before eating their meal.
- Red trays were used to identify patients who required assistance eating their meal, such as help cutting up food. Catering staff told us these patients received their meals last so there were enough staff available to assist them.
- Food was presented carefully and the temperature of hot food was checked to ensure it was hot enough before being given to patients.
- Signs were provided on each patient tray which were to be displayed when the patient had finished eating. This meant the catering staff knew the patient had finished eating and the plate could be cleared away. Staff told us this was implemented to make sure patients were encouraged to eat and so accurate food charts could be maintained.
- Charts were used to monitor how much patients' ate where this was a concern. Some charts had been thoroughly completed whereas the documentation at other times was variable.
- We saw evidence of staff discussing patients who were not eating well and methods to try to improve this during the medical ward rounds. However we saw the same medical staff leave patient bedside tables out of reach so food on the table was not in reach.
- Monthly audits were completed to assess the patient mealtimes against trust-wide standards and a target of 81% or above was identified. Adelaide ward achieved 94-98% and Capetown ward achieved 96-98% between November 2015 and January 2016.
- Water jugs and glasses were available on each patient bedside table and staff told us these were refilled when needed. We observed water was usually left within patient reach.
- We saw evidence fluid balance charts were used with patients on the medical wards however these charts were frequently incomplete or inaccurately completed. For example on Adelaide ward we saw one patient's fluid intake was calculated as +2600mls when the patient had actually had +3600mls.

Pain relief

- A pain scoring system was used with patients across the medical wards. The scale asked patients to rate their pain level between zero (no pain) and three (very bad pain). We saw evidence that patients were usually asked about their level of pain and this was documented alongside the routine patient observations. There were some sets of observations across the medical wards which did not show pain had been assessed.

- Pain management was led by the ward medical teams who reviewed pain level as part of their daily ward round. Staff could access additional pain management support from the pain management specialist nurse who could provide telephone advice or attend the ward to review the patient.

Patient outcomes

- In the most recent (2013) results from the 'National Diabetes Inpatient Audit' (NaDIA), Chase Farm Hospital performed better than in other hospitals in nine domains and worse than in other hospitals for nine domains. A gap analysis completed in January 2016 showed the hospital was mainly partially compliant with NICE recommendations for the care and treatment of patients with diabetes. Non-compliant areas included relevant foot assessments completed within 24 of admission. We saw evidence that the trust-wide diabetes pathway was being reviewed to address this issue.
- No general medical patients were readmitted to hospital within 30 days of their discharge between August and October 2015. The likelihood of being readmitted to Chase Farm Hospital was lower than the national average.
- The mortality rate on Adelaide ward in January 2016 was 5.9%. For the same month, the mortality rate was 1.9% on Capetown ward. These figures were in line with the trust average.

Competent nursing staff

- All permanent and agency staff working on the unit for the first time were given a general induction to their working environment. New starters and students on placement were allocated a mentor for a specified period to help them settle into their role and get to know the ward they were working on. Staff working as mentors had completed mentorship training.
- New nurses underwent a preceptorship programme to accelerate their learning and development during the first few months of their job. New nurses completed a series of competencies and these had to completed during the preceptorship period. The clinical practice educator or the relevant mentor signed off competencies.
- Staff within endoscopy received 'on the job' training as well as opportunities to attend relevant study days and formal teaching sessions when available.
- Nursing assistants on the wards were able to complete the care certificate programme to facilitate their development. This course covered various nursing assistant level competencies and staff were extremely positive about their experiences of learning on the course. At the time of our inspection, there were three nursing assistants on the course.
- Appraisals were completed annually and staff told us they were valuable in guiding their learning and development for the upcoming year. Senior staff told us 89% of staff on Adelaide ward and 50% of staff on Capetown ward had an up to date appraisal. Staff told us the deficit in appraisal completion was due to maternity and long-term sick leave.

Competent medical staff

- Doctors who commenced work at the hospital were required to undergo the generic hospital induction programme and then complete mandatory training modules.
- Medical SHOs at Chase Farm Hospital were mainly long term locum staff. They told us they did not get opportunities for development such as formal teaching or access to study leave however did receive annual appraisals from the consultant they worked under. They told us they also received ad hoc bedside teaching and teaching at the weekly x-ray meeting.
- Consultants told us they accessed courses and conferences to support their continued professional development with the support of the hospital.

Multidisciplinary working

- Staff began discharge planning from the first day of the patient's admission. This involved identifying how independent the patient was prior to their hospital admission and goals to enable their discharge home. Staff liaised with community services to find out additional patient information. For example if the patient was seen by a community occupational therapist, the inpatient occupational therapist would obtain information about the patient's home situation to inform the hospital discharge planning process.

- A board round was held four times per week and this was attended by therapy staff, medics and nursing staff. This involved a quick overview of patients on the relevant ward and any immediate issues or problems were highlighted. Staff told us this was essential in understanding how the patient was each day, for example therapy staff told us the board round would highlight if a patient's blood pressure was very low and therefore the patient should not be mobilised without supervision.
- A formal multi-disciplinary meeting was held once per week on each ward and every patient's progress was discussed, as well as their on-going goals and discharge plan. The role and support of patients' families was also discussed for each patient.
- Discharge summaries were posted to the patients' GPs and various community teams on discharge from hospital. Patients were also given a printed copy of their discharge summary including medicines information to take home with them. Staff told us handover telephone calls often took place between inpatient and community teams to ensure a smooth handover of care.

Seven-day services

- An on call consultant was available over weekend to review any patients newly admitted or patients who became unwell. Staff told us it was never a problem for the weekend consultant to review patients if they needed it.
- Physiotherapists and occupational therapists assessed all patients on admission to the medical wards to ensure appropriate mobility and personal care support was provided during their admission.
- Physiotherapists and occupational therapists were available between 8:30am and 4:45pm Monday to Friday. Support was also available over weekends although this was provided just one member of staff from each department. Staff told us they were "trying to run a seven day service on five day staffing".
- Speech and language therapists (SALT) and dieticians were available on a bleep referral system and were usually able to assess patients within 24 hours of referral. Both SALT and dietetic staff worked cross-site with Barnet Hospital and staff told us this meant they were often very busy.
- There was no availability of SALT or dietetic staff over weekends.

Access to information

- Staff told us patient notes were transferred with patients when they were admitted to Chase Farm Hospital. They told us this meant they had immediate access to the most up to date patient notes for the current admission.
- Staff had access to policies and procedures via the trust-wide intranet. Some wards had printed versions of policies in resource folders. Some policies were being harmonised with those in place in Barnet and Royal Free hospitals therefore the policies were not always within their review date.

Consent, Mental Capacity Act and DoLS

- Staff understood the need to ask patients for consent before completing care tasks or procedures. We observed staff asking patients for verbal consent appropriately.
- Staff were aware of the need for a capacity assessment in line with the mental capacity act if there were concerns a patient might not have capacity to make decisions for themselves. They told us best interest decisions would be made if a patient was found to lack capacity. Staff described that patient families would be involved in helping to guide the decision but were clear a family member could not consent on behalf of the patient.
- The doctor who would be performing the endoscopy completed consent forms with patients prior to the procedure. We saw evidence consent forms were correctly completed, including documented risks of endoscopic procedures.
- Staff within endoscopy told us there were no concerns with patients who lacked capacity to consent as these patients would have been identified at an earlier stage in the referral process and suitable support provided.
- Staff were able to explain Deprivation of Liberty Safeguards (DoLS) principles and provide example

where a DoLS application may be used. We saw evidence of DoLS appropriately in place for two patients who were being supervised by 'specials' on Capetown ward.

Are medical care services caring?

Good

We rated caring for medical services as Good because;

Patient and relative feedback was complimentary about the approach of staff and staff were described as "lovely" and "nice people".

Results from the Friends and Family Test (FFT) suggested most patients would recommend the wards to their friends and relatives.

Patients were involved in making decisions about their care and prioritising goals for their rehabilitation. We saw evidence of relatives being engaged in the rehabilitation process, for example assisting a patient with leg exercises.

However;

Call bell audits showed they were answered within 10 rings 90% of the time on Adelaide ward which met the trust target, however Capetown did not meet the target as they scored 87.5% in January 2016.

Compassionate care

- The 'Friends and Family Test' (FFT) was given to patients to determine whether they would recommend the medical services provided by the hospital to their family and friends. Results for each ward were displayed on the noticeboard at the ward entrance so patients and their families could see them easily.
- The response rate for the FFT across the medical wards was slightly lower than the England average. Results for January 2016 showed 100% of respondents on Adelaide ward were likely to recommend care on the ward and 85.7% were likely to on Capetown ward.
- We saw many thank you cards on display from previous patients and their relatives. Cards described the kindness and diligence of staff and how their contributions to care had helped patients get home from hospital.
- Patients were positive about their experiences on the medical wards and told us "everybody [in the hospital] is lovely" and that the staff are "nice people".
- Relatives were confident their loved ones were being cared for in a safe environment and that staff "[did] their best to help everyone get better".
- Signs were in place above patient beds indicating what each patient prefers to be called. Most staff paid attention to this however we observed doctors on Adelaide ward completing a ward round and calling patients different names to the ones specified above on the signs.
- We observed nursing staff drawing curtains and using do not disturb signs to complete patient care tasks in privacy. However we noted doctors did not fully close the bedside curtains during their ward round, even when completing patient examinations which could implicate patient privacy and dignity.
- A privacy and dignity audit completed in January 2016 scored 89.4% on Adelaide ward and 88.2% on Capetown ward. Staff were aware of these results and areas for improvement.
- Electronic signing systems indicated whether endoscopy patients were in their room alone, with a nurse or in the endoscopy theatre. Staff told us this meant patient privacy and dignity was maintained at all times as they knew immediately if the patient was present in their room.
- Patients in endoscopy told us their privacy and dignity was maintained throughout their procedure and staff took care to keep the patient covered as much as possible.
- We observed that most patients had call bells left within reach. Audit data for January 2016 showed 96% of call bells on Adelaide ward and 91.7% on Capetown ward were within patient reach.
- The trust target was for 90% of call bells to be answered within 10 rings. During our inspection we

noted call bells were answered within a reasonable timeframe, although often after more than 10 rings. Call bell audits were completed on a monthly basis and results for January 2016 showed 90% of call bells on Adelaide ward and 87.5% on Capetown ward were answered within 10 rings.

Understanding and involvement of patients and those close to them

- Patients told us they felt as though they understood the plan of care that was in place for them and had the chance to ask the doctors and nurses questions if they wanted. They told us questions were answered clearly and with patience. One patient told us a doctor had to explain something several times to ensure understanding but that "the doctor didn't mind one bit".
- Patients were involved in setting goals with their therapists in line with what was most important for them to achieve as individuals. Patients told us knowing they were working towards something specific helped keep them motivated.
- One patient told us they "couldn't have better doctors looking after [us]".
- Relative involvement was discussed during MDT meetings and we observed relative involvement in the rehabilitation and care of their loved one. For example we observed a therapist teaching a relative how to complete leg strengthening exercises with the patient. Relatives told us they appreciated the team's attempts to give them a role in the patient's recovery.
- We observed that staff on the medical ward round did not introduce themselves to patients and they were not all wearing name badges, so it was difficult for patients and relatives to know who they were speaking to.

Emotional support

- Patients told us a range of staff provided emotional support to them during their admission. They told us they had built up relationships with various staff members and felt comfortable raising concerns or worries with them.
- Patients told us the therapy team were encouraging but understanding if a patient was having an "off day" and struggled with their rehabilitation. They told us the therapists were supportive and would try different ways to help them achieve their rehabilitation goals.
- Chaplaincy support was available via the Barnet chaplaincy team. The team provided multi-faith spiritual and religious support if requested by patients or their relatives.
- Staff were aware of some external organisations who could be contacted to provide support for patients and their relatives after their admission. One staff member described showing a relative the web site of a support group to encourage them to get involved.

Are medical care services responsive?

Good

We rated the responsiveness of medical care as Good because;

The service was planned to meet the needs of an aging population through the provision of additional rehabilitation beds and development of additional support for patients living with dementia.

There were sufficient rehabilitation facilities including a therapy gym and staff completed home visits with patients to prepare them for discharge. Activities such as board games and arts and crafts were organised to stimulate patients on the ward and provide opportunities for social interaction.

Most patients (70%) did not move ward during their admission and when patients did have to move this did not often occur overnight. The average length of stay for general medicine and rehabilitation patients was much longer than the nation averages.

However;

We noted there were some out of hours discharges, although these made up a small proportion (1.5%) of patients discharged from the service.

Service planning and delivery to meet the needs of local people

Medical care (including older people's care)

- The trust identified the aging population and different types of demand this was place on the medical service within the hospital. They were keen to plan and develop additional services and premises to meet the needs of this type of population, including developing the care provided for patients living with dementia.
- Expansion plans which were due to start in 2016 included a greater number of rehabilitation beds to meet the needs of the local population.
- Staff told us commissioning agreements meant patients from within Enfield were prioritised for beds over patients from other local boroughs. Staff told us this could cause delayed admissions for patients from other local areas.
- The endoscopy suite was open between 8am and 6pm from Monday to Friday. Staff told us there had been some endoscopies completed on Saturdays to improve waiting list times.
- Patients were accommodated in single rooms or in single sex bays. Hospital data showed there were no mixed sex accommodation breaches on Adelaide or Capetown wards from October 2015 to December 2015.
- Visiting times were 2pm to 8pm every day and visitors were limited to two per bed space. Staff told us visiting times could be adjusted if there was a family member who lived a long way away or worked difficult shift patterns.

Meeting people's individual needs

- Each patient undergoing a procedure in endoscopy was allocated a single patient room with en suite bathroom facilities which they used before the procedure, to store their belongings and to recover afterwards. This ensured patients had sufficient privacy throughout the course of their endoscopy procedure.
- Patients living with dementia were highlighted on the elderly medical wards via a blue forget me not flower next to their name on the main patient details board. Staff told us they tried to place patients living with dementia in "high visibility areas" such as in bays opposite the nursing station. This was intended to ensure improved patient safety as staff would be able to see if the patient was at risk of harm.
- A hospital passport was used for patients with specific needs such as those living with dementia or a learning disability. The passport provided the opportunity for family, carers and health professionals to document important things about the patient, including their preferences and dislikes.
- A therapy gym was available on Capetown ward with various items of rehabilitation equipment such as hand bars and practice steps. There was also a therapy kitchen available so activities of daily living assessments could be completed, for example making a cup of team or a sandwich. Staff told us there was no funding available to provide ingredients for these assessments and so therapists often brought items in from home for this purpose.
- Therapists sometimes completed home visits with patients so access to the property and any hazards in the home were identified prior to the patients' discharge.
- A range of activities for all patients was available on Capetown ward, for example during our inspection we observed patients making daffodils from arts and crafts materials. The therapy assistants led this session.
- A weekly social activity was organised for stroke rehabilitation patients to work specifically on their fine motor skills and to encourage social interactivity. Staff told us they used activities like board games for this purpose.
- Special equipment, such as beds and chairs, for bariatric patients was available through an equipment rental agency and staff told us equipment was usually delivered within 24 hours. Bariatrics is the branch of medicine that deals with the control and treatment of obesity.
- Televisions with head phones were available at each bed space so patients could amuse themselves with this.
- Patients and their visitors could access a family room that opened out onto the garden. There were many seats and some coffee tables available along with magazines and information leaflets.

Access and flow

Medical care (including older people's care)

- No patients were directly admitted to the medical wards at Chase Farm Hospital; most were admitted via Barnet Hospital once they were deemed to be medically fit.
- Most patients (70%) were not moved between different wards during their admission at Chase Farm Hospital. A small proportion of patients (8%) were moved once and a slightly larger proportion (17%) were moved twice. 6% of patients were moved three or more times during their admission. This amount of wards moves was in line with the trust average.
- Between August 2015 and January 2016 there were 15 patients who moved wards after 10pm. Most patients (46.7%) who were moved overnight were gastroenterology patients.
- Between August 2015 and January 2016 there were six out of hours discharges; three of these were rehabilitation patients and three were geriatric medicine patients. This made up 1.5% of all patients discharge under these specialities in the period specified. This represented a smaller proportion of patients than in other areas of the trust.
- Between January and December 2014, the average length of stay for general medical patients was 53.2 days which was much longer than the national average (6.4). The average length of stay for rehabilitation patients (44.6 days) was also much longer than the national average (26 days). Staff told us this was due to the patients admitted needing intensive rehabilitation and awaiting packages of care.
- In lieu of opening Napier ward, an additional five medical beds on Wellington ward were allocated to medical reablement patients. Wellington ward was a surgical ward however daily ward rounds were completed by the reablement medical team. Staff told us they placed low-dependency patients on Wellington ward to ensure patients with more complex needs were cared for on the dedicated reablement ward.
- Staff told us discharge planning started from the patient's first day of admission. The discharge policy for the medical wards identified that patients should be medically stable and have achieved their therapy goals prior to discharge. A band six discharge coordinator was in post to assist with patient discharges from Capetown and Adelaide wards.
- Staff told us most discharge delays were due to availability of nursing or residential home placements and domiciliary packages of care. Staff told us the only discharge delay under the hospital's control was related to TTAs.

Learning from complaints and concerns

- Staff were clear they would try to manage any complaints informally at ward level and would involve senior staff to support with this if needed. They told us they would refer patients and their relatives to the Patient Advice and Liaison Service (PALS) if the patient's complaint was serious or could not be managed at ward level. Staff were unclear if formal complaints were monitored or recorded.
- Posters advertising PALS were on display on ward noticeboards and staff knew how patients and their relatives could contact PALS if needed.
- Data provided by the hospital showed there were 13 formal complaints made within the medical services between December 2014 and November 2015. There were six complaints on Adelaide ward, five complaints on Capetown ward and two on Napier ward.
- Data from the ward performance dashboard for January 2016 showed there were two complaints on Adelaide ward and two complaints on Capetown ward that month. Staff attributed this to having more dependent patients and more staff off sick therefore less time to spend with patients on the ward.
- Most complaints on Capetown ward related to the attitude of staff on the unit. There were no other trends to the complaints made. We saw evidence of written complaint responses that contained apologies, investigation details and evidence of learning points where appropriate.

Medical care (including older people's care)

Are medical care services well-led?

Good

The medicine and older people's care service for The Royal Free Hospital NHS Foundation Trust at the Chase Farm site was led by a clinical director and an operational manager. Nursing leadership was provided by the inpatient matron, who also covered Edgware Hospital, and ward manager.

We rated the leadership of the medical services was Good because;

- A clear vision for developing services to meet the needs of older people and patients living with dementia, including reviewing patient pathways and developing dementia specialist staff, was in place.
- A major refurbishment was due to begin shortly and the needs of patients living with dementia were a high priority when finalising the designs.
- We saw evidence of staff engagement with the refurbishment project and the service responded to patient ideas, such as suggestions for ward activities.
- Staff were positive about the leadership of the medical services and we observed a positive and supportive culture on the wards.

However;

There were suitable governance arrangements in place however it was unclear what formal audit activity was due to take place at Chase Farm Hospital and we were unable to review the local risk register.

Vision and strategy for this service

- There was a strong vision for developing services to make them accessible and functional for patients living with dementia. Staff were undergoing additional dementia training and there were plans in place to develop the physical space of the hospital to make it more "dementia friendly". For example with the introduction of a therapy and dementia garden and improved, colour-coded signage around the hospital. Staff were aware of the push to improve services and care for patients living with dementia and were clear on the plans in place to achieve this.
- There were plans in place for a major refurbishment of the medical wards and other parts of the hospital. Plans included an increase in beds available within Capetown ward to 44 (split equally between neuro and general rehabilitation) and expanded rehabilitation facilities, for example the development of a rehabilitation area within the garden. The new hospital building was due to open in the summer of2018 and the refurbishment of the medical wards was planned for Autumn 2018.
- Some space within the redevelopedhospital had not been allocated and senior staff told us they hoped it could be used to accommodate community therapy services to further develop communication and joint working to improve the patient experience.
- 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. Ward staff knew the trust were working on this but felt it was more relevant to the more acute sites rather than the Chase Farm site.
- 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 were aware of this aim.

Governance, risk management and quality measurement

- Regular cross-site specialty governance meetings took place with staff from Barnet Hospital. These were attended by all levels of medical staff as well as senior nursing staff. A range of governance and quality issues were discussed such as risks, serious incidents, complaints, infection prevention and control issues, clinical audit and FFT results.
- Staff told us the trust scrutiny panel were used to discussion serious incidents and investigations were always completed by staff from a different speciality to reduce the risk of bias in investigation findings.

Medical care (including older people's care)

- Divisional board meetings took place to review overall performance of the clinical areas. We reviewed minutes from TASS and urgent care meetings which showed a thorough overview of activity within each division and points where actions were required
- Senior staff told us a formalmorbidity and mortality meeting was held once per year to discuss the care of patients who died while receiving care in the hospital. During this meeting any issues with care given were discussed and learning points were identified. Mortality within the trust was monitored using 'Dr Foster' comparability tools. Informal meetings were held more frequently to review patient deaths, For example the deaths of elderly patients were audited and learning points such as communication issues and completion of death notes were identified as areas for improvement.
- We were provided five risk register documents by the trust however no risks for medical inpatients at Chase Farm Hospital were identified on these documents, despite there being risks present which should have been recorded. For example the waiting list issues meaning that the endoscopy unit was not JAG accredited. Senior staff told us they raised any risks at divisional meetings so they could be considered for documentation on therisk register.
- We saw evidence of trust-wide and site-specific audit programmes for the medical services however it was unclear which local audits were taking place specifically at Chase Farm Hospital. There was evidence of national audit completion on the site, for example 'National Diabetes Inpatient Audit' (NaDIA).
- To address vacancies across the medical wards, a direct student recruitment initiative was introduced where students who completed and passed clinical placements on the wards would be automatically offered a permanent position.

Leadership of service

- The medical care at Chase Farm Hospital was led clinically by an experienced team of senior consultants, with designated leads in elderly and frailty medicine. Nursing leadership was provided by the unit matron, supported by sisters on each ward.
- Staff told us they saw members of the leadership team at various times. They felt the leadership team were visible and approachable. One staff member told us senior members of the leadership team had told him to contact them directly if there were "any problems".
- Staff told us the matron's role recently changed to have time split between Chase Farm Hospital and Edgware Hospital. They told us the matron was not as visible now this had happened but felt they continued to receive appropriate support and guidance despite this.
- Staff told us they felt changes within the hospital were communicated well and they knew what was happening within the hospital. They believed the leadership team were proactive in sharing their plans and ideas.
- The medical management team were proud of the work completed at Chase Farm Hospital and valued the role the staff played in returning patients back to their pre-admission residences. Staff felt the care they provided was appreciated and respected by the leadership team.

Culture within the service

- Staff had a positive approach to their work and their colleagues. They worked together to complete patient care tasks, check medications and share knowledge. We observed staff receiving support and guidance from senior colleagues in a patient and supportive manner. Staff treated each other respectfully and appropriately on the unit.
- Staff told us working at Chase Farm Hospital was often viewed as "less glamourous than working at Barnet or the Royal Free". They felt this was due to the "community hospital" nature of the site and the types of activity which occurred at the hospital.
- Staff said they enjoyed their work and got good job satisfaction from assisting patients to get better and to return home. They told us they developed strong relationships with long stay patients and it was rewarding when patients achieved milestones.
- The average sickness rate for nursing staff trust-wide was 2.1%. No staff sickness data was provided for the medical service at Chase Farm Hospital.

Medical care (including older people's care)

Public and staff engagement

- Patient feedback and ideas were taken on board by the medical service and we saw evidence of this in place. For example, the daffodil making activity on Capetown ward was the result of a patient suggestion.
- Ward staff were invited to provide suggestions and feedback for the refurbishment of the medical wards. Staff told us they wanted to make sure the refurbishment was going to "really usable" and they valued the opportunity to have input into the designs.
- Some senior staff were unsure of the effects of the refurbishment on their individual speciality. For example one consultant told us some patient beds were only funded for a further two months and no communication had taken place to establish what would happen after this time.

Innovation, improvement and sustainability

- Improvement to the physical patient environment was a major priority for the leadership team and we saw evidence of plans in place and funding approval to achieve this. The team felt that this type of service improvement would greatly improvement patient experience and make it easier for staff to perform their roles well.
- Senior staff described their ongoing review of the rehabilitation patient pathway, including consideration of accepting patients directly from the hyper acute stroke unit (HASU). They felt this would benefit patient care by enabling faster initiation of intensive rehabilitation and benefit the organisation by reducing bed pressures in the HASU.
- Staff told us of plans to develop various therapy groups within the rehabilitation service. Examples of different sessions that might be trialled included a balance group and a memory group. Senior staff told us this hadn't been completed before due to availability of staff however a new band five therapist had recently been recruited and plans were beginning for this staff member to begin running groups.

Surgery

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

Information about the service

Surgical services at Chase Farm hospital were managed by the Division of Surgery at the Royal Free London NHS Foundation Trust, which included two surgical wards, Canterbury (25 beds) and Wellington (39 beds). The site had a day of surgery assessment unit and six operating theatres with one theatre dedicated to the chronic pain service and associated areas for anaesthetics and recovery.

Surgical service provision included general surgery, ears, nose and throat (ENT) orthopaedics, ophthalmology and gynaecology.

The service had a spacious four bedded high dependency unit (HDU) with three side rooms, which accommodated post-operative surgical patients. However the unit could take a maximum of five patients.

There were two additional operating theatres (Surgicentre) and associated recovery bays which carried out day case general surgery, urology, gynaecology and orthopaedic surgery with one theatre dedicated to chronic pain management.

There were 11,166 operations performed at Chase Farm hospital over the last 12 months. 70% of the services activity was day case and 30% elective activity. The highest number of episodes were in ENT which was 31%, trauma and orthopaedic 21%, general surgery 18% and ophthalmology 13%.

Emergency surgery did not take place at Chase Farm, patients needing emergency surgery would be treated at either the Barnet or the Royal Free sites.

We spoke with 12 patients and their relatives, held discussion with 36 staff and reviewed eight patient records and 10 prescription charts. We also made observations in surgical areas delivered in a variety of settings and reviewed information provided 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 in order to gain a balanced and proportionate view of the service.

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.

Surgery

Summary of findings

Overall we rated surgical services as Good because:

Staff were able to speak openly about issues and serious incidents. However, staff told us they didn't always report an incident as they were too busy and did not always receive feedback.

The environment was clean and staff followed infection control policies and procedures. There were cleaning schedules on the wards and operating theatres and these were clearly documented for staff to view.

There was appropriate medical and nursing staff to cover the work although some medical staff were uncomfortable with the support they needed for more complex post-operative patients.

We saw the staff use the intranet to access evidence based protocols and care but there were a number of audits either not started or not completed that would demonstrate staff were reviewing their practice in line with national and local standards.

All patients we spoke with were positive about their care and treatment they had received. Staff treated them with kindness and compassion.

Patients were looked after in a responsive manner and we saw patients having to wait for only short periods prior to their surgery.

Surgical services were well led and driven clinically by the matrons who were visible on the wards and departments. There was an appropriate system of governance in surgical care services and arrangements to monitor performance and quality.

Are surgery services safe?

Good

We rated the safety of the service as Good because:

Staff knew how to report incidents and felt confident that when incidents were reported they were listened to and acted upon. We were given examples where learning had taken place and had changed practice. All incidents were analysed and reported to the monthly departmental meetings for further discussion and action.

All areas we visited were clean although some were old and in need of refurbishment, cleaning schedules were completed and we saw documentation to corroborate this.

All area displayed their quality and safety information which demonstrated the days staffing levels, MRSA rates, hand hygiene compliance figures and any patient falls. These were clear and easy to read.

Medical and nurse staffing levels were appropriate for the level of care at Chase Farm.

However not all staff in the operating theatre knew who was the nominated Fire Marshall and some staff told us they were too busy to complete an incident form.

Due to the redevelopment work on the site the service had a dummy evacuation procedure planned for March 2016 from theatres to ensure all staff were up to date with the procedures.

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.
- Chase Farm hospital reported one never event between October 2014 and September 2015. This was related to using a wrong sided implant into the wrong laterality surgical site. Changes in practice were made to prevent a reoccurrence such as developing a protocol for checking of implants for theatres this included a

number of actions to take place before an implant was used such as left and right sided implants to be stored separately and using 'stop before you implant' procedure. We saw this happened across all three sites.
- Surgery 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, and 11 resulting in severe harm.
- 73.5% of incidents reported in surgery resulted in no harm. Patient accidents were the most commonly reported category of incident, accounting for 23.4% of incidents. However none of these resulted in severe harm or death.
- Incidents related to two categories, "Access, admission, transfer, discharge" and "Documentation", showed no overall trends.
- 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 were reported within 90 days. In November all incidents were reported within 60 days.
- However minutes from the Surgical Specialties Clinical Governance and Risk Committee meeting in October 2015 noted the number of incidents reported had reduced. The service investigated the reason for the reduction which was due to staff not reporting as many minor incidents such as the late starting or late finishing of theatre lists.
- We were also told by staff they often did not report an incident as they didn't have time to do so.
- Staff told us about a recent late running of a theatre list which resulted in a number of staff staying late and working on their own in recovery. This was not reported as an incident.
- Staff on the HDU told us they received feedback from an incident at Barnet hospital but nothing additional from Chase Farm.

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.
- We saw that staff, patients and relatives were supported and informed of the outcome in accordance with the trust's Duty of Candour.
- The trust kept appropriate records of incidents that had triggered a Duty of Candour response.

Patient 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 the services Quality and Safety Boards displayed outside of Canterbury and Wellington wards. This showed that for January 2016 no pressure ulcers had occurred for the month of January 2016, there were no falls and no catheter urinary tract infections. There were no trends in prevalence rates of pressure ulcers, falls or catheter infections as there were very small numbers of incidences reported.
- Canterbury ward displayed there had been no Methicillin Staphylococcus Aureus (MRSA) for 778 days, no hospital acquired pressure ulcer for 80 days and 28 days since a patient fell. The ward's hand hygiene was 100% and there were no Clostridium difficile (Diff) infections.
- Also for Wellington ward there had been no Clostridium Difficile(CDiff) and no hospital acquired pressure ulcers for 721 days. The ward's hand hygiene was also 100%.

Cleanliness, infection control and hygiene

- There were dedicated staff for cleaning ward areas and they had been provided with nationally recognised colour coded cleaning equipment for use in defined areas or under specific circumstances. This helped to reduce the possibility of cross contamination.
- We saw cleaning schedules for surgical wards, theatres, the day of surgery assessment unit and pre assessment areas. All were documented as being completed daily and weekly as required. Operating theatres had deep cleaning carried out each evening which was also documented. MRSA positive patients would be operated on at the end of list and the theatre deep cleaned prior to the next operating list.

- The service used external contractors for domestic and cleaning services. We also saw the services staff cleaning equipment and clinical areas as and when necessary in line with the services policies and standards.
- In main theatres they had separate clean preparation areas and facilities for removing used instruments from the operating room ready for collection for re-processing by the trusts decontamination service.
- The service could give detailed information on the turnaround times for instruments at all three hospital sites which was four hours
- Soiled clinical waste was removed from theatres hourly and we saw clinical waste removed from other ward and clinical areas removed twice daily. Bins and waste storage was managed appropriately.
- We observed that the National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008) was followed by staff in the theatre environment. This included skin preparation and management of the post-operative wound.
- According to the trust's meeting minutes there was a lack of handwashing facilities in the pre-assessment unit which could lead to the transmission of infection. We saw hand gel sanitizers were now placed at the entrance to the day of surgery assessment unit and at specific places across the unit.
- There were three surgical site infections (SSIs) for hip operations reported in three consecutive days. The service investigated these incidents and found there to be no commonalities with staff, surgeons or site. There was a mix of micro- bacteria and differing sensitivities. Theatre equipment and ventilation was tested and a full deep clean of the theatres involved were carried out. No further cases had been identified and the incident has been closed unless repeat test results required action (next testing in June 2016) or new cases are identified. The next testing was to be in July 2016.
- We saw that 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).
- Decontamination and sterilisation of instruments was manged in a dedicated facility on the Barnet site and was compliant with the EU Sterile Services Medical Devices Directive
- There was access to personal protective equipment, (PPE) including gloves and aprons in all areas visited and staff used these whilst going about their activities.
- We saw the HDU was clean throughout and there were green 'I am clean' labels on visibly clean equipment. We observed staff washing their hands and wearing PPE appropriately. There were clinical waste bins available at the bedsides. Unused bed spaces were clean and ready to receive the next patient.
- We saw staff had access to infection and prevention control (IPC) policies and procedures via the trust intranet.

Environment and equipment

- Surgical services had a comprehensive equipment record which allowed for the monitoring of equipment and ensured equipment was accessed in a timely manner.
- The services risk register noted there was a lack of oxygen in bay 4 on Canterbury ward and staff were using a portable oxygen cylinder if patients were being nursed in this bay. The service risk assessed the situation and a decision was made not to place patients in bay 4 who needed needing oxygen therapy.
- Minutes from meetings indicated the pre-assessment clinic was not fit for purpose; staff told us it was too cold in winter and was in need of repair/refurbishment.
- We saw the pre-assessment clinic was cramped and provided a poor experience for patients embarking on a surgical journey. A greater proportion of its space was locked, out of use and in a poor state of repair. The clinic was due to be moved in February 2016 with a completion date of no later than 15th April 2016. Staff told us they were not aware of the date of this move.
- The risk register noted the laminar flow in the orthopaedic theatre (theatre five) was noisy. This was reviewed and it was confirmed the risk was rated as a moderate harm, as staff were aware of the issue and to speak louder when operating. The laminar flow had been checked by estates staff and confirmed that it had no faults.
- We experienced the noise level in theatre five and found it to be excessive. Prolonged periods of time spent within the laminar flow system would be tiring and lead to a more stressful experience for both doctors and nurses using this theatre.

- We saw the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to.
- Theatres were well organised and there was single use equipment readily available.
- Equipment on both theatres and HDU was seen to have been portable appliance tested and service dates were visible on some items.
- Operating theatres had equipment for those patients with a high body mass index (BMI) such as operating tables which can hold a patient up to 300 kgs and trolleys and beds that can hold up to 315kgs. Equipment for patients with a higher BMI could be transferred from Barnet Hospital.
- We saw daily checks of equipment such as oxygen cylinders, resuscitation equipment and suction machines were completed and documented the service. However fridge temperatures were not always completed for example for December 2015 and January 2016 the surgicentre had no temperatures recorded. Also the new temperature gauge was not in use and was found on top of the fridge with no battery. Staff were unaware the new gauge should be used.

Medicines

- We found that the pharmacy team provided a well-established and comprehensive clinical service to ensure people were safe from harm. The pharmacy team visited both wards and the day of surgery assessment unit weekly.
- We saw examples of medicines interventions recorded by a pharmacist to guide staff in the safe administration of medicines. Prescription were checked and verified, and medicines reconciliation recorded on the charts by the pharmacist.
- Bulk and intravenous fluids were stored separately in a room, with restricted access.
- Pharmacist visited the ward every morning on weekdays and was involved in ward rounds, which encouraged multidisciplinary working. This was also a forum where medicines updates could be given verbally in 'Safety Huddles'.
- We looked at the prescription and medicine administration records for 10 patients on both wards. Prescription charts had been fully completed and showed that people received their medicines as prescribed.
- For the period between January and December 2015, an overall combined medicines errors across Chase Farm surgical services was 13 with the most amount of errors six experienced in general surgery, three in the operating theatres two in urology, and one each in maxilla facial and orthodontics.
- We observed processes for ordering, storage and disposal of Controlled drugs (CDs) these were stored in locked cupboards, which were secured to the wall. All CD registers we looked at were completed appropriately
- Antimicrobial protocols were visible and there were reminders in anaesthetic rooms about medicines.
- On Wellington Ward, patients were encouraged to bring and administer their own medicines as most admissions were for elective surgery with short inpatient stay. However, when discussed with the ward manager we were told there was no formal risk assessments are carried out or written to ensure patients could suitably self-administer their own medicines.

Records

- We looked at eight sets of patient's notes; these were comprehensive and well documented and included, diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with the patient and families.
- However we saw patient details on the white board in the day of surgery assessment unit could be seen by female patients when they arrived on the unit. We observed five consecutive patients arriving on the unit and looking at the white board in order to find their name. This meant patients could see other patients details and breeched confidentiality. We reported this to the nurse in charge at the time of the inspection.
- 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 the anaesthetic and operating room to recovery and discharge from the theatre.
- The service audited its 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 three of the five steps to safer surgery which showed 100% compliance in step 2, 90% compliance in step 3 and 100% compliance in step 4. However, the service

previously had not documented step1 which was the briefing session prior to commencing the operation and step 5 which was the debriefing session at the end of the operation.
- These checks had now been instigated but needing auditing to ensure compliance.
- We saw assessments of falls, pressure areas and nutritional status were well documented in patients notes.
- Records on the HDU were on a computer-based system and we saw they were thorough yet concise from both medical and nursing staff.
- Assessments such as fluid balance and venous thromboembolism (VTE) were seen to be completed. On discharge from HDU, notes were printed and placed into the patient's paper notes for transfer to the clinical ward there was also a discharge summary completed by the junior doctor and this was handed over to ward medical staff verbally.
- The HDU had recently introduced verbal nursing handovers to ward staff and HDU staff told us this made the process much more effective for patients.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on its intranet. Take up of mental capacity act (MCA) /deprivation of liberty (DoLS) training was 95%.
- Also due to the nature and close proximity of mental health units on the Chase Farm site many of the security guards had undergone specialist mental health training (60%) via Barnet Enfield and Haringey Mental Health Trust. The team also worked across the acute and mental health team sites.
- There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team.
- Staff knew and understood safeguarding; they were clear on what actions should be taken if they had safeguarding concerns. They were aware of DoLS and its links with consent/MCA.

Mandatory training

- Mandatory training was monitored and all staff were expected to attend on an annual basis.
- Staff told us that mandatory training was a mixture of on-line training risk assessments, such as assessment of moving and handling, skin integrity, nutrition, use of bed rails and Venous Thromboembolism (VTE) were recorded in the care records reviewed.
- According to trust data mandatory training the overall attendance was 92% for nursing staff emergency planning and infection control level one were 100%, mental capacity act, children's safeguarding level one was 95%, safeguarding adults and children level one /two was 90% and infection control level two was 85%.
- For medical staff the overall attendance was 90% for emergency planning and infection control level attendance was 100%, mental capacity act, safeguarding adults level two and children's safeguarding was 88%, safeguarding adults level one was 89% and children's safeguarding level two was 92% with infection control level two being 84%.

Assessing and responding to patient risk

- All elective patients were pre-assessed prior to surgery, if a patient had a BMI of more than 35 the pre-assessment nurse would refer to an anaesthetist for further review. A 'Patient Selection For Elective Surgery At Chase Farm Hospital' form would be used to review the suitability of the patient for a surgical procedure.
- The service had a list of suitable high risk patients which could be operated upon at Chase Farm these included removal of the thyroid gland,(total thyroidectomy), realignment of joints (revision arthroplasty), spinal surgery, cervical spine surgery, operations to the jaw (bimaxillary osteotomy), patients with sleep problems and patients requiring frequent overnight monitoring.
- The service used a National Early Warning System (NEWS) which enabled staff to identify patients who were deteriorating and provide them with increased support.
- Both Canterbury and Wellington wards used the NEWS demonstrating whether a patient's condition was deteriorating. We saw good practice in escalating a deteriorating patient where a patient's observation showed a reaction to an anaesthetic drug, this was appropriately escalated and the NEWS used appropriately.
- In December 2015 the service audited its use of the NEWS tool. Both Canterbury and Wellington wards showed that no patient triggered a patient at risk (PAR) score even at the lowest level. Good practice was noted,

in that approximately 50% of the sample had a documented monitoring plan on the front of the observation chart, prescribing the frequency of observations for each patient.

- Nurses were questioned to ascertain their awareness of the local escalation policy for acute deterioration as there was no on-site patient at risk & resuscitation team (PARRT). All were confident they knew how to escalate and had seen unwell patients responded to quickly.
- The service had a graded response and transfer guide for deteriorating patients. This was divided up into three main patient assessment record (PAR)s. A PAR score of 0-two needed a minimum of 12 hourly observations, a PAR score of three to five was an amber alert and resulted in hourly observations and informing medical and nursing staff immediately and a PAR score of six or more was a red alert and may require transfer to the High Dependency Unit (HDU) and subsequent transfer to Barnet hospital.
- The registered medical officer (RMO) would carry out daily ward rounds to ensure patients were improving and there were no signs of deterioration. Consultants would visit on the first post-operative day and then the registrar would visit after that until the patient was discharged home.
- HDU staff told us if a patient was deteriorating this would be highlighted to the anaesthetist responsible for the unit at that time. Nursing staff would begin non-invasive ventilation if indicated and then discuss their actions with the unit doctor. The anaesthetist was responsible for escalating the patient's care and contacting intensive Care Unit (ITU) at Barnet Hospital if additional support was needed. If a patient needed transferring to ITU, a team would be sent from Barnet to retrieve the patient.
- There were daily handovers, one at the beginning of the day and the other towards the end of the day. We saw both medical and nursing handovers and found these to be well structured and detailed.
- Day surgery service was provided in a 23 hour unit and we saw an operational policy that had criteria identifying patients suitable for this environment.
- We saw local preoperative assessment policies were used to ensure that pregnancy status was checked within the immediate preoperative period in accordance with NICE guidelines (CG3). The check was recorded on preoperative documentation used by staff performing final clinical and identity checks before surgical intervention

Nurse staffing

- Staffing levels based on planned and actual needs were displayed on both wards and in theatre areas. The majority of ward staff worked 12 hour shifts.
- Acuity data showed on Canterbury ward there was a 1:6 ratio of nurses to patients which was18 whole time equivalent (wte) planned with an actual staffing level of 14wte. Three registered nurses and two health care assistants. For Wellington ward there was a 1:5 ratio and 20.42wte and an actual staffing level of 12.1wte.
- The vacancy rate for Canterbury ward was 22.2% and for Wellington ward was 26%. The service was actively recruiting staff.
- Patient to nurse ratio on the HDU was 2:1 plus a supernumerary band seven (office hours only). There would be a minimum of one band five and one band six RN on duty at any time, including overnight. All nurses worked cross-site at Barnet ITU.
- Staff on HDU told us they would do one to two shifts per month at Chase Farm and they enjoyed the extra time they could spend with the patients as the unit was quieter with lower acuity.
- Operating 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. However, theatre staff did raise concerns about having to act as 1st assistant when a member of medical staff could not attend. We were told this was being discussed to see that the correct number of medical staff attend theatres to assist operations.
- For the operating theatres there were 61.25wte staffing with an actual staffing level of 56.65wte.
- Nurse staffing vacancies in theatres and recovery was 40% but this figure was due to amalgamating the main theatre and recovery staff with the Surgicentre staff. This amalgamation had led to a reduction in the number of staff needed and the service was reviewing its new establishment figures. There were no agency staff used and very few use of bank nurses for theatres and recovery.

- Staffing in the pre-assessment clinic was one Band 7; six band 6's, one band 5 and two health care assistants (HCAs).

Medical staffing

- There was consultant cover for each surgical speciality during the day 8am to 6pm Monday to Friday whilst operating lists were taking place and consultants would review their patients at the end of the operating lists before leaving the site.
- There were three Registrar Medical Officers (RMOs) to cover the two surgical wards Monday to Friday during the day time with a split rota of 8.am to 5 pm and 12 noon to 8 pm. Weekend cover was via the Barnet Hospital and medical staff would be on site on a Saturday afternoon with the rest of the cover provided from Barnet.
- Patients on the HDU would have an anaesthetist who was undertaking one of the operating theatre lists and would have support from a junior doctor. There was consultant anaesthetic cover 24/7 from the Barnet site and an RMO 24/7 with a medical and surgical registrar on site out of hours.
- Revalidation for the 43 surgeons in the division of surgery at Chase Farm was in progress with 75% of surgeons completing their revalidation.

Major incident awareness and training

- The trust had Emergency Preparedness, Resilience and Response Policy issued in November 2015 which was available on the intranet. The trust had contingency plans for surgical services. These plans covered staffing, beds shortage, closure of the unit, mobile phone and lift failure.
- Staff we spoke with were aware of their role in the event of a major incident. Approximately 95% of staff received emergency planning training.
- However staff in the operating theatres did not know who was the departments' Fire Marshall and so it was unclear who was responsible to take first action if there was a fire. Staff told us who they thought the Fire Marshall was but on checking this with senior staff this was incorrect.
- Staff told us due to the ongoing construction work currently taking place across the site there would be a dummy evacuation procedure planned for March 2016 from theatres to ensure all staff were up to date with the procedures.

Are surgery services effective?

Good

Summary

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

We found that there were arrangements to ensure that staff were competent and confident to look after patients. Patients were cared for by a multi-disciplinary team working in a co-ordinated way and had access to some services seven days a week.

The nutritional needs of patients were assessed at the beginning of their care in pre- assessment through to their discharge from the trust. Patients were supported to eat and drink according to their needs. There was access to dieticians and medical or cultural diets were catered for.

Staff had undertaken training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. There was evidence to demonstrate that staff were trained with respect to mental capacity and deprivation of liberty safeguards although there was variable knowledge amongst some levels of nursing staff.

Staff received an annual performance review, which included discussion of learning and development needs.

There was evidence of multi-disciplinary team working both within the trust and externally.

However;

The majority of patients were treated based on national guidance and local audits. However there were some local audits that had been slow to progress, or had only recently commenced at the time of inspection.

Evidence-based care and treatment

- We saw staff were able to access national and local guidelines through the trust's intranet, which was available to all staff. However we asked some senior staff to access the intranet to find a specific piece of information which they could not do.
- The service sent data to the National Joint Registry on hip and knee replacements and participated in the

elective surgery patients reported measures (PROMS). For the repair of groin hernias, hip and knee replacements and removal of varicose veins the service could demonstrate overall improved outcomes for patients.

- This service provided data on the outcomes of thyroid surgery performed by the British Association of Endocrine and Thyroid Surgeons (BAETS) members in the UK between July 2010 and June 2014. Data extracted from the BAETS database on 31st August 2015 showed better outcomes than previously reported. Mortality of thyroid surgery remained low (less than 0.1%). The circumstances of all reported deaths were also examined, and in no case was death directly related to any surgical complications.
- Early re-operation to control bleeding in the neck was approximately 1% and hospital stay after thyroid surgery was short with most patients being discharged within 24 hours; after total thyroidectomy one to three days and around 2% required re-admission for reasons related to their surgery.
- The HDU at Chase Farm submitted data to the intensive care and research network (ICNARC) through the Barnet hospital site.
- The thyroid MDT contributed to a national study called HiLo study: a multicentre randomized trial of high and low doses of radioactive iodine following surgery for differential thyroid cancer. This had now been reported and its guidelines had been implemented by the MDT.
- The service also undertook local audits and for Chase Farm there were 61 audits to carry out but only 20 had been completed. 18 had been completed by the therapies team and two by the anaesthetics team. One was a patient survey and the other related to resuscitation training.
- Seven audit projects had not been started and the remaining 34 were awaiting completion. This meant the service could not always determine whether there practice was up to date and following good practice guidance

Pain relief

- We observed that consideration was given to the different methods of managing patient's pain, including patient controlled analgesia (PCA) pump and intravenous paracetamol. Nurses on the medication ward rounds would ask each patent if they were in any pain and would give prescribed analgesia if necessary.
- Patients told us nurses came to their aid when they needed extra pain relief, and this was given quickly and the effect checked by nurses.
- All patients we spoke with told us their pain had been managed very well and staff would regularly check to see if a patient was in any discomfort.
- Chase Farm and Barnet sites used a 0-4 pain scoring tool which was different to the pain tool used at the Royal Free site. Patient controlled analgesia (PCA) pumps were also different to the pumps used at the Royal Free site.
- 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.
- We saw wards practiced a nurse rounding system (NRS) which meant checking on patients hourly, pain is monitored during NRS.

Nutrition and hydration

- We attended a staff focus group where staff told us they had a very high opinion of the quality of meals available to patients and staff.
- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of being under nourished.
- Patients told us the food was generally good and there was plenty of choice. We saw menus which supported this. Meals were carefully placed so patients could access their food and patients had access to drinks by their bedsides.
- Pre-admission assessment included nutritional assessment of patients.
- A recent audit undertaken at the Chase Farm site 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 day of surgery assessment unit and 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

- The service monitored mortality using the Dr Foster tools. We were told 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 board committee. We had seen evidence of meeting minutes from this committee.

- Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator) scores.
- The SHMI and HSMR for the trust were 85.33 and 88.23 respectively for the period April 2014 to March 2015. The trust was a positive outlier on both measures, a feature consistent across its two main sites, and maintained over several years. The trust was ranked 7th of English non-specialist acute providers for the current SHMI.
- The trust HSMR was 84.28 for the 6-month period to August 2015 (the most recent HSMR data available). The trust was ranked 23rd of English non-specialist acute providers on this measure, and a positive outlier.
- The trust benchmarked their performance against national comparisons with other NHS Trusts such as the national hip fracture database.
- One member of the anaesthetist team told us they felt the selection criteria for some surgery were challenging and they had very little input to developing the criteria. The surgical service at Chase Farm was one of elective and day care and as such it was no set up to provide more complicated post-operative medical care specifically around acute compromised airway management.
- There had been one incidents of post-operative bleeding after thyroid surgery since the merger of Barnet and Chase Farm hospitals in 2014.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- 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. For those medical staff working at Chase Farm alone 94% undertook ILS level one and 76% level two.
- 75% of recovery staff had attained level two resuscitation training and 15% ILS training.
- There was a specific induction programme for staff and included orientation to the wards, specific training such as infection control and fire safety and awareness of policies.
- Appraisal rates for nursing staff were 100%.
- Band six nursing staff had access to intermediate line management training which included HR issues and governance training. We saw the day of surgery assessment unit had an education board and topics such as managing stress were discussed.
- Other clinical training was available such as the management of catheters and intravenous infusions across the wards and the day of surgery assessment unitday of surgery assessment unit .
- Staff within the thyroid MDT attended educational events in conjunction with the Imperial Hospital thyroid cancer MDT.
- Junior medical staff told us they enjoyed working at Chase Farm and there was good educational support for their continued training and career progression. Senior staff would sit with them and go through their training programme to ensure doctors in training were exposed to the appropriate level of support.
- However there was no education provided on site and RMO's had to go to one of the other sites to attend development events.
- 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.

Multidisciplinary working

- The service took part in bi-monthly multi-disciplinary team meetings via videoconferencing and attended by all core members of the thyroid cancer team according to the generic standards for thyroid cancer speciality multi-disciplinary teams.
- The service provided a two weekly joint school which was run jointly by nursing staff, physiotherapists, occupational therapists, pain nurses and anaesthetists for patients at Chase Farm and Barnet hospitals.
- The purpose of this was to prepare patients for their surgery and enhance their recovery through the provision of information and early exercise routines.

- New pathways had been developed with nursing, medical and therapy staff in knee and hip replacements which were starting to see a reduction in the days patients stayed post-surgery.

Seven-day services

- The trust had identified the 24/7 working scheme as an integral part of its quality strategy and had undertaken a preliminary self-assessment exercise to review the extent to which services are provided seven days a week to help assess the capabilities to provide going forwards. The review was undertaken across national clinical standards, specifically time to consultant review, access to diagnostics, access to consultant-directed Interventions and on-going review.
- Further, as part of the trust's strategic patient safety programme, it has been identified that there was a need to clarify, strengthen and harmonise across sites key processes and capabilities that ensure they are delivering optimal levels of patient safety. These relate to medical staffing at night, including team-working across professional groups, medical review at weekends, site and ward level safety briefings and our generic escalation policy. A 24/7 medical cover working group had been set up and consists of the following work streams: overnight medical cover and team working, site patient safety briefings, ward safety briefings, seven day consultant review and escalation.
- Physiotherapists were available 24/7 from 8.15am to 4.30 pm and covered the two wards along with the . An on call service was provided at weekends.
- Pharmacy provided a full weekday services from 9.00 am to 5.30 pm with a dispensary service available at weekends 10.00 am to 3.00 pm Saturdays and Sundays.
- The day of surgery assessment unit was open from 7.30 am to 8. pm Monday through to Friday.

Access to information

- Staff told us they had individual email accounts and information was shared with staff through emails, newsletters, staff meetings and handovers.
- Medical staff told us there were protocols on the trust's intranet which were reviewed regularly, were well written and easy to follow.
- However we asked to see the services policy for retained swabs and instruments which we were told was on the intranet. This was not the case as the policy had yet to be ratified.
- For patients undergoing thyroid surgery GP's were notified of the patient's diagnosis by the consultant following surgery via a discharge letter which was sent to the GP and patient within 24 hours of discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust did not require staff to attend specific training in relation to Duty of Candour (DoC), as the trust considered that the Being Open policy was well understood and embedded, and the Duty of Candour merely enshrined these principles in law. However, the trust had clarified DoC requirements within the DoC Policy and had provided additional training in both an ad hoc context and specifically within a training programme lead by Head of Legal Services. The trust had provided three sessions in the training programme and had specifically trained 65 members of staff. The training was ongoing and was supported by the Divisional and Corporate Patient Safety and Risk Managers, the policy and the webpage where staff can access when needed.
- Patients told us they had been informed of the risks involved in having surgery before they signed the consent form. Other patients confirmed that staff discussed with them what they were going to do before treatment or care, ensuring they obtained their consent.
- The consent process generally occurred in the pre-assessment clinic. We observed a patients journey through the day surgery unit from the consultation with the anaesthetist and surgeon to transfer to the operating theatre for their operation. We observed consent being obtained prior to the patient to their procedure. This was explained in full and included the risks to the surgery.
- An audit of informed consent for local anaesthetic procedures was undertaken in 2015 which showed patients were happy with the communication at pre assessment and prior to surgery and patients commented 'we were very well informed' and 'communication was great'.

Surgery

Are surgery services caring?

Good

We rated caring in the service as Good because:

All patients told us the care they received was excellent; they felt well informed and involved in their care planning.

Interactions we saw were professional and maintained their privacy and dignity at all times.

However;

We saw some patients were anxious about the waits they had in the day of surgery assessment unit this was rectified once we had brought it to staffs attention.

Compassionate care

- Patients told us 'care could not have been better' and 'the nurses were fantastic, can't complain about any of my care'.
- Interactions between staff and patients were positive. We saw a staff member taking time to chat to a patient about his interests and they watched a short video about motor racing on the patient's iPad. Staff were kind when they spoke to patients and chatted to them as they worked.
- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experiences.
- The service had a 37% response rate in the Friends and Family test which was higher than the England average of 36%. At ward level there was varied performance for percentage of patients who would recommend the hospital.
- Friend and Family Test November 2014 to October 2015 for Wellington ward showed a 37% response rate and 95% said they would recommend Chase farm as a place to be treated.

Understanding and involvement of patients and those close to them

- Patients told us their families had been involved with planning their care and had discussed their discharge with occupational therapists and social services.
- Patients told us they had been involved in planning their discharge home and how the equipment they needed to help them mobilise once home was already in place before they had an operation.
- Patients were involved with their care and decisions taken. We saw evidence in the clinical notes that patients were involved in making decisions about care and treatment.

Emotional support

- We observed a number of patients waiting in the day of surgery assessment unit reception area who were anxious about their arrival at the unit. We saw the reception area was not manned so patients and their relatives did not know if the staff in the day of surgery assessment unit knew they had arrived. This led to patients and their relatives walking through into the main assessment area and looking for assistance.
- We took action and informed the nurse in charge that people were anxious and needed to be alerted to what was happening to them. This then led to patients looking at the white board for their name. We reported this in the another part of the inspection report. The service placed a sign in the reception area welcoming patients to the day of surgery assessment unit and informing them they would be seen shortly.
- There was a chaplaincy service providing a 24 hour service with a full time lead chaplain supported by part time chaplains.

Are surgery services responsive?

Good

We rated the responsiveness of the service as Good because;

The percentage of operations cancelled was generally better than the England average of less than 1%.

Patient pathways were designed and monitored to ensure they meet the needs of patients.

There was specialist support in place for patients who were living with dementia.

However;

The trust did not achieve the referral to treatment time indicator of 90% of patients to be treated within 18 weeks.

Surgery

Service planning and delivery to meet the needs of local people

- The service had identified the 24/7 working scheme as 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 to provide going forwards. The review was undertaken across national clinical standards, specifically time to consultant review, access to diagnostics, access to consultant-directed Interventions and on-going review.
- As part of the trust's strategic patient safety programme, it has 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. These related to medical staffing at night, including team-working across professional groups, medical review at weekends, site and ward level safety briefings and our generic escalation policy.
- 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.
- The service was also part of the plans to develop a specialist endocrine surgery by consolidating endocrine surgery for thyroid cancer on the Case Farm site.
- Chase Farm was also included in developing the trauma and orthopaedic department's ambition to consolidate services and establish a major elective centre on the redeveloped Chase Farm site.

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. This ensured early escalation and early resolution.
- The trust was not meeting the referral to treatment time standard of 92% of patients on an open pathway to be treated within 18 weeks.
- Hospital episode statistics (HES) June 2014 to June 2015 showed the average length of stay for elective patients for trauma and orthopaedic was 3.5 and was similar to the England average, urology 1.4 days and ENT 0.9 days were better than the England average.
- The percentage of operations cancelled was generally better than the England average of less than 1%. The percentage of patients whose operation was cancelled and not treated within 28 days varied between April 2013 and June 2015 with a higher percentage than the England average for three quarters out of nine. However numbers had remained similar with eight patients between July 2014 and June 2015 and nine patients between July 2013 and June 2014 not being treated within 28 days.
- The statistics also showed that for readmissions after surgery for elective cases general surgery and trauma and orthopaedics was better than the England average but for ENT this was slightly worse than the England average.
- We saw the white board in the day of surgery assessment unit was used to track the journey of the patients coming through for their surgery and through to discharge. Differing coloured tags were used to show where the patient was in the assessment and preparation process. For example a yellow tag meant the patient had been admitted by a nurse, a red tag meant the patient was ready to be seen by an anaesthetist and doctor and a green tag meant the patient had been seen by both anaesthetist and doctor and was ready for surgery. A blue tag showed the patient was ready for discharge.
- We saw this system in use and it was clear that at any given time all staff knew what was happening to the patients. The process ran smoothly and was effective.
- Patients were taken into the operating theatres and then after surgery would go to recovery and then back to the day of surgery assessment unit ready for discharge. Where patents were staying overnight they would be taken to either Canterbury or Wellington wards for the remainder of their stay.
- Staff in both the recovery and ward areas told us at times transferring a patient from the recovery area to the wards was delayed. This was because if staff from recovery escorted the patient to the ward there would

be insufficient staff to care for the remaining patients in the recovery area. Also there were times when the wards could not supply a nurse to escort the patient due to a shortage of nursing staff.
- We were told this was a frequent event and put those patients in recovery at risk. Staff had reported this to the theatre manager and had yet to be resolved.
- Times for patients coming into the day of surgery assessment unit for surgery were staggered so that those coming for morning surgery arrived at 7.30 am and those having surgery in the afternoon arrived from 12 noon. This means patients did not have to wait for long periods in the day of surgery assessment unit.
- From the information supplied to us, the recovery area was used rarely to accommodate patients overnight when bed shortages occurred. We saw the services data for November and December 2015 showed there had been no patients staying overnight in recovery.
- The operating theatres were open Monday to Friday between 8.am and 7.pm with the recovery area opening until 8.pm with no staff covering overnight. Staff told us if a patient was late leaving the operating theatre they may transfer to the HDU until the patient was ready for transfer to the ward.
- Patients admitted to the HDU were predominantly for short stay post-operative care and were booked in prior to their procedure at least 48 hours before surgery. Staff reported frequent cancellations to HDU as patients often did not require critical care support and were well enough to go directly to the ward. Patients stayed no more than two days and were stabilised before being transferred to a ward.
- There were some medical patients who were escalated from the wards however nursing staff reported this was relatively rare up to five per month. Patients could be accepted with central lines and arterial lines in place, although they were usually removed quickly upon admission as patients were usually stable enough to not require them. Staff told us the unit was being used less frequently for medical patients and was closer to being a short stay surgical unit.
- The pre-assessment clinic was open from 8.30 am to 4.30 pm Monday to Friday and would see approximately 100 patients per week.

Meeting people's individual needs

- The service had who clinical nurse specialists one for breast care and the other in orthopaedics with a lead for surgical site infections. There was also a link nurse for people living with a learning disability and for those patients living with dementia. These nurses worked across the Barnet and Chase Farm sites.
- The day of surgery assessment unit had separate male and female entrances and separate male and female bays so there were no breeches of single sex accommodation.
- Staff told us patients living with a learning disability always had their carers with them and would be placed at the beginning of a list so as to reduce anxiety. This was picked up at pre-assessment and passed on to the day of surgery assessment unit .
- An interpreting service was available for both in-patients and out-patients within the trust. Carefully screened, qualified and experienced interpreters who offered a strictly confidential service in a wide range of languages.
- Telephone interpreters were provided for hospital appointments, these did not need to be pre-booked. When patients attended an appointment they were requested to inform reception staff at the clinic that they required interpreting services.
- When patients required a face-to-face interpreter this was identified and booked by staff. The service offered British Sign Language interpreters, lip speakers and touch sign interpreters.

Learning from complaints and concerns

- Patient information advising patients how to make a complaint or raise a concern with PALS was available on the trust website and 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.
- From February 2015 to October 2015 there were four complaints two for Canterbury ward and two for Wellington ward. Three related to staff attitude and one related to a lack of handwashing. The trust investigated all four complaints and apologised to the complainant.
- The Surgical Specialties Clinical Governance and Risk Committee reviewed and discussed complaints at their six weekly meetings. For example there was a trend relating to complaints about cancelled appointments which resulted in improving communication with patients once they had been seen by the consultant.

- Written complaints were managed by the matron and at a service level. A full investigation was carried out and a written response provided to patients.

Are surgery services well-led?

Good

We rated the leadership of the service as Good because;

There was a clear vision for the service and staff understood their role within the vision.

The leadership team was well established and clinically well led by the matrons and senior team.

Managers spoke enthusiastically about their ward or department and staff were highly complementary about the frontline management team.

Matrons were dynamic, supportive and visible in clinical areas and they inspired others to work together.

Leadership of service

- The service was led at the site level by a tripartite model of service line lead, matron and operation manager. This reported to the clinical director, head of nursing and senior operations manager.
- 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.
- The leadership team was well established and had clearly defined roles and responsibilities which demonstrated good leadership across the service.
- We saw examples of good clinical leadership within the surgical teams. Relationships within the teams were working well and there were a number of opportunities for developing and supporting junior staff.
- Nursing staff told us the director of nursing was visible and approachable. All staff we spoke with felt well supported and empowered to do their jobs.
- The surgical teams were led well by the matrons who provided on-site visible clinical leadership.
- Staff felt the medical director was 'championing' quality and medical staff felt more involved in decision making about their services.
- Staff reported the leadership culture made them feel valued, included and respected.
- Staff told us that the nursing leaders and managers in their areas of work inspired them and encouraged them to work together in achieving enhanced patient care.
- Group emails were frequent and positive in nature and the Chief Executive undertook monthly briefings which were recorded 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

- The service had a range of developments to further enhance the provision of surgical services in the future on the Chase Farm site and there were a number of plans to support the further development of day care and elective surgery.
- Staff we spoke with were aware of the trusts vision and values and they could tell us what the strategy meant to them, which was to provide the best care for patients and to put patients first.
- Specialities had their own strategies such as breast, urology, elective orthopaedic and thyroid surgery.
- We observed the trust's vision and values were prominently displayed in hospital corridors, on 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

- The service had strong governance reporting systems in place to support day care and elective surgery with responsibilities defined that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service.
- 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.
- 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.
- Other items were discussed such as patient safety and risk issues, clinical performance and patient experience and included learning from serious incidents and complaints.
- The service demonstrated the recent never event had been taken seriously and were committed to learning from these events and preventing them from reoccurring.
- The service investigated its serious incidents and action was taken to prevent reoccurrence. We reviewed three root cause analysis reports which demonstrated clear actions and changes to practice.
- There were patient safety and risk feedback newsletters including incidents and learning from an incident.
- There was a risk register available and was under continual review to ensure that the content of the register reflected the actual risks within the department.
- There were three risks on the service's risk register rated as high risks which had been reviewed and monitored regularly and actions taken where necessary.
- Senior clinicians and managers told us they could raise issues for discussion and resolution through a network of performance, clinical governance and safety meetings that took place on a planned basis throughout the surgical division.

Culture within the service

- Staff were positive about working at Chase Farm and for those who worked at Barnet as well they felt it complemented their work. Staff felt confident with the escalation process and with the medical support provided and thought it was safe for patients.
- However, clinicians told us they were unhappy about different job plans across sites and felt workloads were not equal.
- Clinicians told us there was little communication or involvement regarding changes to services.
- Our observations and feedback we received about the culture in theatres was that there was lots of communication, through a range of methods. There were opportunities for staff to raise concerns and staff confirmed they were generally happy. Informal weekly meetings took place to ensure issues were raised in a timely manner.

Public and staff 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.
- 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.
- 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.
- Medical and nursing staff told us this was a good place to work and they felt engaged in reviewing their services in light of the redevelopment of the Chase Farm site.
- Weekly resilience meetings were used to update staff on the progress of the redevelopment of Chase Farm. If staff could not always attend the matron would feedback to staff.

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 a palliative care team, end of life care guidelines and an education programme.

The trust's medical director 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.

Chase Farm Hospital reported 93 deaths in the period 2014/15. The palliative care team based at Barnet Hospital received 63 referrals for Chase Farm Hospital patients from January to December 2015. Of these 63% (40) were cancer and 37% (23) were non-cancer.

Chase Farm Hospital was a non-acute site and had beds for rehabilitation and elective low-risk surgery only. End of life care was provided by clinical staff on the wards and supported by the palliative care team based at Barnet Hospital. The mortuary, bereavement and Patient Advice and Liaison (PALS) offices were accessed at Barnet Hospital.

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 the chapel and Adelaide, Canterbury and Capetown wards. We reviewed the medical records and drug charts of three patients at the end of life and two Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records.

We spoke with 10 clinical staff at Chase Farm Hospital. We spoke with 11 other staff at Barnet Hospital who provided services which covered Chase Farm Hospital. We observed the care provided by medical and nursing staff on the wards. We spoke with two patients receiving end of life care. 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 end of life care at Chase Farm 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.
- The mortuary, bereavement office and PALS were based at Barnet Hospital. Staff in these departments supported the palliative care teams and ward staff at Chase Farm Hospital to provide dignified and compassionate care for 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 at end of life care at Chase Farm 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 provided us with the incidents relating to end of life care at the hospital with evidence of learning achieved and the resulting changes in practice that took place. The trust used an electronic incident reporting system. Staff gave us examples of how they reported incidents and the feedback they received. Staff informed us that they were encouraged to report incidents to enable learning as an organisation.
- There were robust systems and processes to ensure that a high standard of infection prevention and control was maintained. 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.
- We observed the appropriate prescribing of medication for patients who were on the end of life care plan. The palliative care team documented changes in patient care needs and the management of their medications in the records.
- 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.
- One incident had been logged since October 2014 which was attributed to end of life care at Chase Farm Hospital. This related to the transfer of a patient whose medical records did not contain clear information of the patient's treatment. There were inconsistencies of whether the patient was for active treatment. The learning/investigation field of the incident was not completed and the incident closed six months later.
- The mortuary was based at Barnet Hospital and accommodated patients from Chase farm Hospital. 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, based at Barnet Hospital, 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.

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.

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.
- When we spoke to staff they were able to describe the rationale and process of duty of candour.

Cleanliness, infection control and hygiene

- 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.
- We observed that all areas of the mortuary at Barnet Hospital, including the viewing area were visibly clean. There were cleaning rotas.

Environment and equipment

- Trust wide incident reporting had highlighted that there was a shortage of available syringe drivers. We saw evidence that the trust had obtained 40 new McKinley T34 syringe drivers to rectify this. These were maintained and regulated by the equipment services.
- We saw and were provided with the up to date servicing and maintenance records for all the equipment used in the mortuary at Barnet Hospital.

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.
- None of the patients we saw at Chase Farm were receiving medication via a syringe driver.
- 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 three 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 trust told us that in 2016 they will review the speed of access to medications for both inpatients and outpatients. They aim 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

- All palliative care records were hand written and managed in line with trust policy.
- Patients receiving care from the palliative care 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.

- 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.
- Across the wards we visited we reviewed three medical records and nursing notes which contained individualised end of life care plans. All the records contained evidence of discussion with family. However, none of the records contained evidence of being assessed for the patient's psycho-spiritual care. Additionally none of these patients had been assessed for DNACPR or mental capacity.
- However across the wards we did see two DNACPR forms for patients who had dementia and were not on the end of life care plan. These were both completed as per national guidance.
- Effective systems were in place to log patients into the mortuary at Barnet Hospital. They explained the process and showed us the ledger record book that contained the required information. We observed that the book was appropriately completed.
- The bereavement office at Barnet Hospital had systems to process death, burial and cremation certificates. An officer showed us the process and explained what the role involved.

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 eight 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.

End of life care

- 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.
- The mortuary staff, patient affairs and bereavement officers at Barnet Hospital 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 at Barnet Hospital 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 was based at Barnet Hospital. The team 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) CNS and psychologist vacancy at the hospital and they were in the recruitment process. The lead nurse actively managed the staffing daily to ensure a safe service provision.
- The Patient Advice and Liaison (PALS) office at Barnet Hospital 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 that 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 Barnet Hospital for both Barnet and Chase Farm patients. This was held every Tuesday, Thursday and Friday morning. 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 all 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 to 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 an 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 the effectiveness of end of life care at Chase Farm Hospital as Good because;

- 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 palliative care team provided an end of life care service Monday to Friday 8am to 4pm, with out of hours telephone support for palliative medicine provided by a consultant. A business case had been secured to provide a seven day service for Barnet and Chase Farm sites.
- The chapel was accessible 24 hours a day, 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

- 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.
- 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.
- The DNACPR forms we observed were completed as per national guidelines.

However;

- There were inconsistencies in patient's assessments for DNACPR and 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.
- We saw evidence across the wards we visited that the palliative care 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 three 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 three 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.
- Chase Farm Hospital had 459 deaths 2013/14 and 93 deaths 2014/15.
- The palliative care team based at Barnet Hospital received 63 referrals for Chase Farm Hospital patients from 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 85.33 and 88.23 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 both 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.

- 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. 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 skill, 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 hospital told us that trust wide the appraisal rate was 70.8%. The appraisal rate for the palliative care team based at the Barnet Hospital was 75%.
- The palliative care team 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.
- We saw evidence that clinical staff based at Chase Farm Hospital and relevant staff based at Barnet Hospital (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 Barnet 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 meetings were

recorded and shared with the extended team. We saw that the team administrator co-ordinated the meetings ensuring an accurate list was kept of patients discussed and a record of attendance.

- 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.
- 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 at Barnet Hospital 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 Macmillan office at Chase Farm Hospital was open Monday to Friday 10am to 4pm.
- The chapel was 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 mortuary at Barnet Hospital 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 Patient Advice and Liaison (PALS) office at Barnet Hospital was open Monday to Friday 10am to 4pm.
- The bereavement office at Barnet Hospital was open Monday to Friday 9am 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 at Barnet Hospital was provided with a trust wide information wallet. This contained contact details for bereavement support, hospital contact details and a feedback card.
- 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.
- Noticeboards throughout the hospital clearly displayed how the PALS and chaplaincy services could be contacted.

End of life care

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 provide 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 two DNACPR forms. We saw that all decisions were recorded on a standard form and signed by an appropriately senior clinician. Both forms were kept in the front of the patients' notes and had evidence that there had been discussion with relatives. The 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.
- Both 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.
- However, we saw the appropriate DOLS assessment and documentation for two patients. Staff explained to us the process and demonstrated a good understanding of completion of DOLS for patients as 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 Chase Farm Hospital as Good because;.

- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life. We were told about and shown evidence of collaborative working across the teams to provide exceptional care for end of life care patients.
- Patients and relatives who were complimentary about the care they had received.
- We observed compassionate and caring staff who provided dignified care to patients who were at the end of their lives.
- 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 the 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.
- An end of life care patient on Canterbury ward told us that the staff "are fantastic" and staff respond immediately when they action the call bell.
- A patient on Adelaide ward told us staff were "very good and caring". Another patient told us "the staff are their family and they feel they are never alone".
- On Canterbury ward and Capetown ward we saw thank you cards and letters displayed on the boards.
- A student nurse told us "I love working here; it is the first time in my training I am being allowed to do proper nursing care".
- 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 (based at Barnet Hospital) was very sympathetic and also very helpful with regard to registering the death. Thank you for your kindness".

Understanding and involvement of patients and those close to them

- We spoke with two patients. 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 Adelaide 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 responsiveness for end of life care at Chase Farm 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 the patient and plan care. The team achieved face to face assessments within 24 hours for all urgent referrals and within 48 hours for non-urgent.
- We found that staff supported relatives to stay with end of life care patients and assistance was given with parking permits.
- The chapel accommodated all faiths as well as 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 mortuary at Barnet Hospital had a viewing area that was visibly clean and appropriate for relatives.
- The bereavement office at Barnet Hospital told us that they aimed to issue the death certificate on the day of death and had clear systems in place to support faiths requiring a funeral within 24 hours.
- 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.
- 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 Adelaide 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 as in the dying phase all wards would offer patients and their families side rooms dependant on availability and suitability.
- The mortuary at Barnet Hospital 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 at Barnet Hospital 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 aim 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 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 at Barnet Hospital 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.
- The mortuary at Barnet Hospital 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 with areas that could be sectioned off to accommodate separate faiths. Access to the chapel could be gained by contacting the switchboard.
- 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.
- Chase farm Hospital had a 'garden project' specifically designed for dementia patients.

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.
- 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 Chase Farm Hospital.
- In the event of a death the ward contacted the site manager who arranged transportation to Barnet Hospital mortuary.
- 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 Herts Valley CCG averaged 3.3 days for time from application to funding being granted and average 4.5 days to

discharge. Applications for one clinical commissioning group (CCG) granted funding on average 1.5 days and discharge average 3.2 days. Another 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.

- We were told two patients, on Capetown and Adelaide wards their discharge was delayed due to waiting for the provision of equipment.

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.

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.

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 the leadership of end of life care at Chase Farm 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 trust wide medical director had overall responsibility for the palliative care service. Three divisional directors reported to the medical director and there was a palliative care service line lead, who was the clinical lead for end of life care.
- 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.

End of life care

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

- 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 team based at Barnet 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. Three divisional directors reported to the medical director and there was 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 that members of the board were visible and the chief executive visited the hospital monthly. A member of staff told us "senior managers were good examples of the values".
- Staff on the wards 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

- 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.

End of life care

- 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

Chase farm Hospital offers outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up were required. The hospital had medical and surgical specialty clinics, as well as paediatric or obstetric clinics. There were 158,299 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 scans. On average 7,423 patients attended the diagnostic imaging departments each month.

During the inspection, we spoke with 31 members of staff, which included managers, nurses, administrative staff and allied health professionals. We spoke with 4 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 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

However;

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

There was no method of recording the number of hospital prescriptions issued.

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.

There were good systems of incident feedback to staff and to governance committees.

Good records management was in place and over a 12 month period almost 100% of records were available for clinics.

However;

Medicines management was good on the whole, but there was no system of monitoring how many hospital prescriptions had been issued and medicines were not always stored securely.

Incidents

- Staff reported incidents using an electronic reporting system. Staff received feedback automatically received from this system. 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.
- Staff received monthly emails about the numbers of incidents reported.
- No incidents were reported to the Care Quality Commission in line with Ionising Radiation (medical exposure) Regulations 2000

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.
- All areas we visited were tidy, clean and uncluttered. In four of the clinic rooms we entered, all had daily cleaning checklists, which had been completed. Disposable curtains hung around examination beds. They were clean, free of dust, labelled and dated. The dates were within six months of the inspection. A recent environmental audit scored 85% which was above the target score.
- 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 where sharps may be used. This was in line with Health and Safety Regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed and by who.
- 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' was on 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%. We were unable to see staff hand washing between patients, as clinic room doors were shut when patients attended.
- Personal protective equipment was available in all areas we visited. We saw staff using it appropriately.
- The endoscopes used in the ear, nose and throat (ENT) equipment were cleaned between each use with a triple cleaning system. At each of the three stages of cleaning, a label was stuck in a record book, which demonstrated which wipe staff used. 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. We saw a member of staff carrying out the process and all steps were followed.
- Seating in waiting areas was made of wipe clean fabric.
- If a patient with an infectious disease required an examination in the diagnostic imaging department, they were booked on the end of the list and the room was deep cleaned after.

Outpatients and diagnostic imaging

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.
- There was a tea bar available in one outpatient waiting area, which was run by volunteers.
- Electronic self check-in booths were available for patients as well as reception staff.
- 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, documented on checklists.
- In the phlebotomy department we saw there were individual cubicles for patients to have blood tests in. This is in line with Hospital Building Note (HBN) 12, 4.42, which recommends areas providing blood tests should provide individual cubicles for patients.
- We saw some areas of the hospital were in a state of disrepair and we saw cables hanging from the ceiling.

Medicines

- 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 good medicines management.
- Medicines were removed from the locked cupboards at the start of clinic and placed in unlocked clinic rooms with doctors in attendance. During clinic medicines were the responsibility of the doctor in the clinic.
- Doctors' hand wrote hospital prescriptions that could only be dispensed in the hospital pharmacy. Each prescription had a serial number on it. 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 two prescription pads in an unlocked clinic room.
- 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.
- In the diagnostic imaging department medicines were stored securely in a locked room.

Records

- A total of 115,861 medical records were pulled for outpatient clinics last year. Over a 12 month period 99.98% of complete medical records were available
- In clinics we visited, we saw medical records were stored in a trolley. The trolley was kept next to a member of reception staff. We saw doctors take the notes from the trolley and returned them as the patient left. This indicated records were never left unattended.

Safeguarding

- Staff level one and two vulnerable adult safeguarding training and level one and two children's' safeguarding training. Safeguarding training was a part of the mandatory training programme
- Staff we spoke with demonstrated a good awareness of what to do if they had safeguarding concerns and who to contact should they require advice. They gave examples of where a safeguarding alert had been raised.
- If an adult or child patient did not attend an appointment, a doctor would decide what further action to take.
- Staff told us there was no flagging system to alert staff to patients with safeguarding concerns.

Mandatory training

- The outpatient nursing team were 97% compliant with mandatory training which was above the 95% target.

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 that 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, which indicated they had read the rules. 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 records of these checks.
- Lead aprons limit exposure to radiation. Lead aprons were available in all areas of diagnostic imaging for children and adults.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging departments in line with best practice.
- We saw three point identification checks in place for patients in line with best practice.
- There were checks in place to ensure patients did not receive more than one screening scan in a 12 month period in diagnostic imaging.

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 for nurse numbers in the outpatient department . Nursing cover was calculated on the number of clinics running and the numbers of patients attending clinic.
- 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.

Major incident awareness and training

- Staff in the diagnostic imaging department had a clear understanding of the process should a major incident occur. The 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. 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

- 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).
- We saw copies of staff competencies, which indicated staff were competent in a variety of clinical skills.

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.
- The diagnostic imaging department had training across the three hospital sites to share learning.

Seven-day services

- There were no seven day outpatient services at the hospital.

Access to information

- Staff told us they had good access to medical records. We saw data which confirmed this.
- Radiology examinations were available on a secure computer system. Staff had individual pass codes to log on to the system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were consent forms available in all ENT rooms, for consenting patients to procedures.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring in the service as Good because;

Staff in the outpatients and diagnostic imaging departments treated patients with kindness, respect and staff they interacted with behaved in a professional manner.

Patients and their carers were involved in the planning of care.

We found there were processes in place to respond to patients' emotional needs.

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%.
- Clinic doors were shut during consultations to maintain patient's privacy and dignity. We saw staff knock and wait outside examination rooms.
- Signs offering patients a chaperone were clearly visible in all clinic rooms we visited. Staff were available to act as chaperones, which was in line with the chaperone policy.
- In the diagnostic imaging department the chaperone policy was displayed on examination room walls.

Outpatients and diagnostic imaging

- Staff treated patients with kindness, dignity and respect. Staff interacted with patients in a positive, professional and informative manner. This was in line with National Institute for Health and Care Excellence (NICE), QS 15.
- Staff in the diagnostic imaging department took time to deal with patients individual needs and gave us an example of where they had done so.

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.
- Patients told us they had difficulty finding wheelchairs. One carer told us when they eventually found a wheelchair there was not enough room in the corridor to move it around.

Emotional support

- Macmillan nurse support was available for patients attending clinics. They could offer emotional support to patients is they received bad news.

Are outpatient and diagnostic imaging services responsive?

Good

We rated the responsiveness of the service as Good because;

- Although the trust had not met the referral to treatment (RTT) time standard or England average since April 2015, there was a significant programme of work in place to reduce the backlog. The RTT's had improved consistently and were on track to reach the target by the end of the financial year.
- 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.
- There was a consistent reduction in 52 week waiters from 195 patients in May 2015 to 15 patients in November 2015
- The hospital provided a walk in service for patients who needed an ECG

Service planning and delivery to meet the needs of local people

- The hospital provided a walk in service for patients who needed and ECG. This service was available two days a week and times were available in the morning or the afternoon.
- The phlebotomy department was open from 8:00am five days a week. It remained open until 7:30pm three days a week, 6:30pm on one day and 4:00 pm on another. Patients could choose a time most convenient for them.
- Patients attending outpatients had a choice of whether to use the electronic check in system or to book in with a receptionist.
- A free phone was available in the main reception area for contacting taxis.
- Diagnostic imaging department was available from 8:00am to 5:00pm, Monday to Friday. The department operated an appointment only system.

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.
- Although the trust had not met the referral to treatment (RTT) time standard or England average since April 2015, there was a significant programme of work in place to reduce the backlog. The RTT's had improved consistently and were on track to reach the target by the end of the financial year.
- 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.

Outpatients and diagnostic imaging

- 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 October 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 from October to January 22% of clinics cancelled at Barnet and Chase Farm hospitals with less than 6 weeks notice were due to annual leave . This was not in line with the trusts elective access policy which stated six weeks' notice should be given for all planned 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.
- One-stop clinics enabled patients to access a variety of health professionals, examinations and treatment at one appointment.
- 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 six weeks for an MRI or ultrasound scan, four weeks for a CT scan.

Meeting people's individual needs

- Children attended clinics in the main outpatient departments, but here were no paediatric link nurses to provide specialist advice.
- Medical secretaries prepared medical records prior to clinic. They checked to see if transport or interpreters were required. They then checked to see if these had been booked.
- A telephone interpreter line was available and staff could book interpreters.
- We saw there were a lot of steps and stairs around the hospital and some wheelchair lifts were seen.
- Patients with learning disabilities or on transport would be seen as a priority on arriving in the outpatient departments.
- Staff in the diagnostic imaging department gave us an example where a patient with learning disabilities required a scan. They brought the patient to the department prior to their test in order to familiarise them with the department.
- The changing room in the diagnostic imaging department was suitable for a wheelchair user.

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 from 75 days 12 months ago 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 was available in all of the areas we visited.

Outpatients and diagnostic imaging

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.

The clinical director reported 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.

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 in outpatients and diagnostic imaging 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 strategies and 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 that 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 provide clinical oversight and review of patients on the waiting list to minimise risk to these patients.
- The diagnostic imaging department had a monthly risk clinical meeting.

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 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 were contactable if issues arose.
- We spoke with eight members of staff in outpatient clinics where four different speciality clinics were running and in the diagnostic imaging department. We asked to speak with the service manager for each of the different specialities. One staff member knew who the manager was, but not where to find them. The other staff did not know which manager we were referring to or where they were located in the hospital. This indicated not all managers were visible to staff.

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 were not acknowledged for the good work they did.

Staff engagement

- Managers told us staff who were registered health professionals in their own country were supported to do further training which would enable them to register in this country. We spoke with a staff member who was doing this type of training. The staff member and their manager were very happy with the process.
- Staff spoke positively about working in outpatients. They had an excellent understanding of their roles
- Staff told us they felt that appraisals were a useful process and development was positively encouraged.
- Some staff told us they did not always feel valued for the work they did.
- Diagnostic imaging had weekly staff meetings and we saw minutes of these.

Innovation, improvement and sustainability

- The referral management, booking, cancellation and call centre teams had recently been relocated in one area in Enfield. The area 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 rust- wide. The outpatient improvement programme was a key part of this and focus was on building the rust's capability for the future. This included updating computer systems, changing the physical environment and changing patient pathways. We saw minutes of these meetings and on-going progress was evident.
- The RTT project was working through the backlog of patients waiting for appointments and were looking to future planning for capacity and demand.

Outstanding practice and areas for improvement

Outstanding practice

The UCC at Chase Farm Hospital was an outstanding example of a nurse led multi-disciplinary team providing excellent outcomes for patients. Patients were seen promptly and obtained good clinical outcomes. The close working relationship with the Paediatric Assessment Unit significantly enhanced the service provided to children and young people.

The Matrons in surgery were dynamic, supportive and visible in clinical areas and they inspired others to work together.

Areas for improvement

Action the hospital MUST take to improve

Remove the inconsistencies that existed in patient's assessments for DNACPR and the recording of Mental Capacity Act assessments.

The hospital must reduce the number of outpatients appointments it is cancelling.

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

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

Action the hospital SHOULD take to improve

Risk assessment documentation must completed in areas such as falls risk assessments, nutrition charts and fluid balance charts.

The trust should ensure grading of surgical referrals occurs within acceptable timescales.

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

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

The trust should ensure the safer surgery policy is implemented and staff awareness on the policy should be enforced.

The trust should continue with its work around implanting the 5 steps of safer surgery until embedded and audited to ensure full compliance.