Care Quality Commission

Royal Free London NHS Foundation Trust

The Royal Free Hospital

Quality Report

Pond Street, London, NW3 2QG
Tel: 020 7794 0500
Website: http://www.royalfree.nhs.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

This was the first inspection of The Royal Free Hospital under the new methodology. We have rated the hospital as Good overall.

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

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

Our key findings were as follows:

Safe

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

There were concerns with infection prevention and control practices, such as variable hand hygiene, staff wearing nail varnish and jewellery and doors left open to patients in isolation.

The safety thermometer data and many patient risk assessments or records, including fluid balance charts, were incomplete.

Departments performed frequent audits such as the theatre checklist and hand hygiene. Audits were analysed and the results cascaded to staff through staff meetings, notice boards and safety briefings.

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

Suitable governance arrangements and appropriate incident reporting meant staff learnt from mistakes and near misses to improve care.

A formal early warning system was not consistently to identify deteriorating patients in the ED at the Royal Free site, which could lead to a delay in identifying deteriorating patients.

Effective

Clinical practice was benchmarked against national guidance from organisations such as NICE.

Caring

Staff were caring, compassionate and respectful and the staff we spoke with were positive about working in the hospital.

Caring staff maintained patients' privacy and dignity and provided emotional support to relatives.

Responsive

The trust's ED performance on waiting times for treatment was inconsistent but they often met the 4-hour target.

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.

Summary of findings

The palliative care team was highly thought of throughout the hospital and provided support and education to clinical staff. The team worked closely with the practice educators 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.

An interpreting service was available for both in-patients and out-patients within the hospital.

Ambulance turnaround time did not meet the national target of handover. Patients were also not consistently receiving an assessment within 15 minutes of arrival, which was not in line with College of Emergency Medicine (CEM) guidance.

Patients' individual needs and preferences were mostly considered when planning and delivering services.

The trust had consistently not met the referral to treatment time standard or England average for the past ten months. The time to triage referrals as to their priority varied between specialities and could take as long as 34 days.

There had been a deterioration in performance of the 62 day cancer performance compared to the national standard.

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

There was a lack of bereavement facilities on the labour ward. The designated room for bereaved mothers was a standard labour room and was sometimes used for other patients, such as those with an infection, which meant that women were cared for in the birth centre.

The poor post-operative recovery facilities for children exposed them to potentially upsetting sights and sounds.

Well Led

Patients achieved good outcomes due to receiving evidence-based care from suitable numbers of competent staff who enjoyed their work and were well supported by a visible management team.

There was an appropriate system of governance in surgical care services and arrangements to monitor performance and quality.

The trust promoted and encouraged both local and national innovations to improve patient care and treatment.

We saw several areas of outstanding practice including:

A 'Foetal Pillow' had been designed to aid delivery of the baby at caesarean section. The foetal pillow was used to elevate the baby's head making operative delivery easier.

Particular praise must be given to the volunteers who provided additional caring activities such as massages for patients and supported patients with dementia.

We observed dynamic nursing leaders who supported clinical environments are were essential in the development and achievement of best practice models.

The neonatal unit had level 2 UNICEF accredited baby friendly status where breast feeding was actively encouraged and mothers are given every opportunity to breast feed their babies.

The vigilance and recording of mandatory training and other aspects of post qualifying education by the paediatric practice education team was exemplary.

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

Importantly, the trust must:

- Take action to ensure compliance with The National Patient Safety Agency (NPSA) alert PSA001 31st January 2011.

Summary of findings

- The trust should ensure the 62 day cancer wait times are met in accordance with national standards.
- The trust data base of clinical guidelines and procedures hosted via “freenet” must be updated as soon as possible.
- The recovery area of the operating theatre must be altered to protect children from witnessing upsetting sights and hearing frightening sounds.
- Nursing staffing levels on the children’s ward must be improved.

In addition the trust should:

- Clearly define the ‘low risk’ pathway for women identified as suitable for birth centre care.
- Improve termination of pregnancy pathway.
- Identify a dedicated bereavement facility for women and families to use in or near the labour ward.
- Use lessons learned from Barnet Hospital in reducing Caesarean section rates.
- Undertake a maternity acuity staffing assessment to identify staffing requirements for the merged service.
- Improve antenatal risk assessments.
- Ensure the theatre swab, needle and instrument policy is ratified and new practices are embedded in all relevant departments across all sites.
- Ensure a safer surgery policy is produced and ratified.
- Ensure appropriate staggering of arrival times with the day surgery unit to minimise the time patients are prohibited from eating and drinking.
- Ensure ED staff are fully trained and able to identify and support patients living with dementia.
- Ensure the ED risk register captures and manages all risks.
- Ensure that there is an electronic system in place to flag patients who may require additional support.
- Ensure that medical and nursing records are fully completed without gaps or omissions.
- Ensure that RTT is met in accordance with national standards.
- Ensure all staff interacting with children have the appropriate level of safeguarding training.
- Ensure security of prescriptions forms is in line with NHS Protect guidance.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	Staff were proactive in reporting incidents and we saw evidence of learning taking place as a result of incidents. Learning was shared with all staff via safety briefings and posters were displayed in the seminar rooms. Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. The trust's performance on waiting times for treatment was inconsistent but often met the 4-hour target. The trust has been above the England average for percentage of patients seen within four hours since February 2015. The department was responding to most complaints within the agreed time frame but staff we spoke with were unable to tell us about any learning or changes implemented as a result of a complaint. Staff were caring and compassionate, although the design of some accommodation meant that patient's privacy and dignity were not always protected. Staff felt supported in their roles and innovative ways were introduced to retain staff. There was an open culture so staff could raise concerns and staff felt the trust was investing in them. There was clear nursing and medical leadership visibility with the department, and staff felt able to highlight issues to them. The governance arrangement was clear to staff we spoke with and, from the meeting minutes we reviewed, it was clear the leadership team understood the service. However; During our inspection, we observed staff did not always wash their hands between seeing patients. Checks on resuscitation trollies and defibrillators were not carried out regularly although we noted the resuscitation trolley to be fully stocked during our inspection. Patients were also not consistently receiving an assessment within 15 minutes of arrival, which was not in line with Royal College of Emergency Medicine (RCEM) guidance. There was no formal scoring or early warning system to identify deteriorating patients in the department, which could lead in a delay in identifying deteriorating patients.

Summary of findings

The needs of people living with dementia were not always being met as there was no flagging system to identify these patients and some staff had not received training and hence showed a limited understanding of the condition.
The department conducted their own local audits against RCEM standards but did not submit data to the Royal College of Emergency Medicine in 2014-2015. Clinical leads confirmed that this was only a one off year and they were registered for 2015-2016 audits.
We noted that risks were discussed regularly, but not all the risks we identified were on the department's risk register.

Medical care (including older people's care)

Good

Patients achieved good outcomes due to receiving evidence-based care from suitable numbers of competent staff who enjoyed their work and were well supported by a visible management team.
Results from the Friends and Family Test and patient feedback suggested most patients would recommend the service to their loved ones and were happy with the care they received.
Suitable governance arrangement and appropriate incident reporting meant staff learnt from mistakes and near misses to improve care.
We saw evidence of relevant service development and innovation, particularly in the HLIU where equipment design was reviewed after each patient admission. Patients across the country could access the HLIU with a direct consultant referral.
There were concerns with infection prevention and control practices, such as variable hand hygiene, staff wearing nail varnish and jewellery and doors left open to patients in isolation.
The safety thermometer data and many patient risk assessments or records, including fluid balance charts, were incomplete.

Surgery

Good

There was a good culture of reporting incidents and we saw evidence of changes to practice as a result of investigations, and there were robust systems in place.
Departments performed frequent audits such as the theatre checklist and hand hygiene. Audits were analysed and the results cascaded to staff through staff meetings, notice boards and safety briefings.
The trust promoted and encouraged both local and national innovations to improve patient care and treatment.

Summary of findings

We saw emergency equipment and medicines were appropriately stored and checked in line with protocols.
We spoke to 30 members of staff who were passionate about working at the hospital and showed pride in their work. All staff said they felt supported and senior staff were visible.
Staff were aware of the safeguarding policies and procedures and had received training. Most staff understood their responsibilities under the Duty of Candour and were able to provide examples.
There was an appropriate system of governance in surgical care services and arrangements to monitor performance and quality.
An interpreting service was available for both in-patients and out-patients within the hospital.
Arrangements were in place to support people with disabilities and cognitive impairments. However there was no electronic flagging system currently in place but a business case has been submitted for such a system.

Critical care

Good

We found there were processes and systems in place which prioritised patient safety and allowed staff to deliver evidenced based care. Staff were proactive in reporting incidents and there was evidence that learning from investigations had taken place consistently with an effective system in place to ensure all staff were aware of updates to practice.
Critical care services were delivered in a newly refurbished modern and clean environment, with a large number of isolation rooms available. Staff adhered to infection prevention and control guidleines and rates of hospital acquired infection were low.
Staffing levels were reviewed continually using an established nursing acuity tool and there were enough staff to provide care and treatment in accordance with national guidance. The education team were providing in-house university accredited post registration training in critical care and ensured all staff received training prior to working independently on the unit. Agency staff underwent stringent induction and background checks before working on the unit.
The critical care team had access to multidisciplinary specialists who contributed to decision-making and ward rounds to ensure best care for patients. An established critical care outreach team supported patients across the hospital, pre and post admission to the critical care unit.

Summary of findings

Clinical practice was benchmarked against national guidance from organisations such as NICE.
Caring staff maintained patients' privacy and dignity and provided emotional support to relatives.
There was a lack of written information available to patients and their relatives and patient engagement was limited. Staff had not achieved the trust target for most of the mandatory training modules, with some key training, such as resuscitation having low completion rates for medical staff.

Maternity and gynaecology

Good 

We saw examples of safety incident reporting systems, audits concerning safe practice, and compliance with best practice in relation to care and treatment.
Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed that staff carried out care in accordance with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists(RCOG) guidelines.
Patients told us they had a named midwife. The ratio of clinical midwives to births was in mainly in line with the national average of one to twenty eight women.
The trust provided evidence of one-to-one care during labour which is recommended by the Department of Health. Women told us they felt well informed and were able to ask staff if they were not sure about something.
Patients and their relatives spoke highly of the care they received in both the maternity and gynaecology services.
However,
There were three never events involving retained swabs in 2014, 2015 and 2016.
Record keeping was inconsistent and on-going risk assessment in pregnancy was not recorded in patient records.
Patients' individual needs and preferences were mostly considered when planning and delivering services.
The designated bereavement room was not always available for bereaved mothers and they were therefore sometimes cared for in the birth centre.

Services for children and young people

Good 

The trust met the Royal College of Paediatrics and Child Health (RCPCH) standards for paediatric consultant staffing levels but nursing levels on the children's ward were not always complaint to the Royal College of Nursing (2013) standards.

Summary of findings

The special care baby unit generally met the British Association of Perinatal Medicine standards (2011) for staffing neonatal units.
There was generally good access and flow within the children's service. Patients received evidenced based care and treatment and good multi-disciplinary working existed between the children's services, external providers and the child and adolescent mental health service (CAMHS).
The poor post-operative recovery facilities for children exposed them to potential hostile sights and sounds.
Staff were caring, compassionate and respectful and the staff we spoke with were positive about working in the service and there was a culture of flexibility and commitment.
The service was well led and a clear leadership structure was in place. Individual management of the different areas providing acute children's services were well led. A governance system was in place and we saw that clinical risks identified. Feedback from staff, parents and children and young people was generally good.
We saw that although services provided evidenced based care as identified within evidenced based clinical guidelines, many of these were out of date posing potential risks to patients.
There was an over reliance on agency nurses to fill gaps in the nursing rosters.

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

Medical records were available electronically but delays occurred when scanning paper records onto the system. There was no method of recording the number of prescriptions issued.
The trust had consistently not met the referral to treatment time standard or England average for the past ten months. The time to triage referrals as to their priority varied between specialities and could take as long as 34 days.
There had been a deterioration in performance of the 62 day cancer performance compared to the national standard.
The hospital cancelled 35% of outpatient appointments in the last year. From October to January 34% of short notice cancellations were due to annual leave, which was not in line with trust policy.

Summary of findings

The outpatient and radiology departments followed best practise guidelines and there were regular audits taking place to maintain quality.
Staff contributed positively to patient care and worked hard to deliver improvements in their departments.
Staff felt supported by their managers and stated their managers were visible and provided clear leadership.
We saw clinical staff were not consistently bare below the elbow at the point of care.

The Royal Free Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to The Royal Free Hospital

The Royal Free Hospital is situated in the borough of Camden which has a population of around 230,000. The hospital has a total of 666 beds. The hospital has a full Accident & Emergency (ED) and Urgent Care Centre (UCC).

Our inspection team

Our inspection team was led by

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

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

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

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

How we carried out this inspection

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

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

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

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

Detailed findings

- End of life care
- Outpatients and diagnostic imaging

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

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

Facts and data about The Royal Free Hospital

The hospital provides a full range of adult, elderly and children's services across medical and surgical specialties. The hospital provides dedicated specialist wards for older people, a cardiology service (including a heart attack service) and a range of treatments to patients with kidney problems and kidney failure. The Royal Free Hospital is a national tertiary referral centre for complex aortic disease specialising in endovascular and open surgery for aneurysms and aortic dissection.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

The Royal Free Hospital NHS Foundation Trust has emergency departments (ED) on two sites; one at Royal Free Hospital and another at Barnet Hospital. Both sites provide a 24-hour, seven days a week service. 208,949 patients attended the ED department on both sites during 2014-2015. About 22% of ED attendances resulted in admission during March 2014 - April 2015.

The ED at Royal Free Hospital saw 80,513, adult patients during 2015 compared with 76,741 in 2014 and 17,673 paediatric patients in 2015 compared with 16,845 in 2014.

The ED department is currently undergoing a major upgrade and rebuilt with and investment of £25million. The built is currently behind schedule with anticipated completion in next 6 months.

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

There were different areas in ED depending on the severity of condition of patients. There was a four bed resuscitation unit, commonly known as 'Resus', for patients with immediate life threatening illnesses and injuries. The majors area, for patients with acute illnesses, had thirteen cubicles and one room which could be used to isolate patients or provide privacy. There was one psychiatric assessment room.

The area for treating low risk patients whose condition wass not life threatening, often called 'minors', had three cubicles, a triage room, a plaster room and two treatment rooms. There was a minors waiting area with six chairs next to the nursing station in the middle.

There was a nine bedded clinical decision unit, divided into two sections with four female and four male beds and one side room for isolation.

There was a separate children's ED. The waiting area was also the play area. It had three cubicles with beds and three observation beds. One bay in the resuscitation unit was also equipped for children.

All Walk-in patients registered with staff at reception. There were thirty chairs in the waiting area. A nurse streamed adult patients to the appropriate area. All children undergo triage with a children's nurse in the Paediatric ED. Patients arriving by ambulance are taken through a separate entrance. Seriously ill patients are taken to Resus and those less seriously ill were assessed by a nurse in a rapid assessment room before transfer to ED.

During our inspection, we spoke with 55 members of staff, 15 patients, and their relatives. We examined 15 sets of medical notes for patients treated in the department. We visited the department again unannounced on 17 February 2016.

Urgent and emergency services

Summary of findings

Overall we rated the Royal Free Hospital Emergency Department as Good because;

Staff were proactive in reporting incidents and we saw evidence of learning taking place as a result of incidents.

Learning was shared with all staff via safety briefings and posters were displayed in the seminar rooms. Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children.

The trust's performance on waiting times for treatment was inconsistent but often met the 4-hour target. The trust has been above the England average for percentage of patients seen within four hours since February 2015.

The department was responding to most complaints within the agreed time frame but staff we spoke with were unable to tell us about any learning or changes implemented as a result of a complaint.

Staff were caring and compassionate, although the design of some accommodation meant that patient's privacy and dignity were not always protected.

Staff felt supported in their roles and innovative ways were introduced to retain staff. There was an open culture so staff could raise concerns and staff felt the trust was investing in them. There was clear nursing and medical leadership visibility with the department, and staff felt able to highlight issues to them. The governance arrangement was clear to staff we spoke with and, from the meeting minutes we reviewed, it was clear the leadership team understood the service.

However;

During our inspection, we observed staff did not always wash their hands between seeing patients. Checks on resuscitation trollies and defibrillators were not carried out regularly although we noted the resuscitation trolley to be fully stocked during our inspection.

Patients were also not consistently receiving an assessment within 15 minutes of arrival, which was not in line with Royal College of Emergency Medicine (RCEM) guidance.

There was a chart based early warning score system to identify deteriorating patients, however this was not consistently used and staff said they were relying on nurses' observations and judgement.

The needs of people living with dementia were not always being met as there was no flagging system to identify these patients and some staff had not received training and hence showed a limited understanding of the condition.

The department conducted their own local audits against RCEM standards but did not submit data to the Royal College of Emergency Medicine in 2014-2015. Clinical leads confirmed that this was only a one off year and they were registered for 2015-2016 audits.

We noted that risks were discussed regularly, but not all the risks we identified were on the department's risk register.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safety in the Emergency Department as requires improvement because;

The early warning system to identify deteriorating patients was not consistently used, which could lead in a delay in identifying deteriorating patients. Staff said they relied on nurses' observations and judgement to escalate deteriorating patients.

We observed staff did not always wash their hands between seeing patients and although equipment had a green label indicating they had been cleaned, we saw the dates on the label were a week old.

The secure room for mental health patients had only one door, which did not meet the standards set out by the Psychiatric Liaison Accreditation Network

Checks on resuscitation trolleys and defibrillators were not carried out regularly although we noted the resuscitation trolley to be fully stocked during our inspection.

Medicines were stored appropriately, with a separate locked cupboard for controlled drugs. However, fridge temperatures were not being recorded in accordance with recommended guidelines.

Patients were also not consistently receiving an assessment within 15 minutes of arrival, which was not in line with Royal College of Emergency Medicine (RCEM) guidance.

However;

Nurses and doctors we spoke with told us there was always enough staff to meet the needs of patients and consultant presence met RCEM guidance for weekdays.

Staff were proactive in reporting incidents and we saw evidence of learning taking place as a result of incidents.

Learning was shared with all staff via safety briefings and posters were displayed in the seminar rooms. Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children.

Incidents

- The trust had an incident report writing policy and used an electronic incident reporting system.
- The ED department reported 615 incidents to national reporting and learning system (NRLS) between January 2015 and December 2015, accounting for 7% of all incidents reported by the trust. 77% of these incidents reported by ED resulted in no harm. The main categories of incidents reported were access, admission, transfer and discharge, implementation of care and on-going monitoring and clinical assessment.
- Between January 2015 and December 2015, 32% of incidents reported to the NRLS were reported more than 90 days after the incident. 62% of incidents were reported more than 60 days after the incident. However, timeliness of incident reporting was improving and all incidents were reported within 60 days between September 2015 and December 2015.
- There were no Never Events reported within ED Department. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The department reported eight serious incidents between November 2014 and October 2015. We saw root cause analysis (RCA) were completed as part of the investigation of incidents. Lessons learned from incidents were shared across teams.
- There were no recorded instances of pressure ulcers, falls or catheter related urinary tract infections in the department between September 2014 and September 2015.
- Staff said they were encouraged to report incidents and received direct feedback from their line manager, clinical leads and in teaching sessions. Staff were aware of the incident reporting procedures and how to raise concerns, junior doctors and nursing staff showed us how to report incidents on an electronic incident reporting system. Learning from all incidents was shared via the governance notice board and daily at safety briefings.
- There were posters and information on display in the staff seminar room regarding learning points from a

recent serious incident, when a patient absconded from the department. The information included steps staff should take if they were concerned a patient would abscond, the escalation process and how to access the relevant guidelines.

- Unexpected deaths as a result of an incident within the department were discussed at the monthly multidisciplinary ED specialty meeting and the clinical governance meeting minutes was shared with the group. Both the clinical director and clinical governance lead reviewed these incidents and identified any learning or changes to policy or process that maybe required within the department.

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.
- All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice. Staff told us that they receive training on duty of candour at induction. Staff working throughout ED told us that they had a good understanding of their roles and responsibilities in relation to the duty of candour. A consultant gave an example of a recent incident which related to a blood transfusion error. The duty of candour was fully implemented and the patient was made aware of the error. The learning from this incident was shared at junior doctors teaching session.

Cleanliness, infection control and hygiene

- The trust had policies and procedures for hand hygiene and infection prevention and control.
- There were no cases of MRSA, C.Diff, and E Coli reported for the ED during the period of April 2015 to October 2015.
- The trust audited hand hygiene in the ED on a weekly basis. Between April 2015 and November 2015 compliance levels were reported at between 84% and 95%.
- There were dispensers with hand sanitising gel situated around the ED walls including the main waiting area and reception.
- During our inspection, we observed staff did not consistently comply with hand hygiene practice. Not all staff regularly cleaned their hands as they moved around the ED from one area to another, or when leaving or entering the department. We observed poor infection control practice in triage area whereby staff did not wash their hands in between seeing patients and vital signs equipment was not cleaned in between patients.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this appropriately when delivering care. We noted that staff generally adhered to the "bare below the elbows" guidance in the clinical areas.
- Most of the equipment we examined such as commodes, vital sign monitors, wheelchairs, toilet rising seats were visibly clean. We observed green 'I am clean' labels were in use to indicate when equipment had been cleaned. We also observed staff cleaning equipment with sterile wipes after use and beds being cleaned. However, during our unannounced inspection we noticed that majority of the green stickers had week old dates on them.
- There was 24-hour cover for domestic staff. We observed domestic staff cleaning the department throughout the day and they undertook this in a methodical and unobtrusive way. We saw cleaning schedules displayed on the back of some toilet doors but this was not displayed in all toilets. Cleaning staff told us that the cleaning rota was kept with the supervisor. Weekly cleaning audits indicated the department scored between 87% - 90% in November 2015.
- Disposable curtains around the cubicles were clean and stain free with a clear date of first use indicated on them.
- The ED department's main entrance and surrounding pathways were clean and uncluttered. However, the ambulance entrance corridor was cluttered with trolleys and entrance to resuscitation area was cluttered with monitors. The corridor also crossed over to access between the major area and clinical decision unit and

part of the corridor was blocked with different equipment. Staff were aware of lack of storage for these equipment but did not see this as a risk and it was not on the risk register.

- Staff told us that the room used by patients who were awaiting a mental health assessment was repainted in 2015. On the first day of our inspection, we noticed that there was a broken chair in the room and the room had an unpleasant odour, staff told us that a patient had just been discharged and room was due to be cleaned. On later inspection the room was in a clean state.

Environment and equipment

- The department looked clean, despite visible marking on some walls, where equipment/fittings had been removed and the floor being worn. Staff told us that the ED department was currently undergoing a major redevelopment and there was a temporary pathway via the new build to enter the main reception area.
- There was no dedicated x-ray unit within the department, although ED patients had priority over other patients. Computerised tomography (CT) scanning was on the first floor and access to it was via the lift. Staff told us that its location caused occasional delays of up to 25 minutes and this was listed on the department risk register and all staff were aware of this.
- Documentation submitted by the trust indicated that the majority of equipment was in service, and the rest had a job reference number assigned with a service date. We randomly checked equipment in the adult and children ED and all equipment was in working order, with clinical engineering checks completed and within the service date. All medical vital signs equipment was checked by the medical electronics department, signed and dated ID labels were applied to all machines.
- We checked three trolleys and mattresses and all were clean. There were no tears in the mattresses and brakes and cot sides were in working order. Staff told us that these were serviced yearly.
- The resuscitation trolleys were correctly stocked but the logbook was not maintained and the resuscitation trolley was not kept locked. Staff told us they were aware of this issue and placed this on their risk register. They needed to keep it unlocked due to easy access in case of emergency. Staff told us that there was always a staff member present within the resuscitation room and we witnessed this during or visits.
- There was no log book to indicate regular checks were carried out on defibrillator in the resuscitation room.
- In adult ED, the environment was poor for patients living with mental ill health. The secure room for mental health patients had only one door, which did not meet the standards set out by the Psychiatric Liaison Accreditation Network. Nursing staff we spoke with raised their concerns about this room and they did not feel safe caring for the patient in that room. A survey by the estates department identified this room to be non compliant with EFA standards and it was placed on the risk register, however staff safety was not identified as one of the risks and was not on the department's risk register. Staff told us the new ED building, once completed, would have two secure rooms and these would fully comply with standards.
- The trust provided a dedicated 24/7 children's emergency service and children were triaged in ED and suitably qualified children's nurses cared for all children.

Medicines

- Medicines were stored appropriately and controlled drugs in the resuscitation area were in locked cupboard. We checked the logbook of the last three months and observed checks were carried out daily. Controlled drugs were checked by two registered nurses each night.
- There was a separate cupboard and register for storing strong potassium chloride in line with the medicine regulations.
- Staff told us a member of the pharmacy team did daily stock checks and pharmacy stock items were topped up as needed. The antidotes cupboard was also checked regularly by the pharmacy team to ensure stock level were adequate.
- Staffs were also able to contact the main pharmacy department with clinical queries relating to medicines.

- There were pre-filled syringes for emergency medicines (adrenaline, atropine etc.) stored on trolleys, which allowed nurses to access them quickly. These were stored in drawers on the trolley, out of reach of patients and visitors.
- Fridges were locked to ensure safety and security of medicines. Staff checked and recorded current fridge temperatures, but there was no evidence that the fridge was reset daily, and no records were kept of the minimum and maximum temperatures. There was no record of daily temperature checks for the last week for the fridge in resuscitation area and temperature was checked for only seven out of fifteen days for the fridge in minors reception area. During our unannounced inspection the fridge in minor's reception area, which was locked during earlier inspection, was not locked and medications could be accessed by anyone.
- The separate fridge where two units of emergency blood supply for trauma cases were kept, was not checked regularly. During the announced inspection, that fridge was not working and was reported to the engineers. There was clear notice on the fridge and staff were able to tell us the contingency process to access blood units.
- Patient records contained appropriate documentation of medicines prescription and administration.

Records

- There was a system for managing patients medical records adequately to ensure these were accessible and accurate. Reception staff generated a paper record, containing basic patient details, name and address when patients registered. When the patient was discharged this was returned to reception for filing. The reception staff would scan the paper documents including treatment records, into the patient's computer record. If the patient was admitted, the reception staff would make a "green file" and would scan the documents and add the paper documents in the file, to be sent with the patient to the relevant in-patient ward.
- We looked at ten sets of patients' records to check that timely care was given to the patients and the department was routinely carrying out risk assessments such as for pressure ulcers.
- We found that allergies were documented in all cases (100%), analgesia prescribed in four out of ten (40%) and four out of ten cases (40%) were seen by the ED doctor within one hour, Where applicable, appropriate antibiotics were prescribed and administered. In six cases, patients were referred for input from other specialities and in all six cases patients were not seen within 1 hour of referral and did not meet the department escalation policy.
- Monthly patients notes audit results carried out within in the department between November 2015 and January 2016 indicated compliance levels at 90%,83% and 69% respectively. The trust did not include details of audit measures and what actions were taken to improve results.

Safeguarding

- Staff we spoke with had a good understanding of safeguarding of adults and children**.** Access to information on how to report a concern was available and displayed on boards in the department.
- The department had a positive focus on child safeguarding. All children who attended were checked to identify if they were 'at risk' within their home environment. We observed the input of patient details on the ED electronic system, staff showed us examples of the flagging system used to identify children deemed 'at risk.'
- The paediatric ED had effective working relationships with the main paediatric in-patient department and in the community.
- Overall 92% staff were compliant with safeguarding children level one training, 93% with level two and 85% with level three. 92% staff were complaint with safeguarding adult level one and 88% with level two training. Staff in the paediatric department had up-to-date training and exhibited a good level of knowledge about safeguarding children

Mandatory training

- Staff had relevant, up-to-date training in life support and advanced life support and paediatric life support. All consultants were competent in advance trauma life support (ATLS), Advance paediatric life support (APLS) and advance life support (ALS).
- We looked at the e-Learning system reception staffs used to complete their mandatory training, which

included Level 1 and 2 safeguarding training, information governance, infection control, non-clinical waste management, quality and diversity, and major incident planning.

- Although the department staff were not meeting the trust target of 95% for mandatory training, overall staff compliance with relevant areas was good. 88% staff were compliant with conflict resolution, 88% with equality and diversity, 92% with mental capacity act and deprivation of liberty(DoLs) training, 91% with waste management and 92% with infection control level one training. However, there was an action plan by the practice development nurse to increase compliance.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority ("blue light") were transferred immediately to the resuscitation area. The ambulance service called the hospital in advance for these cases and staff were aware of their arrival so could plan accordingly.
- A nurse in the rapid assessment area assessed lower priority patients arriving by ambulance after receiving a handover from the ambulance crew. There was only one room with space for one trolley and one nurse was allocated to the assessment area.
- Ambulance turnaround time did not meet the national target of handover. The target for ambulance handover was 15 minutes, however in 98% of cases, the ambulance turnaround time for Royal Free Hospital between December 2014 and November 2015, was more than 15 minutes. We saw patients and ambulance crew waiting in the corridor at busy times for longer than 15 minutes, which led to delays in assessment.
- We observed two ambulance handovers. One ambulance crew waited 26 minutes to handover the patient. However, another handover we observed was within 15 minutes.
- Ambulance median time to initial assessment for the trust was lower than the England average until March 2015. From March 2015 onwards, the trust has performed above the England average. This data is published nationally at trust level only and the median time to initial assessment ranged from 2 minutes to 11 minutes.
- There had been 39 'black breaches' (ambulances waiting over 60 minutes to hand over a patient) during November 2014 –October 2015. Data submitted to us prior to inspection showed, that on two occasions, there were seven and six ambulance that had to wait over 60 minutes to handover the patient. Staff told us these breaches happened when ambulances arrived in batches within a short period of time. This put extra pressure on the ED, which was already very busy on those days.
- Walk in patients registered with a receptionist. There were two nurses allocated to the initial assessment area, who made initial observations and directed patients to the appropriate waiting area. Royal College of Emergency Medicine (RCEM) guidance recommends patients to be seen by a clinical practitioner for initial assessment within 15 minutes of arriving in an A&E department. On the afternoon of our inspection, the department had a 50 minute wait for patients to be triaged and there were eight patients waiting in the waiting area. We observed one patient who was triaged in 40 minutes. Staff told us this happened frequently during busy period.
- The trust told us that the department had a chart-based early warning score (EWS) system. However, staff told us that they did not use a formal EWS and relied on nurses to observe abnormal vital signs and escalate it. Staff told us that department was planning to use the patient at risk score (PAR) but it was not clear when this would be in place. Patients whose condition might deteriorate in majors and minors were therefore at risk of not being identified early enough.
- Nurses were inconsistent in their practice in recording risk. For example, skin and falls assessments were not carried out in all relevant cases.
- After booking at main reception, children were immediately directed to a separate children's waiting area. Child triage included a pain score. If a doctor had a concern about child safeguarding they would contact social care while the child was in the department. We observed one initial assessment of a paediatric patient by a nurse, which was detailed and covered all relevant areas.
- Staff told us one of the two nurses also covered the ambulance rapid assessment area in which case there

would be only one nurse at times to triage patients. Staff told us during busy times other medical staff would be re-deployed to assist but we did not see this happening during the inspection, even when the waiting room was busy.

- Nurses working in the initial assessment room confirmed that they were certified as competent to triage patients and that agreed clinical protocols for triage, aligned to the universal triage tool were used.

Nursing staffing

- All nurses we interviewed told us there was always enough medical and nursing staff on duty.
- The trust assessed staffing levels and skill mix based on the Royal College of Nursing (RCN), Emergency Care Association (ECA), and the Faculty of Emergency Nursing (FEN) recommendations. RCN guidance recommended two registered nurses to one patient in cases of major trauma or cardiac arrest and one registered nurse to four cubicles in either major or minor trauma.
- At Royal Free Hospital, the trust established nurse to patient ratio at 1:2 for resuscitation room and did not meet the RCN recommendations. For major and minor area, the nurse to patient ratio was 1:4 and met the RCN recommendations.
- During our inspection, the department was staffed by two whole time equivalent (WTE) band 8a matrons, 14.14 (WTE) band seven, 29 (WTE) band six, 24.2 (WTE) band five, 115 (WTE) emergency department assistants (healthcare assistants) and one band 7 practice development nurse. Matron told us that a business case had been submitted for the extra band five nurses.
- Nurse vacancy rate was low at 5% and the matron told us there were staff retention plans in place. This included in-house foundation and adult emergency care courses, accredited by Middlesex University and the University of Greenwich, which were transferable and would enhance recruitment and retention.

Medical staffing

- The adult emergency department had eight whole time equivalent (WTE) consultants and one locum consultant at the time of our inspection, which was fewer than the 10 recommended by the Royal College of Emergency Medicine.
- Consultants were present on site from 8am until 10pm weekdays and until 7pm on weekends. However, consultants reported that they often stayed until midnight when the department was busy. The RCEM standard states that consultants should provide 16 hours emergency cover seven days a week, however the department did not meet this criteria for weekend.
- When locum doctors worked in the department for the first time, they received a full induction and orientation to ensure they were informed of local practice and policies.
- There were two middle grade doctors overnight supported by an on call consultant and a rolling rota of junior doctors.
- Doctors and nurses we spoke with told us junior medical cover was satisfactory and the junior medical staff we interviewed were confident there were sufficient numbers of staff available.
- Doctors we interviewed told us medical cover was good with enough middle grades available at all times. Trainees told us the consultants were fully involved in care delivery.
- Nursing staff we spoke with told us they got the support they needed from consultants and had no difficulty accessing them overnight and at weekends.
- When we visited the service on 3 and 5 February 2016 and unannounced on the evening of 18 February 2016, we observed there were sufficient medical staff to meet the demand.
- ED consultants did not have Paediatric Emergency Medicine (PEM) training. Two paediatric consultants were PEM trained and supported the paediatric ED.
- The department had low levels of sickness absence for medical staff (0.3%) and medical vacancy rate was 7%.
- All consultants had obtained advance life support (ALS), advanced paediatric life support (APLS) and advanced trauma life support (ATLS) accreditation. All foundation year 2 and middle grade doctors were ALS accredited. Thirteen out of sixteen middle grade doctors were ATLS accredited

Major incident awareness and training

Urgent and emergency services

- Staff we spoke with told us the hospital staff practice for major incidents regularly, and the hospital could be secured in the event of a major incident.
- All staff received 'in-house' training at induction and for major incidents and decontamination incidents.
- All staff we spoke with were able to describe the process to follow in case of a major incident.
- 91% of nurses and 94% of other staff had completed the emergency planning training.
- Equipment for major incidents was stored in a designated locked room and accessed via swipe cards.
- Security staff were called in to provide additional support for nursing staff when patients required one-to-one observation because of risk of violence or aggression. We spoke with three security staff members and they told us they were not all employed by trust and there was a dependence on agency staff. During the night, there were four security staff members on duty for the whole hospital. Security staff received basic training in restraining but had no training in dealing with patients living with dementia or mental ill health patients. They told us they would follow the instructions of doctors in those cases.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effectiveness for the Emergency Department as good because;

- The trust utilised a range of policies and guidelines which were based on national guidance. Staff were aware of these guidelines and had received appropriate induction and training to carry out their roles.
- There was very good evidence of multi-disciplinary working within the department and all members of the MDT worked well together to try and overcome challenges they faced during busy periods.
- Pain scores were recorded for most patients and we observed staff offering pain relief to patients within the triage and treatment areas.

However;

- The department did not participate in all relevant national audits in 2014-2015. We saw the department had performed above the England average in some audits in 2013-2014 but worse in others. The team had put in place plans to address the areas where they had been worse than the England average.

Evidence-based care and treatment

- The department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided and local policies were written in line with these.
- Staff showed us how they would access the local guidelines on the trust intranet. Junior doctor told us that clinical guideline were easily accessible and were regularly updated.
- Staff used a variety of information technology within the department to enhance speed and access to patient care and treatment. This included internal electronic systems and systems used for digital imaging.
- The Manchester triage tool was in use. This tool determines the priority of patients treatments based on the severity of their condition and is widely used in the UK
- Staff confirmed their awareness of the Mental Capacity Act 2005 and the protocol to access the external mental health crisis team.
- There were specific pathways for certain conditions such as sepsis, acute cardiac syndrome and renal colic. Staff displayed good knowledge of treatment options when treating patients who had sepsis. We saw the "sepsis six protocol" was used by clinicians in patient's notes.

Pain relief

- The trust scored similar to other trusts in the A&E survey 2014 related to pain relief offered to patients.
- We observed patients in triage. They were asked to indicate their pain level on a scale of 1 to 10 with 10 described as extreme pain and were then offered pain relief accordingly. Patients within the treatment area were also being offered pain relief.

- We checked ten sets of patient's notes, which showed staff had recorded pain scores in six out of ten cases and were followed up appropriately.
- We spoke to one patient in minors with a leg infection who was offered pain relief within 15 minutes of arrival. We observed one patient in paediatric ED, receiving a pain assessment and pain score.
- As a result of "pain in children audit" in 2015, the department designed patient/parents leaflets with information regarding analgesia and pain scoring to empower parents to improve pain soring and administration of analgesics to children within 30 minutes. We saw pain leaflets were available in the children's A&E, which were in child friendly design, asking the child to point to the face that best describes how they feel and scoring from zero (not hurt) to ten (hurts worst).

Nutrition and hydration

- The trust scored similar to other trusts in the A&E survey 2014 related to availability of food and drinks.
- During daytime there were two hostesses responsible for ensuring that patients were offered hot or cold drinks and sandwiches. Patient in the clinical decision unit (George Quince ward) were offered hot meals at dinnertime. We were showed the kitchen which was well equipped with microwaves. During evening and weekends, there were no ward hostess and food and drink was offered by domestic and nursing staff.
- We observed patients and their relatives being offered hot and cold drinks on an ad-hoc basis.
- All patients we spoke with told us they were offered food or drink while they had been there

Patient outcomes

- The department scored above average for eight out of twelve indicators in the RCEM "severe sepsis and septic shock 2013- 2014" audit, including vital signs measured and recorded in the ED notes (94%), initiation of high flow oxygen (94%) and administration of antibiotics (96%).
- In the RCEM Asthma in Children 2013-2014 audit, the department scored lower than the England average for six out of ten indicators. These were related to initial observations within 15 minutes for example observation of respiratory rate, oxygen saturation (40%), temperature (38%), peak flow (4%), pulse (40%) and systolic blood pressure (2%). The department was expected to meet the standard of 100%.
- In the "paracetamol overdose" audit 2013 – 2014, the department performed lower than the England average for two of the four indicators, including patient receiving plasma level test (19%) and patient receiving the recommended treatment in line with MHRA guidelines (7%). Since then, the department put in place interventions including reinforcement of information on staff notice board, easy access to RCEM guidelines on trust ED website and prominent display of RCEM guidelines in designated mental health folder by the nurses station. We observed the availability of this guideline on the trust intranet and in the mental health folder. The department was due to complete another audit in March 2016 to asses if implemented actions had made a difference to patient care.
- The department did not register with RCEM for the national audits in 2014-2015. However, they carried out their own local audits against the RCEM standards, including mental health in ED, delirium and cognitive impairment assessments and fitting child audits. The clinical lead told us that at that time the department was already in the middle of an audit cycle for those three topics and did not wanted to initiate the audit cycle again. However, they confirmed that they had registered to participate in 2015- 2016 national audits.
- We saw good sharing of results and actions from these audits displayed on governance board in the staff room. For example, we saw the adult mental health triage form that was developed because of mental health, risk assessment and absconding audit.
- All junior doctors we spoke with had an allocated audit to participate in.
- As a result of fracture neck of femur audit in 2012 - 2013, the department had improved the management of care of fractured neck of femur (NOF) patients They created a clinical ED NOF team consisting of a ED consultant, matron, registrar and nurse. The team provided monthly analysis of performance; ensured daily communication with the ED team; ensured good working practice;

followed up delays in management of patients. They were also responsible for the development of more efficient and effective ways in working to streamline the management of fractured neck of femur patients.

- The trust told us treatment of fractured neck of femur patients improved since the national audit data in 2012. An audit done in 2014, showed that pre-hospital analgesia was given to 80% of patients compared to 64% previously. To improve pain relief in these patients, a training program was delivered to ensure all senior ED doctors were proficient in the skill. Audit results in August 2014 showed that 100% of NOF patients received appropriate treatment.
- The unit contributed to the Trauma, Audit and Research Network (TARN) audits. The department performed within the expected range between January 2012 to September 2015.
- The un-planned re-attendance rate (number of patient re-attending within 7 days of a previous attendance at A&E) for the trust was 8%, which was higher than the England average of 7.6.3% and always above the 5% standard. The trust was aware of this and informed us there were a number of frequent re-attenders. One patient attended the Royal Free department 365 days in 2015 which resulted in high percentage for this indicator. The department had agreed on interventions to respond to patient's needs, for example there was specific care plan to address their anxiety issues, which included finding a day activity of their choice. Staff worked with a GP and commissioners jointly to resolve it.

Competent staff

- We observed clinical practice by both doctors and nurses was within published guidelines. Staff were competent and demonstrated a good level of knowledge and understanding of evidence based practice. They were aware of NICE and RCEM guidelines.
- Junior doctors told us they felt well-supported and had access to training. There was protected time allocated for teaching.
- Appraisals of staff performance should be undertaken annually. Junior and middle grade doctors we spoke with had up to date appraisals. Junior and middle grade doctors we spoke with had up to date appraisals. 49% of ED staff were appraised up to November 2015 for the full year 2015 - 2016.
- Emergency nurse practitioners (ENPs) worked independently. They told us there was joint working with practice development nurse (PDN) at Barnet Hospital and that they shared study days and courses. They set up an accredited A&E course for nurses in partnership with the local university.
- A band 7 practice development nurse (PDN) was responsible for professional development of the staff. Matron told us that PDN would remind staff quarterly for any outstanding training and would ensure that staff booked their training dates.
- Nurses who streamed patients were trained in the Manchester Triage System (a widely used clinical risk management tool to manage patient flow).
- Staff told us there was good support when they needed to attend external courses as part of their skill development.
- All the junior doctors we spoke with confirmed that they had an allocated educational supervisor. They described how different cases were discussed at the weekly training sessions to allow for learning

Multidisciplinary working

- We observed two handovers from the ambulance service to the ED staff. These were well structured and ensured that all the relevant clinical information about the patients was conveyed appropriately.
- We spoke to four members of the London Ambulance Service during the inspection. They all told us there was very limited space for patient handover and long waits were common, but staff working at the department were very professional.
- ED staff worked well with "TREAT team" (Triage and rapid elderly assessment team)to ensure prompt and effective assessment and discharge of elderly patients. These good working relationships meant staff were able to follow up and to provide support within the community with a view to avoid future re-attendance.
- We observed two nursing handovers of care during our visit. The handover focused on allocation of staff and

bed capacity. There was good leadership and staff were clear of their role. However, there was no safety briefing or update on any incidents or sharing of learning information.

- We observed good MDT working and positive interactions across all staff levels and close working with local GP in streaming areas.
- Staff were aware of the acute alcohol withdrawal guidelines, we saw the "alcohol withdrawal" folder in nursing station with relevant referral forms and guidance for staff. There was one alcohol liaison lead nurse for the whole hospital. We were told that the ED department used to have a dedicated alcohol liaison nurse but this post was removed due to funding constraints. The ED Matron was the responsible lead on this for ED. Staff told us they admitted intoxicated patients to bays visible from nursing station. Staff told us that alcohol liaison nurse gave advice on external support agencies for both alcohol and drugs.
- There was access to psychiatric input from the psychiatric liaison service 24 hours a day.

Seven-day services

- The A&E services for adults and children were open 24 hours a day, seven days a week.
- The on-call consultant was accessible out of hours.
- There was appropriate imaging and pharmacy support available 24 hours a day, seven days a week.
- The hospital provided 24 hour a day, seven day a week access to emergency diagnostic tests.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours, 7 days a week.
- MRI was available on weekdays 9:00 am - 6:00 pm and mornings only over weekend. Ultrasound access was on on-call basis out of hour and at weekends.

Access to information

- The department IT clinical management system allowed staff to have access to detailed and timely information to enable them to care and treat patients in a safe and effective manner. However, there was no process for early identification of patients with dementia on the system and this could affect the care for some of these patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us consent was mainly obtained verbally for procedures such as receiving medicines and minor procedures. We did not see examples of patients who did not have capacity to consent to their procedure. However, most patients were seen to be accompanied by a friend or relative who could help staff with these questions and staff showed that they understood the requirements of the Mental Capacity Act 2005

Are urgent and emergency services caring?

Good

We rated caring in the Emergency Department and Good because;

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

Compassionate care

- We observed compassionate care delivered by nurses and doctors, particularly to children. Staff engaged in an open and positive way with patients and their relatives.
- Patient feedback was collected through the NHS Friends and Family Test. In September 2015, 84% patients surveyed would recommend the ED department to friends and family. This was lower than the England average (88%).
- The trust scored similar to other trusts for all questions in the 2014 A&E survey relating to caring. The survey

covered a broad spectrum of questions including staff communication with patients, information given to patients about their condition while they were in A&E and patient involvement in decisions about their care.

- General observations confirmed staff respected the privacy and dignity of patients. However, during busy periods, open curtains in cubicles sometimes compromised people's privacy and dignity. We observed that when staff became aware of this, they addressed this by closing the curtains or providing additional blankets and privacy screens.
- We observed that patients who arrived by ambulance were waiting in the corridor on trolleys as there was only one cubicle to triage these patients. On two separate occasions we saw patients with intravenous drips were sitting with other patients in minors waiting area whilst waiting for an available cubicle.
- Staff informed us that during busy periods, patients waited in the corridor. However, these patients were moved to a cubicle if examination was required. During our inspection, we observed care provided to a patient on a trolley in the corridor, next to nursing station. Staff put up privacy screens but these did not allow for full privacy. We also observed that during that busy period a relative of one patient waiting in the corridor was sitting on the floor as there were no chairs to sit on.
- On two occasions, staff advised patients of the outcome of their clinical investigation in clear hearing of other patient sitting in the minors waiting area.

Understanding and involvement of patients and those close to them

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

Emotional support

- The A&E staff had a protocol on how to deal with relatives who experienced bereavement. They demonstrated compassion when talking about this area. There was a 'bereavement box' with lots of useful information for staff and leaflets to give to relatives to inform them of steps they should be taking and where to obtain emotional support.
- Staff in the paediatric A&E department told us if parents wished, they would do foot and hand print of the deceased child for them. They also said they provided support to children if parents have passed away in the ED department and took appropriate steps to ensure local authority and appropriate agencies were informed to provide support. Patients and families were informed of how to obtain counselling service if they wanted to.
- Staff told us after each untoward incident they organised a short debriefing session to discuss learning, and the impact on individual members of staff.
- The trust scored similar to other trusts in the A&E survey 2014 related to availability of food and drinks.
- During daytime there were two hostesses responsible for ensuring that patients were offered hot or cold drinks and sandwiches. Patients in the clinical decision unit (George Quince ward) were offered hot meals at dinnertime. We saw the kitchen which was well equipped with microwaves. During evening and weekends, there was no ward hostess and food and drink was offered by domestic and nursing staff.
- We observed patients and their relatives being offered hot and cold drinks on an ad-hoc basis.
- Staff were able to accommodate cultural preferences. We noted the food menu had vegetarian and halal food options among others.
- All patients we spoke with told us they were offered food or drink while they had been there.

Urgent and emergency services

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

Good

We rated responsiveness in the Emergency Department as Good because;

- The trust has been above the England average for percentage of patients seen within four hours since February 2015.
- There was an electronic flagging system in place for people with learning disabilities and the trust employed an acute liaison nurse based at the hospital who was available to support staff caring for patients with learning disability.
- The department was responding to most complaints within the agreed period although staff we spoke with were unable to tell us about any learning or changes implemented because of a complaint.
- The trust had identified the current ED did not have the capacity to meet the demand of the local population and therefore a new building for a larger, better equipped department was currently underway.

However;

- There was only one secure room used for patient living with mental health issues when there was often more than one patient needing the room.
- The needs of people living with dementia were not being met as there was no electronic flagging system to identify these patients and some staff had not received training and hence showed a limited understanding of the condition.
- Patients arriving by ambulance were triaged in a small room and we observed elderly patients on trolleys waiting in corridors for ambulance handovers.

Service planning and delivery to meet the needs of local people

- The £25 million redevelopment of the emergency department (ED) at the Royal Free Hospital began in December 2014.The redevelopment will include a new 23-hour assessment unit as well as a rapid assessment and treatment area, a larger resuscitation area and a diagnostic hub, for x-ray and CT scanning services. The plans also include the redevelopment of the urgent care centre and the provision of a dedicated children's emergency department. The staff understood the challenges of parallel redevelopment whilst delivering services of a fully functioning ED throughout the construction period. The first phase of the construction work began on 1 December 2014 and the project was due for completion in 2017. The project was currently 6 months behind schedule.
- The current ED was built to care for up to 60,000 patients a year and currently treats more than 90,000 patients every year. Staff told us that the new facility would ensure the emergency department was fit for purpose.
- A consultant led ambulatory care unit was open between 9am and 5pm. This initiative was a pilot to attempt to reduce pressure on ED and to re-direct patients with certain pathways for example deep venous thrombosis (DVT) and cellulitis. However, staff told us this facility had not been used to its full potential but felt things would improve once the new build was complete.

Meeting people's individual needs

- The environment of children's ED was not child-friendly, the room was dark as there was not a lack of natural light, there were few drawings made by children put up on the wall. There was a play area and a seating area. There were clean toys and books for smaller children but nothing was provided for older children. There was no TV and the floor looked dirty and had food crumbs on it.
- One parent told us there were colouring sheets for children to use but not enough crayons to colour in and their child got bored quickly. There was one toilet with nappy changing facilities. There was no access to drink and food and parents had to use the machines for drinks and food in the adults waiting area.
- There was access to a psychiatric liaison team for patients within the hospital and the team could be contacted for any patients with specific mental health needs, including delirium. However, there was no registered mental health nurse employed by the trust and security staff supervised the patient until the arrival of an agency mental health nurse, if one was required.

Urgent and emergency services

- There was only one secure room and during our unannounced visit, there were four metal health patients who required to use it. This meant that three patients were kept in generic cubicles, which posed an increased risk for the patient, other patients and staff.
- Prolonged waiting times for a suitable bed in a mental health hospital meant patients frequently stayed over 12 hours in ED. For example a patient who was awaiting bed placement at the time of an inspection had spent over 12 hours at the department before they were able to transfer. Staff told us that secure transport for mental ill health patients was another issue which caused delays in patient transfer and was placed on their risk register. The trust had worked with the provider of local mental health services to try and reduce waiting times.
- We found the needs of people living with dementia were not being met. Staff told us not everyone had received training in caring for people living with dementia. Junior staff showed a limited understanding of the condition. The department used an electronic system for patient records, but there was no process to flag patients living with dementia. Senior staff told us that there is a dementia box with useful information; however, none of the junior staff was aware of the dementia box. There were no dementia friendly cubicles and there were no dementia friendly clocks within the department.
- Junior staff told us they would have to ask for support from the senior staff when caring for patients living with dementia and those patients who might require additional support.
- The trust dementia lead nurse had been involved in the design of the new building and we were told of changes made to the flooring after the dementia lead identified that the original design was not dementia friendly.
- We looked at the relative's room where people waited while their seriously ill relative was being cared for, or where people were informed that a relative has passed away. We found the room to be clean, although some of the furniture was chipped and there was no drink making facility available. Staff told us they usually brought drinks for relatives when required. There was also no separate viewing room where people could see their deceased relative within the ED.
- There was an electronic flagging system in place for people with learning disabilities (PWLD) and the trust employed an acute liaison nurse based at the hospital who was available to support staff caring for patients with learning disability.
- There is a large Jewish community within the area and there was a Jewish community funded ambulance used for the discharge patients from the Jewish community. The ED department work closely with this service. There was a Shabbat cupboard with kosher food packs available in the relative's room to cater for Jewish patients.
- The department used telephone and face-to-face interpreting services. However, staff told us they hardly ever used the face-to-face interpreter service, as there usually was someone with the patient to interpret.

Access and flow

- Nationally agreed emergency department quality indicators state that 95% of patients should be seen, treated, discharged or admitted within four hours. An overview of the compliance report of the four-hour performance against this target between January 2015 to December 2015, indicated the Royal free hospital achieved 94%, which was below the national target, but above England average.
- The trust scored the same as other trusts, for all questions in the 2014 A&E survey relating to responsiveness. For example, questions included related to privacy when discussing their condition or when being examined or treated and waiting time in ED.
- There was a higher proportion of emergency admissions via A&E (Royal free and Barnet hospital combined) waiting between 4 and 12 hours following the decision to admit, particularly in January 2015. Between September 2014 and August 2015 there were 5,437 people waiting 4 to 12 hours but zero people waiting over twelve hours from decision to admit to admission.
- The trust performed above the England average for total time spent in A&E between January 2013 and September 2015. The figures started to decline from March 2015.
- Around 2.8% of A&E attendees left without being seen, which is above the England average of 2.7%.

Urgent and emergency services

- We saw that the flow of patients through minors and streaming was handled in a timely and methodical way. However, during busy periods, the initial assessment and triage took as long as 50 minutes. Staff indicated it was often "the norm". Additional staff were re-deployed to assist, but they also covered the ambulance triage, which could cause delays.
- There were 23 breaches of the four-hour target on one of the days of our inspection. We observed the bed management meeting in the morning and staff told us delays were mainly due to no appropriate beds being available for the type of care required as an in-patient. There were four daily bed management meetings within the hospital and four sitrep/escalation reviews within the department to monitor bed status.
- Patients arriving via ambulance requiring urgent care were directed to the resuscitation area. There was only one small room, with space for one trolley, used to triage other patients. We observed on two separate occasions where elderly patients were waiting to be triaged on trolleys in the corridor outside the room.
- We spoke to four ambulance crew members and they all spoke highly of the staff. However, they reported space was a major issue and caused delays in handing over on several occasion.

Learning from complaints and concerns

- Trust-wide A&E received 179 complaints between December 2014 and November 2015, which was 13% of all complaints received by the trust. The three most common causes for complaint were clinical treatment, communication and attitude of staff.
- Patient information on 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 in the department.
- Depending on the nature of the complaint, the clinical director, matron or operational manager dealt with formal complaints. Staff told us how they accessed information on complaints, but only senior staff were able to tell us what learning if any was implemented because of a complaint. We were told as a result of patient feedback, a room was allocated within the minors area to use for taking blood where the patient was not in a cubicle.

Are urgent and emergency services well-led?

Good

We rated leadership for the Emergency Department as Good because;

- Staff felt supported in their roles and innovative ways were introduced to retain staff. Operational managers and clinical staff worked together as a team to manage the capacity in the hospital and address the challenges faced by the ED on a daily basis.
- There was an open culture so staff could raise concerns and staff felt the trust was investing in them. Staff sickness was very low and there was a stable workforce within the department.
- There was clear nursing and medical leadership visibility with the department, and staff felt able to highlight issues to them. There was a clear shared strategic vision for future service development.
- The governance arrangement were clear to staff we spoke with and from the meeting minutes we reviewed, it was clear the leadership team understood the service.

However;

- The department conducted their own local audits against RCEM standards but did not submitted data to Royal College of Emergency Medicine in 2014-2015.Clinical leads confirmed that this was only a one off and they were registered for 2015-2016 audits.
- By November 2015, only 49% staff had their appraisals for the year 2015 - 2016.
- We noted that risks were discussed regularly, but not all the risks we identified were formally on the department's risk register.
- Public engagement was only via the Friends and Family test.

Vision and strategy for this service

- The trust had a five-year strategy (2015-2018) in place for the emergency department rebuild. The department long term vision was to develop a state of the art, fully

integrated emergency department, ambulatory care service and clinical decision unit. The strategy included development of new pathways, developing ED nursing course and diagnostic optimisation.

- All staff we spoke with wanted to be part of the department rebuild and were excited with the prospect of delivering care in a state of the art environment, which will meet the increased demand on ED service.
- Staff were aware of trust's values and vision. Staff could name them and knew what they meant. Staff we spoke with in all roles and at all levels told us the vision for the service was to improve the safety and quality of patients experience and that they were aware they had an important part to play in that on a day to day basis.

Governance, risk management and quality measurement

- Staff were able to articulate the department governance arrangements and which individuals had key lead roles and responsibilities within ED. They were also clear of their own individual roles and responsibilities and commented on the considerable amount of governance information available in the staff seminar room.
- The ED had monthly governance meetings and monthly unit meetings. We noted from the minutes of these meetings that complaints, incidents and emerging risks were discussed, evaluated, and monitored. However, wider learning from complaints was not cascaded to all staff.
- The ED undertook monthly audits of its compliance with safe good practice and these ward assurance results were displayed where staff could easily see them. However, there was limited information displayed on the boards for patients or visitors.
- We looked at the risk registers for the department. Each risk had a red, amber or green (RAG) rating, there were details actions taken to mitigate risks and progress was recorded, demonstrating active management of identified risks. However, there was some misalignment between the recorded risks on the risk register and what staff expressed was on their 'worry list'. For example, the lack of a NEWS scoring system to identify deteriorating patients.

Leadership of service

- A clinical director, an operational manager and two matrons led the ED department at Royal Free Hospital. This was a separate leadership team from Barnet hospital and feed into the trust divisional structure. The nurses and doctors we spoke with were all clear as to their lines of supervision.
- The senior leaders, clinical director, clinical leads and matrons had a clear vision as to how the new ED would operate and were piloting new ways of working to try to move the department away from the current traditional patient flow.
- Managers were aware of the areas where the hospital had challenges, the need for more isolation rooms and managing the growing demand for beds. They were working with relevant contractors/partners to deliver the new extended emergency department within the time frame.
- We observed good leadership skills during handovers. There was clear communication with junior staff regarding their role and responsibilities for the shift. We saw consultants give explanations and support to junior staff in decision making for patient treatment. Nurses considered their managers supportive.
- The department did not register with RCEM for the national audits in 2014-2015. However, they carried out their own local audits against the RCEM standards, including mental health in ED, delirium and cognitive impairment assessments and fitting child audits. We saw good examples of change to practice as a result of those audits. The clinical lead told us that at that time the department was already in the middle of an audit cycle for those three topics and did not wanted to initiate the audit cycle again. They confirmed that they had registered to participate in 2015- 2016 national audits.
- The staff appraisal rate for the year 2015 - 2016 was very low. Only 49% of staff were appraised up until November 2015. It was unclear whether there were any plans to meet the trust's target of 95% by April 2016.

Culture within the service

- There was a strong team spirit from top to bottom and each member of staff felt their contribution was valued,

which meant morale in the department was high. We observed good team working among nurses and shift leaders were very committed to patients and to supporting their staff.

- Junior doctors felt very well supported in their training and supervision. We saw that the medical team worked well together, with consultants available for junior doctors to discuss patients and receive advice. There was very visible clinical leadership.
- All staff we spoke with were passionate about providing empathetic care. Staff told us they enjoyed working in the department and all said everyone got on well with each other.

Public and staff engagement

- Feedback from patients was obtained from the NHS Friends and Family test and 85% of people surveyed would recommend the emergency department at Royal Free Hospital.
- We reviewed the urgent care divisional board report, which showed that FFT results were discussed and monitored at this bi-monthly meeting. However, we did not see other ways of gathering feedback from users.
- Staff were aware of the current stage of the emergency department new build and felt part of the project. There was involvement of ED staff and the trust dementia lead in the development of new build.

Innovation, improvement and sustainability

- In order to ensure that the current and future nursing workforce is fit for purpose the Emergency Department and Urgent Care centre across the Royal Free, Barnet and Chase Farm site have had to look at different ways of working in order to " grow our own" senior workforce. In order to support this strategy the ED and UCC departments have developed a 'foundations in emergency nursing course', accredited at the university of Middlesex. All of the courses are transferable worldwide and have the added benefit of being able to income generate from external candidates.
- The Royal Free set up a pilot ambulatory emergency care unit in June 2015. The unit is consultant led and is using the learning from membership of the ambulatory emergency care network to develop and expand ambulatory pathways and processes to reduce unnecessary admissions to ED for appropriate conditions.

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

Medical care provided by the trust fits under two divisions; the urgent care division and transplant and specialist services (TASS) division. Urgent care included cardiology, elderly and frailty medicine and acute, respiratory, neurology and stroke medicine. The TASS division included nephrology, medical oncology, haematology, infectious diseases and one hepatology ward. There were 11 wards and an endoscopy suite encompassed by the medical service, with 308 allocated inpatient beds. A four-bedded high level isolation unit (HLIU) was available for the treatment of patients with highly transmittable and serious illnesses, such as Ebola. There were approximately 18,000 patients admitted to the Royal Free Hospital under the care of the medical service each year.

We visited the medical service at Royal Free Hospital for two announced inspection days and one unannounced inspection day. During our inspection we inspected all wards and the endoscopy suite, spoke with 68 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the medical leadership team, 21 patients and 13 relatives. We checked 38 patient records and many pieces of equipment.

Summary of findings

We rated medical service at the Royal Free Hospital as Good overall because;

- Patients achieved good outcomes due to receiving evidence-based care from suitable numbers of competent staff who enjoyed their work and were well supported by a visible management team.
- Results from the Friends and Family Test and patient feedback suggested most patients would recommend the service to their loved ones and were happy with the care they received.
- Suitable governance arrangement and appropriate incident reporting meant staff learnt from mistakes and near misses to improve care.
- We saw evidence of relevant service development and innovation, particularly in the HLIU where equipment design was reviewed after each patient admission. Patients across the country could access the HLIU with a direct consultant referral.
- Most patients were admitted to an appropriate ward for the course of their admission and most patients (72%) had no ward moves.

However;

- There were high numbers of out of hours ward moves and discharges, patient pathways through the medical services were being reviewed to address flow and discharge problems such as these.

Medical care (including older people's care)

- There were concerns with infection prevention and control practices, such as variable hand hygiene, staff wearing nail varnish and jewellery and doors left open to patients in isolation.
- The safety thermometer data and many patient risk assessments or records, including fluid balance charts, were incomplete.

Are medical care services safe?

Requires improvement

We rated safety for medical care as requires improvement because;

- There was an increased risk of patient harm. We observed many patients receiving oxygen therapy, in some cases at very high levels, without a prescription which could have adverse consequences.
- Safety thermometer data was incomplete, however indicated a high number of new venous thromboembolisms (VTEs) and catheter related urinary tract infections.
- There had been several cases of Clostridium Difficile (C. Diff) and root cause analysis showed two cases may have been transmitted. We observed staff hand hygiene was variable and audits demonstrated the hospital target for this was frequently not met.
- Not all staff were bare below the elbows and we saw some incorrect disposal of personal protective equipment. Isolation rooms were used to accommodate barrier-nursed patients however we observed the side room doors were frequently left open which was against hospital infection prevention and control advice.
- Staff in the discharge lounge told us they did not have access to patients' 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms and so there was a risk CPR was commenced inappropriately if patients collapsed. The trust commented that patients being transferred home or to another care facility with DNAR orders would normally be discharged from the ward and not the discharge lounge. The transport driver would receive a copy of the DNAR form from the ward.
- There were several risk assessments in place across the wards, for example bed rails assessments, however patient records were not always fully or accurately completed. Patient observations were usually completed sufficiently to allow correct use of the medical escalation process.
- Uptake of mandatory training, including key topics such as infection prevention and control and safeguarding, was lower than the hospital target.

However;

Medical care (including older people's care)

- Wards were suitably staffed but acute and elderly medicine had high levels of nursing vacancies and used many agency staff.
- Despite low safeguarding training uptake, staff demonstrated good understanding of safeguarding principles and we saw evidence of safeguarding referrals.
- Staff understood how to report incidents and received feedback about learning points identified.
- Duty of candour requirements were understood by staff and adhered to when incidents occurred but staff failed to recognise the need to implement this for near miss situations.
- Infection prevention and control procedures and equipment as well as the environment on HLIU demonstrated outstanding practice in this area.

Incidents

- There were 893 incidents reported under the medicine directorate between October 2014 and September 2015 and all information under this section relates to incidents reported within this period. All medical wards were seen to have contributed to incident reporting.
- There were 54 serious incidents and no never events reported between November 2014 and November 2015. 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.
- Staff reported incidents via an online reporting system and were able to locate the reporting form on the intranet. Several staff had worked at the hospital for many months and told us they had never needed to complete an incident form.
- Staff told us team debriefs took place to discuss the outcome of incident reports and staff were aware of learning points from some incidents within the medical division, such as when a patient became hypoglycaemic on 10 West (cardiology). Staff on the ward instigated a quality improvement project and learning was disseminated to other staff through posters, teaching and meetings.
- We saw evidence of dissemination of learning from an incident during a board round on 8 East, where doctors were reminded that gentamycin prescriptions needed to be calculated according to patient ideal body weight rather than their actual body weight.
- Common themes of incidents logged included falls or potential falls, medicine prescribing or administration errors and pressure ulcers;
  - There were 224 falls or potential falls logged as incidents, most of which were reported by 10 West (72), 8 East (38) or 6 South (35).
  - Incidents regarding medicines totalled 98. Of these, 39 were reported on 10 North, 19 (including six for controlled drugs) were reported on 8 East and 13 were reported on 8 North.
  - There were 53 incidents reported involving pressure ulcers grade 2-4. Almost all pressure ulcer incidents were reported on wards 8 North, 8 East and 10 West. This does not corroborate information from the NHS Safety Thermometer which suggested 9 North and 8 West were the worst performing wards with regards to pressure ulcers.
- Trust-wide medical data showed significant delays in reporting incidents to the National Reporting and Learning System (NRLS); 67% of incidents were reported after more than 60 days and 35% were reported more than 90 days after the incident occurred. NRLS is responsible for analysing common risks and identifying opportunities for improving patient safety.

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.
- Senior staff were aware of most duty of candour principles and explained how this was implemented in practice through face to face explanations and apologies to patients or their families if possible, backed up by written information at a later date. We saw evidence of documented discussions in patient notes and written information supplied to patients and their families when incidents had occurred.

- Some ward staff were unfamiliar with the term duty of candour but most were able to describe the need to be honest and open with patients and their families about mistakes.

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. Safety thermometer data detailed below covered the period January to December 2015. Some data from this period was incomplete including seven months not recorded for 6 South, five months not recorded for 8 North and four months not recorded for 9 North and 8 West.
- 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 29 new pressure ulcers across the medical wards recorded by the safety thermometer. The worst performing wards were 9 North and 8 West (hepatology and geriatric medicine wards) with five and seven new pressure ulcers respectively. We saw evidence that the SKIN care bundle or 'Waterlow Pressure Ulcer Prevention Score' were used across the medical wards to assess patient pressure areas and respond to patients with increased risk of pressure areas. For example we saw evidence that pressure relieving mattresses and seat cushions were used.
- A total of 25 catheter related UTIs were recorded via the safety thermometer. The majority (13) of these occurred on 10 West (cardiology). A urinary catheter daily assessment sheet was used to encourage staff to review whether the catheter was still required. We saw these forms were in place and completed for most patients with urinary catheters however they were not consistently completed on a daily basis.
- 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.
- There were 30 falls with harm recorded by the safety thermometer, including 12 that occurred in December 2015. The worst performing wards were 8 East (respiratory medicine), 10 South (nephrology) and 10 West (cardiology) which all recorded five falls with harm each. The trust was part of the first national audit of inpatient falls and trust-wide results published in October 2015 suggested there were less falls per 1000 occupied bed days than at other organisations (4.34 in comparison with 6.63), however the number of participating organisations was limited.
- A total of 36 new VTEs occurred across the medical wards. 10 West and 8 East had the most VTEs reported with 14 and seven respectively. Hospital audit data showed fluctuating compliance with VTE assessments between September and December 2015. Four wards achieved the 95% target of VTE assessments in December 2015 (8 North, 8 East, 10 North and 10 East) however four wards did not.

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.
- 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. None of the medical wards met the 95% training target and endoscopy had the highest compliance with 93.4% The three worst performing wards all had less than 75% compliance; 10 West (61%), 11 West (64%), and 11 South (74%).
- Staff were mainly complimentary about the mandatory training provided although told us it was sometimes difficult to organise training around staffing on the

wards. They told us their managers usually reviewed their mandatory training as part of their one to one meetings and would highlight if anything needed completing urgently.

Safeguarding

- The medical wards had access to the hospital safeguarding team on a bleep referral basis. There was a trust-wide safeguarding policy in place which was accessible to all staff via the intranet. We saw some wards had safeguarding information folders containing the latest trust policy and some additional information about safeguarding.
- Staff were aware of the types of scenarios which would constitute as a safeguarding concern and were able to describe the escalation process for these situations, such as making a referral to the local safeguarding team and highlighting concerns the ward manager. Staff were clear they could refer directly to the local safeguarding team themselves and did not require support from a more senior member of staff to do so. Some staff were aware of who the trust safeguarding lead was.
- Staff provided appropriate examples of when safeguarding referrals had been made for vulnerable patients and we saw evidence of completed safeguarding documentation.
- The trust target for staff members to have completed safeguarding adults level two training was 95% and just two areas in medicine achieved this target; endoscopy (100%) and 11 East (95%). The four were performing wards were 11 South (40%), 10 West (55%), 10 South (61%) and 11 West (61%).
- The trust target for staff members to have completed safeguarding children level two training was 95% and endoscopy (100%) was the only area to achieve this target. Four wards had 60% or less compliance: 11 South (46.7%), 8 West (57.9%), 10 West (58.6%) and 6 South (60%).

Cleanliness, infection control and hygiene

- There were two domestic assistants working from 7am to 3pm allocated to each ward. Additional domestic support could be obtained outside of these times via a bleep system. The domestic assistants cleaned the wards according to the specified schedule of work. This schedule was on display on some wards which meant patients and staff on those wards knew when and how often cleaning should occur.
- 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.
- Cleaning audits were completed on a monthly basis by the housekeeping supervisor in conjunction with the ward managers and results were displayed on the corresponding ward noticeboard. All results we observed for January 2016 surpassed the 95% target compliance score.
- We noted most patient areas on the medical wards were visibly clean and we observed staff cleaning high level surfaces and floors correctly. Some other areas on the wards, such as the doctors' office, treatment rooms and patient bathrooms were not always seen to be clean; for example we observed a layer of grime around the edges of a bathroom floor and at the water level in a toilet bowl.
- We observed staff cleaning items of equipment once it had been used, for example zimmer frames, hoists and observations equipment were cleaned with disinfectant wipes. We noted green 'I am clean' labels were used to identify clean equipment and the date it was cleaned. Staff told us equipment was cleaned on a weekly basis even if it was not used, however we saw a blood pressure machine labelled as clean and dated 21 January 2016, which was 12 days prior to our inspection. We also observed that the arterial blood gas analyser on 8 North had several drops of dried blood.
- 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.
- All waste generated from the HLIU patients including used bedding was removed from the pod using an airtight bagging technique to ensure the integrity of the

pod was maintained. All waste was autoclaved within the unit to minimise risk of cross contamination by transporting the highly infectious waste away from the unit.

- 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.
- Infection control training was provided and mandatory for all clinical staff. The trust target for training completion was 95% and none of the medical wards met this target. The three worst performing wards had less than 50% training compliance each; 10 West (31%), 11 South (46.7%) and 9 North (47.1%). 11 South had two cases of possible transmissions of C Diff between April and October 2015, which could have been caused by poor hand hygiene.
- Basic personal protective equipment (PPE), such as aprons and gloves, was readily available throughout all areas of the medical wards. Additional PPE, for example facemasks, was also available and in use for staff caring for patients with certain illnesses like influenza. We observed staff using PPE appropriately to perform patient care tasks however we noted some staff removed and disposed of their PPE incorrectly, for example placing used gloves in the recycling waste rather than yellow infective waste.
- Staff working in HLIU wore disposable clothing and additional protective suits when performing patient tasks. Special clogs were provided for staff working in this area which were designed to withstand the extremely high temperatures of the autoclave, so the clogs could be used again. Staff were also required to shower when leaving the isolation area to prevent the risk of cross contamination.
- Staff working in HLIU were required to undergo extensive infection prevention and control training to ensure they were adept at following all procedures including an airtight bagging method for disposing of waste.
- Patients being transferred to the HLIU were transported in sealed pods and the necessary corridors and lifts were closed to staff, patients and visitors to the hospital when needed.
- Specialist air-tight isolation equipment was available on the HLIU and this allowed staff to perform all patient care tasks, including taking blood and inserting central lines, without breaking the seal. This meant staff were protected while caring for patients with highly contagious conditions.
- When patients from HLIU no longer required such high levels of isolation, they were transferred to a side room on 11 West with negative pressure capabilities. This meant the airflow out of the side room was controlled so particles within the room could not escape.
- We saw isolation warning signs in use throughout the medical wards. The signs specified the type of isolation required and advised what precautions were need when entering and leaving the room. All signs stated that the door to the room should be kept shut, however we observed many isolated rooms with open doors on the medical wards.
- 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. Staff told they would seek additional guidance from the infection control team if they were unsure about a patient's infection status.
- There were 19 positive pressure side rooms available on 11 South (haematology) for patients with compromised immune systems. This meant patients in these rooms were protected from potentially infective organisms as the airflow moves air out of the room rather that into the side room.
- We saw evidence that isolation patients were last on the endoscopy unit list each day. This ensured that all patient areas could be deep cleaned once the barrier nursed patient had been through the unit, reducing the risk of cross contamination with other patients.
- Equipment used during endoscopies was identified as used by being encased in a red disposable cover. The equipment was transferred to the 'dirty' store prior to being cleaned. Autoclave facilities were available on site to clean used equipment. Equipment was clearly marked as clean and placed in the 'clean' store so it was readily accessible when required.

Medical care (including older people's care)

- There were 15 cases of Clostridium Difficile (C. Diff) identified between April and October 2015. Root cause analysis for these cases identified three occasions where a lapse in care occurred; one due to inappropriate antibiotics given and two possible transmissions. Four cases of C Diff (including the two possible transmissions) occurred on 11 South (haematology).
- 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.
- 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.
- Most staff complied with 'bare below the elbow' principles however some nurses and doctors were observed wearing rings with stones, bracelets and nail varnish on the medical wards.
- Hand hygiene was mainly compliant with the 'five moments of hand hygiene' on the medical wards however we observed some occasions where staff did not clean their hands prior to patient contact.
  - Hand hygiene audits were completed regularly throughout the medical wards. Results from November 2015 to January 2016 were frequently lower than the 95% hospital target. Results from January 2016 for medicine wards within the urgent care division showed compliance ranged from 80% to 96% and 10 West was the only ward to meet the target in January 2016. Within the TASS division, audits results from wards 11 East and 11 South showed 100% compliance. However, 11 West scored lower that the target at 90%.
- Staff told us they received feedback from the hand hygiene audits during ward handovers and the results were displayed on the ward noticeboard.

Environment and equipment

- The Royal Free Hospital participated in the 'Patient Led Assessments of the Care Environment' (PLACE) 2015 audit and scored better than the England average for cleanliness and overall appearance and maintenance of facilities.
- Medical wards were in a horseshoe layout with a central nursing station and treatment room. There were four-bedded bays which had shared bathrooms and individual side rooms, some of which had en suite bathroom facilities.
- There were four lead lined side rooms on 11 East (oncology) to allow patients to receive radioactive therapy. Lead shields and aprons were also available to protect staff from patients who had received radioactive radiotherapy. Nursing staff described processes in place, such as maximum timeframes with high risk patients, to ensure their exposure to potential harmful radioactivity was limited. We saw all staff on the ward also wore monitors to audit their exposure.
- Endoscopy was performed in five rooms; split between the main endoscopy unit and clinic 9. There were three admission rooms where patients were consented and able to change. Their items were placed in secured lockers and patients recovered from their procedure in the eight bedded recovery bay. Spillage kits were available within the endoscopy unit to address any spills of bodily fluids.
- The environment of the HLIU was designed to maintain a 'clean' area and an 'infective' area. This was indicated by colour coding on the floor of the ward which changed according to which type of area you were in. This meant staff did not unknowingly move between the two areas in potentially contaminated clothing.
- Consumables were stored in labelled drawers within storage cupboards, alongside spare items in boxes. We noted some boxes were placed directly on the floor which was not appropriate storage. We identified two out of date items of equipment on 8 North and staff discarded these items immediately.
- During a board round, we noted that a patient had been unable to have a nasopharyngeal aspirate (NPA) for three days due to lack of availability of the correct equipment. Staff told us this did not happen frequently

but may have delayed the treatment received by the patient on this occasion. Senior staff were aware and told us they would source the equipment from another ward to ensure the NPA happened that day.

- Resuscitation trolleys were located on each medical ward and contained all relevant equipment, including emergency medicines. We saw evidence of regular equipment checks and notes indicating that expired equipment was replaced.
- Basic resuscitation equipment, such as oral airways and oxygen masks, was available in the discharge lounge and there was no defibrillator located in the immediate area. Staff told us the nearest full resuscitation trolley and defibrillator was available in the adjacent outpatients clinic. Access to this equipment was suitable in the event of an emergency.
- We saw all electrical equipment had a registration label affixed and was maintained and serviced in accordance with manufacturer recommendations. We also saw appliance testing labels were attached to electrical systems showing they had been inspected and were safe to use.
- There were between three and eight commodes on each ward depending upon the needs of patients on the ward. All commodes we checked were suitably clean and labelled with a green 'I am clean' sticker.

Medicines

- Staff told us new prescription charts were introduced in December 2015 following consultation with the antibiotic stewardship committee. The new charts were designed to encourage closer monitoring of antibiotics after 48 hours and seven days of being prescribed. The chart prompted staff to review the type, route and dose of antibiotic prescribed.
- Prescription charts we reviewed were suitably signed, dated and legible. Patient allergies had been documented and medicines were prescribed correctly. We saw evidence prescription charts were reviewed and annotated by ward pharmacists where needed.
- Trust policy identified prescriptions for chemotherapy medicines had to be completed by registrar level doctors or consultants. We saw evidence that staff complied with this policy in their practice.
- Medicines were stored in lockable cupboards and trolleys within keypad locked treatment rooms. On one ward we observed the medicines trolley had been left unlocked whilst placed in the treatment room. This was raised with staff who acknowledged the mistake and locked the trolley immediately.
- Some medicines were stored in dedicated, lockable fridges. We saw documented evidence that the temperature of these fridges were checked most days. On 8 North we noted the lock on the medicines fridge was broke and staff told us this had been reported three weeks before this but had yet to be fixed.
- Controlled drugs (CDs) were stored in lockable wall cupboards on each ward and the contents were recorded and monitored via the ward's CD stock book. Contents were checked against the number written in the CD book by two nurses during each shift. We checked the contents of CD cupboards on two wards and found their contents were correct against the documented numbers. We observed staff administering CDs followed correct protocol and procedures.
- Nurses had to complete medicines administration competencies for giving oral and intra-venous (IV) medicines to patients. The clinical practice educator or a senior nurse had to sign staff off once their competency had been established as consistent. We observed staff administering oral medicines following correct procedures including checking patient name and date of birth as well as for allergies.
- Medicines rounds were completed by nursing staff who used a portable trolley. We observed nurses were interrupted by other members of staff whilst completing medicines rounds. This is not in line with best practice guidance which identifies that nursing staff completing medicines rounds should be 'protected' from distractions.
- Medicines to take away (TTAs) were requested by junior doctors and prepared by pharmacy staff. Doctors tried to complete the TTA prescriptions on the day before patients were due to be discharged so TTAs were ready as early on the day of discharge as possible. When ready, TTAs were delivered to the patient on the ward or in the discharge lounge. Patients and staff told us there were frequently long delays for patients to receive their TTAs and this often led to delays in patient discharges.

Medical care (including older people's care)

- Patients in the discharge lounge were required to self-medicate if medicines were due while they were waiting in the lounge. This was because the patients' prescription chart was retained by the ward they were being discharged from and so the discharge lounge were not able to administer medicines. Discharge lounge staff told us patients who were unable to self-medicate would receive medicines from nurses from the patients' discharging ward who would bring the prescription chart to the discharge lounge and administer the patients' medicines there. They told us this occurred infrequently.
- Oxygen cylinders were located on each ward and most were stored correctly in designated gas cylinder holder. All oxygen cylinders were seen to be in date.
- During our inspection we noted many patients receiving supplementary oxygen with no prescription or with an incorrect prescription. Patients with some medical conditions should not be exposed to additional oxygen for safety reasons and consistently providing oxygen without a prescription could place patients at risk. We observed a patient who had been prescribed 2 litres of oxygen per minute receiving 15 litres of oxygen. The patient had been reviewed by the medical team but the prescription had not been updated to reflect the patient's clinical need.
- The hospital completed the BTS Emergency Oxygen Audit in September 2015 and found 39% of patient receiving emergency oxygen had an oxygen prescription in place. This was worse than the national average of 58%. Action points were identified to address this such as highlighting it to junior doctors during their induction.
- Pharmacists took a lead role in medicines reconciliation in line with NICE guidelines. This meant an accurate and up to date list of medicines was made for each patient and dispensed once the patient was discharged back to the care of their GP. Pharmacists were also involved in referring patients to smoking cessation services within the hospital.

Records

- Paper based records were used and two recording systems were in place across the medical wards. The first included a separate medical notes folder and a bedside folder which contained all risk assessments, observations, care plans and the prescription chart. The second system used three folders; one for medical notes, one for observations and prescription charts and a separate folder for risk assessments and care plans. Agency staff commented that working across different medical wards could be confusing due to the differing recording systems in place.
- We noted that paper documents were not always filed logically in the various folders and loose pages were often apparent. This meant sheets containing confidential and potentially important patient information could be misplaced.
- Medical notes were stored in lockable units, usually within the doctors' office or in the ward corridors. We observed notes storage was kept locked when in the open ward area. Nursing notes, including observations and risk assessments, were stored unsecured outside patient rooms.
- Medical notes we reviewed were mainly legible and it was usually clear who had written the notes and reviewed the patient. Daily ward round reviews and antibiotic assessments were not always evident.
- Nursing notes were completed for most shifts however full nursing assessments were infrequently completed. Risk assessments were in use often but were mainly incomplete. We saw some inaccurate calculations of patient risk assessments, for example on 10 West the 'Waterlow Pressure Ulcer Prevention Score' was calculated at 16 for one patient when it should have been 21. This placed the patient at 'high' risk of pressure ulcers, rather than 'very high'. This could detrimentally affect patient care if incorrect actions were taken because of incorrect calculations.
- Notes and prescription charts for patients using the discharge lounge remained on the ward they were being discharged from. This meant discharge lounge staff had no access to medical information about the patients in the lounge, including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders. This meant CPR would be commenced for all patients who required it while in the discharge lounge, even if the patient was supposed to have a DNACPR. While en route to the patient, the crash team was responsible for contacting the

discharging ward to identify if the patient had a DNACPR or not. Staff told us this had happened on more than one occasion, although we were unable to locate evidence supporting this.

Assessing and responding to patient risk

- In line with NICE guidance, an early warning score (EWS) was used across the medicine wards to track patient observations and trigger escalation to the Patient at Risk and Resuscitation Team (PARRT). If any observation was noted to be outside of normal parameters, the nurse in charge and junior ward doctors should be informed. The next stage of escalation would involve informing the patient's registrar and PARRT.
- A hospital audit across eight wards (including six medical wards) and 238 patients was completed in December 2015. Audit results showed full observations were completed in 92% of the patient notes on all wards. Some observations were missed due to patients refusing. Audit results showed 4% of patients had observations outside of normal parameters. All of these patients had been escalated appropriately and in a timely fashion.
- Throughout our inspection, we noted most sets of patients observations were fully completed although where gaps occurred it was unclear why this was the case. We were able to track the escalation process in practice by reviewing patient notes and saw this was effectively used across the medical wards.
- Staff on 8 North told us that one of the bays on the ward was sometimes "used as an HDU" due to the availability of monitoring equipment. Nursing staff felt that patients were sometimes transferred inappropriately for this purpose and it placed patients at risk, particularly due to the 1:4 staffing ratio. During our inspection, patients in the monitored area did not meet high dependency criteria.
- To reduce the incidence of falls, patients on the medical wards were risk assessed in accordance with NICE guidance and mobility plans were put in place. The physiotherapy team completed a mobility plan audit on 10 North in January 2016 that showed 87.5% of patients had a plan in place. This was an improvement from the previous two months where results were 82.8% and 66.7% respectively.
- Hospital-wide audit results from January 2016 showed 71% of patients admitted for 24 hours or longer needed a falls screening assessment. This assessment had been fully completed for 19 patients, partially completed for 26 patients and not completed for two patients. Due to the presentation of data, it was unclear where the incomplete and missed assessments occurred however patient notes we reviewed during our inspection showed evidence of falls screening.
- Environmental assessments had been completed on a bay by bay basis to identify any areas which may pose a risk for patients falls. Where a risk was identified, staff were able to describe actions taken to reduce the risk, for example lowering the height of patient beds. However results from the national inpatient falls audit 2015 showed environmental aspects posed a greater risk of falls to patients than in other units.
- The 'Visual Infusion Phlebitis (VIP) Score' was used to facilitate the timely removal of intra-venous cannula. We saw evidence this was in use on some medical wards.
- The 'Multi Racial Visual Inspection Catheter Tool Observation Record' (MR VICTOR) was used to assess and identify early signs of infection linked to central venous vascular access devices. The tool provided a visual guide of the changes you would expect to see on the skin of people of different races if infection was present.
- Bed rail assessments were used to establish if bed rails were safe to be used with certain patients. We noted the assessment was sparse and only required a justification note written by nursing staff. In all sets of records checked during our unannounced inspection, staff documented "for safety" as the rationale behind using the bedrails which did not indicate a full risk assessment.

Nursing staffing

- The site management team reviewed nurse staffing levels at the morning and evening bed meetings to ensure the right numbers and skill mix of staff were distributed appropriately throughout the hospital. We observed staff were transferred to work on other wards to meet patient needs.
- 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.

- The number of registered nurses working each shift varied depending upon the ward in question and the acuity of patients on the ward, for example 8 North planned to have nine RNs on duty during the day and overnight, whereas 10 North were planned to have six RNs during the day and four overnight. Staff told us the nature of patients admitted to 8 North meant they were often more unwell and unpredictable and so a greater number of nurses were required to care for patients safely.
- Patients on the HLIU were nursed on a four nurses to one patient basis. Staff worked in 12 hour shifts with the first six hours spent completing direct patient care in the isolation room and the remaining six hours working as a 'runner'. Additional nursing support could be obtained from critical care staff if the patient required ventilation.
- As observed during our inspection and upon reviewing the number of planned RNs on shift against the actual number on shift, wards were usually staffed appropriately.
- We saw evidence of bank and agency staff use to fill gaps in shifts created by staff sickness or vacancies. High use of agency staff was noted in acute medicine (41%), stroke (30%) and elderly medicine (29%). Senior staff told us this was due to difficulties in recruiting permanent members of staff to these clinical areas.
- All permanent and agency staff working on the unit for the first time were given a general induction to their working environment. Agency staff spoke positively of their induction process however it was unclear if the induction would be repeated if the staff member did not work on the ward for a period of time.
- We saw evidence of 'specials' being used for patients who required one to one nursing, such as those with mental health needs and a patient who collapsed frequently. '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 agency staff were often used as 'specials' as it could be difficult to get additional permanent staff to cover shifts at late notice.
- Nurses worked shifted from 8am to 8:30pm and 8pm to 8:30am. Handovers were completed at the start of each shift where the staff coming off duty would pass on clinical details of the ward patients to staff coming on shift. The nurse in charge gave an overview of all patients on the ward and then nurses from each ward area would give specific details to the nurse allocated to take over.
- Several medical wards had much higher vacancy rates than the trust average (17%), including 8 East (27%), 10 North (23%), endoscopy (23%) and 8 West (21%).
- Nursing assistants (NAs) supported the RNs across the medical wards by assisting with tasks such as washing and toileting patients and changing beds. Wards had between one and seven NAs on shift at any one time

Medical staffing

- Medical staffing comprised of consultants, specialist registrars, senior house officers (SHOs) and foundation level doctors. Rotas we reviewed demonstrated appropriate numbers of specialist trainee registrars and foundation year doctors to support the consultants during daytime hours, evenings and overnight. We observed the actual number of doctors on the medicine wards was also appropriate and staff feedback said they had sufficient medical staff.
- Some consultants and registrar level doctors were also responsible for running medical outpatient clinics, for example in oncology. Ward doctors told us they were able to contact their senior colleagues even when they were in clinic and seek advice or support if needed.
- Overnight the medical registrar (minimum of an ST3 grade) with support from an SHO and foundation year doctor was responsible for medical inpatients. An additional medical registrar was located in accident and emergency to care for patients who attend the emergency department with medical problems. There was a consultant and registrar also located on 8 North to care for newly admitted patients overnight.
- All registrars were expected to have an advanced life support qualification and staff we spoke with confirmed they had completed this.
- Some staff raised the night-time medical cover as an issue and told us this was exacerbated by some SHOs

who did not have on call duties listed on their job plans and so were not involved in the on call rota. Senior staff told us the job plans were being modified to include on call cover to address this problem.

- The hospital at night team met briefly at the start of their shift to identify all team members and their contact numbers. Any hospital-wide or staffing issues were identified and actions to address these agreed if possible. The team also received handover of relevant patients from PARRT.
- Doctors completed daily wards rounds including regular reviews by the consultant or senior registrar of the relevant team. We observed ward rounds took place shortly after the morning board round, during which all relevant patients were briefly discussed with the night doctor (if appropriate), the nurse in charge of the ward and any therapy staff in attendance. This meant the doctors had an up to date clinical picture of the patient before attending the patient's bedside, allowing them the opportunity to prioritise the most unwell patients and those who were ready for discharge the same day. An estimated discharge date was set in conjunction with staff in attendance of the board round.
- Staff told us outlying medical patients (medical patients who were located on a non-medical ward) were reviewed on a daily basis by the relevant medical team who conducted 'safari' ward rounds. We observed evidence of these reviews in patient notes.
- There were fewer medical vacancies in medicine (2%) than in comparison with the trust average (4%) however we observed some use of locum staff, particularly in acute medicine (19% in March 2015) and elderly medicine (12%).

Major incident awareness and training

- There was a trust-wide major incident policy that was available to all staff via the hospital intranet and we noted many wards also had printed copies available at the nursing stations.
- The site management team were responsible for initiating and implementing the major incident emergency plan when needed. Staff were aware that a ward based contact person would be identified (usually the nurse in charge) and all instructions from the site team would be communicated via this member of staff.
- Emergency planning training was mandatory for all staff. Hospital data showed two wards (endoscopy and 8 East) met the 95% training target with 100% and 96.2% compliance respectively. Compliance in other areas ranged from 93% (11 South) to 65% (9 North).

Are medical care services effective?

Good

We rated the effectiveness of medical care as Good because;

- Competent and well inducted staff gave care and treatment according to evidence-based recommendations and guidance.
- Good patient outcomes were noted for several national audits, including the 'Sentinel Stroke National Audit Programme' (SSNAP). There was a strong multidisciplinary approach to patient care, including regular meetings and the involvement of community teams at an early stage in the discharge planning process.
- Staff were aware of the need to gain patient consent before completing care tasks and demonstrated an understanding of the mental capacity act. Not all staff were aware of Deprivation of Liberty Safeguards (DoLS) however we saw DoLS appropriately in use on the wards.
- Patient nutrition and mealtimes were well managed, including ensuring all patients received hot food and help if required. Patients were provided with suitable hydration however fluid balance charts were rarely completed fully or correctly.

However;

- Some policies were seen to be out of date and the number of unplanned readmissions was higher than the national average.
- Staff appraisal rates were variable and some services had limited seven day availability.

Evidence-based care and treatment

- We saw evidence of policies in use across the medical wards which had been developed in line with evidence-based practice and NICE guidelines, for example for sepsis and diabetic ketoacidosis (DKA).

- We saw a number of policies, which staff identified as currently in use, had passed their review dates for example the DNACPR policy specified August 2015 as the review date. Staff told us they would refer to the most recent policy they could find on the intranet, even if it appeared to be out of date. Staff told us policy documents were out of date due to the harmonisation with other sites in the trust.
- New algorithms for the management of hypo or hyperglycaemic patients had been developed according to recent research and evidence-based practice. We observed pilot use of these algorithms on 10 West and staff were positive about support provided by the new documentation. Audit results from February 2016 showed improvements in staff awareness and an improvement in the number of patients started on the correct blood sugar pathway.
- A specific evidence-based care bundle was used to guide the management of patients with acute kidney injury (AKI). An audit which investigated the treatment of these patients in September 2015 showed variable compliance with best practice guidance. The retrospective data showed 59% of patient received appropriate fluids, 77% were reviewed by a middle grade doctor or above if they needed more than 2000mls and basic investigations were completed in 86% of patients. All patients with a physical kidney insult had this removed. Learning from this audit was identified and disseminated in teaching sessions.
- NICE guidance recommends patients demonstrating certain risk factors should be assessed for delirium on admission to hospital. Hospital audit data from October 2015 showed poor levels of delirium screening for appropriate patients on the medical wards. Learning points identified the need to complete education with relevant staff and to create a delirium pathway for medical patients; however we did not see evidence of this during our inspection.
- 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.
- 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.

Nutrition and hydration

- Patients were reviewed by a dietician if there were concerns with their weight or food intake. Dietary supplements such as fortified milkshakes were given to patients who needed a higher calorie intake.
- Fluid balance charts were used in many patient records across the medical wards. Almost all charts we reviewed had not been fully completed and the overall fluid balance for the patient had not been calculated. During our unannounced inspection, we observed the fluid charts for one patient were incomplete for four continuous days on 8 North however this did not appear to have a clinical impact on the patient. Staff were unsure when fluid charts should be used with patients and when they were not needed.
- An IV fluid audit was completed in March 2015 to assess compliance with NICE CG174 guidance. Results from this audit showed poor compliance with some aspects of the guidance such as giving an initial fluid bolus, completing a full patient reassessment following the fluids and seeking expert advice if more than 2000mls were given to a patient. Appropriate action plans were identified and staff told us they were due to re-audit this data in March 2016.

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.
- Staff told us pain issues were primarily managed by the patients' admitting medical team, however additional support could be received from the pain team.
- Hospital data stated that an audit of patients living with dementia was completed in relation to their pain and found that these patients are less likely to have

adequate pain relief. The hospital planned to implement the 'Abbey Pain Scale' on the elderly medicine wards however we did not see this in use during our inspection.

Patient outcomes

- The stroke service at the Royal Free Hospital participated in the 'Sentinel Stroke National Audit Programme' (SSNAP) which assessed the quality of care provided at stroke services across the country. A score between A and E was awarded, where A marks the best quality care. For the assessment period between April and June 2015, the stroke services scored an A rating, indicating the hospital was achieving good outcomes for stroke patients in comparison with the national average. This was an improvement from the previous B rating.
- The hospital participated in the 'Myocardial Ischaemia National Audit Project' (MINAP), which assessed the management of patients with a heart attack. In results published in 2015 (for patients seen during the period 2013/14), the hospital performed better than the England average in all domains for patients with non-ST-elevation myocardial infarction (nSTEMI).
- In the most recent (2013) results from the 'National Diabetes Inpatient Audit' (NaDIA), the Royal Free Hospital performed worse than in other hospitals across all 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 diabetes pathway was being reviewed to address this issue.
- The trust participated in the 'BTS Pleural Procedures Audit' 2014 which monitored chest drain insertion procedures and ongoing care. Results showed the hospital performed better than other centres nationally across four key domains and worse in two domains, although these two domains scored better than the previous audit.
- The hospital participated in the 'National BTS COPD Audit' 2014 which assessed the care provided to inpatients with a diagnosis of chronic obstructive pulmonary disease (COPD). The hospital was ranked as joint 21st out of 183 unit who participated nationwide. Three priority areas for improvement were identified by the trust.
- In October 2015, 31% of general medical patients were readmitted to hospital within 30 of being discharged. This was worse than the trust average of 27% and was in line with performance in previous months.
- In January 2016, the mortality rate on the medical wards varied from 0% on 9 North (hepatology) to 16% on 11 South (clinical haematology). The average mortality rate was 5%, which equated to 37 patient deaths during January.

Competent nursing staff

- 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 and told us this training was invaluable in helping them provide suitable support for their mentees.
- 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 be completed during the preceptorship period. The clinical practice educator or the relevant mentor signed off competencies.
- Specific training was available for staff working within specialist areas and certain specific competencies had to be completed. For example staff working on 10 North underwent specific training about caring for patients with liver conditions and staff working on 8 East had tracheostomy care training from PARRT. There were also study days for respiratory, dementia and complex patient care.
- Shadowing opportunities were available for staff working in specialist areas or those with specific interests. Staff told us they had shadowed the liver transplant coordinator to help develop their knowledge and understanding of the transplant process.

Medical care (including older people's care)

- There were some rotational opportunities within the medical wards, for example staff working on 10 West (cardiology) could rotate to work on the CCU. This meant staff could develop additional knowledge and skills within their role.
- Staff working on the HLIU were mainly infectious diseases nurses although other staff for example critical care nurses also assisted on the unit. All staff were required to undergo extensive infection prevention and control training. Training was completed by senior infectious diseases staff who also trained nurses from other hospitals in these methods.
- Senior nurses (band 6 and above) were allocated to be the lead for specific areas of responsibility on their ward, such as hand hygiene audits and appraisal rates. Staff told us they enjoyed being involved in ensuring quality and safety of their ward area and there was some competitiveness to make their ward "the best".
- Staff told us clinical practice educators were available in some areas of the medical wards but not others. Staff on 8 North (acute admissions unit) told us they had no practice educator allocated to them. Educators were intended to be supernumerary however on our unannounced inspection staff told us one of the educators was working on the ward that day due to short staffing.
- Between April and November 2015 the rate of nursing staff with completed up to date appraisals varied significantly depending on the ward. The worst performing wards were 10 West, 9 North (which is now ward 10 North) and 8 East with 26%, 38% and 45% respectively. We noted each of these wards also had poor appraisal compliance over the previous three financial years. Endoscopy, 6 South and 11 East met the trust target for completed appraisals (85%) with 100%, 95% and 88%.

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.
- Doctors were inducted into their specific working areas by their colleagues who had not also newly rotated into the area. This meant some inductions were completed by foundation year doctors when the registrar was not available. Staff told us the ward inductions were not comprehensive but they were happy to asking ward staff for help in locating forms or equipment as needed.
- We observed medical staff completing teaching with more junior colleagues and medical students both prior to seeing patients and also at the patient bedside. Staff provided clear explanations during their teaching and were patient when answering questions and queries.
- Formal teaching sessions were scheduled for foundation doctors and registrar level doctors on weekdays, depending upon which area the doctor was working in.
- Doctors told us they had opportunities to be involved in research projects and to attend at nationwide conferences for development purposes.

Multidisciplinary working

- We saw liaison between staff working on each ward, for example doctors handing over information to nursing staff after their ward round. On 10 East we were told that doctors left a printed list of tasks for nursing staff if they were unable to locate them to handover personally. Staff told us this system worked well and meant important tasks weren't missed.
- Therapists were involved in ward rounds or board rounds on some wards, such as 6 South where an occupational therapist and physiotherapist attended the consultant morning ward round.
- Multidisciplinary team meetings took place regularly on some wards such as 6 South and 8 North. During these meetings all aspects of patient care was discussed including any outstanding issues and an estimated discharge date and a plan of action was agreed.
- On some medical wards, joint training sessions were held with therapists and nursing staff. Staff told us this had helped their working relationships to develop and helped them to understand each other's roles.
- We saw evidence of hospital staff liaising with local community teams to find out information about their patients, such as how they usually manage at home, and to facilitate discharges home.

- District nurses were routinely invited to discharge planning meetings where patients were known to their community nursing service. Hospital staff told us this helped to make the discharge transition process occur more smoothly.
- 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

- A consultants was available to provide telephone support or to review patients seven days per week to ensure they received suitable treatment, whatever day of the week they were admitted. Staff told us consultants were happy to come into the hospital to see patients if needed.
- Access to physiotherapy and occupational therapy was limited to weekdays only (with the exception of the physiotherapy respiratory on call service which was available out of hours and at weeks, 24 hours per day). To ensure patients continued their rehabilitation over weekends, therapy staff on 6 North created a "sitting out list" which identified patients who should sit out of bed over the weekend. This was led by the nursing assistants on the ward who liaised with the therapy staff prior to the weekend.
- Staff told us accessing certain types of imaging for medical inpatients could be difficult. They told us it was often easier to organise complex imaging like MRI scans rather than simple x-rays but this was likely due to how busy the radiology department was on an individual day. Staff told us this meant some investigations were delayed due to more urgent investigations being prioritised and this had a detrimental knock on effect on patient length of stay.

Access to information

- Staff told us patient medical notes could be accessed quickly when needed. The ward clerk in each area was responsible for locating and requesting medical notes.
- Staff had access to policies and procedures via the trust-wide intranet. Some wards had printed versions of policies in resource folders. Staff told us some policies were being harmonised with those in place in Barnet and Chase Farm hospitals therefore the policies were not always within their review date.
- Staff had access to national guidance on ward computers which could access internet sites. They told us this was invaluable for accessing NICE guidance and other key reference documents.
- Patient investigation results were accessible electronically, including blood tests and imaging reports. Staff printed results off and placed them in the patient medical notes.

Consent, Mental Capacity Act and DoLS

- Staff understood the need to ask patients for permission before completing any procedures and we observed staff asking patients for verbal consent before completing basic care tasks such as taking patients' blood pressure. If a patient refused to give consent, staff told us they would explain the rationale behind the task and the risks of not completing it to ensure patients were aware of the consequences of their decision. Staff told us they would raise this as an issue with the nurse in charge if, for example, a patient continued to refuse observations.
- We observed staff discussing a patient's capacity assessment results during a board round and debating how they could best support the patient in order for the patient to make an informed decision about the care plan proposed. We also observed discussion regarding the use of court-appointed deputies for patients who were unable to make their own decisions.
- Patients told us staff asked for permission prior to touching them or completing care tasks. One patient told us staff asked for consent before they instigated a nursing 'special' which was indicated due to the patient's history of falling.
- Most staff were familiar with DoLS although not all staff questioned could accurately describe what it entailed or the implication of DoLS in a hospital setting. We saw evidence of DoLS assessments and applications in use on the medical wards. Appropriate capacity

assessments had been completed prior to the application for DoLS. Staff told us the safeguarding team played a key role in the logistics of obtaining permission for DoLS.

Are medical care services caring?

Good

We rated caring for medical care as Good because;

- Patients were cared for and their dignity respected. Results from the 'Friends and Family Test' showed most people would recommend the medical services provided by the hospital.
- Patient confidentiality was maintained by staff during handovers, multidisciplinary meetings and ward rounds. Nursing staff were allocated to specific ward areas and signs were in place to ensure patients were aware which nurse was caring for them. Patients told us their privacy and dignity was preserved at all times and care we saw supported this.
- Almost all feedback from patients and their relatives was complimentary about the care they received on the medical wards; they told us staff were kind and tried to make them feel comfortable.
- Patients told us staff came quickly when they used the call bell and hospital audit data showed most wards met the hospital target of answering call bells within 10 rings.

However;

- We observed and were told of some examples where care provided by staff was not optimal, for example a doctor who spoke over the patient during bedside teaching, staff who reprimanded a patient for using the call bell and infrequent intentional nursing rounds.

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 varied from 81% of respondents on 10 South and 10 South to 100% of respondents likely to recommend care on 11 South.
- We saw evidence of many thank you cards and letters on display on noticeboards throughout the medical wards. Staff were identified as "kind and caring" and relatives thanked them for "always going the extra mile".
- Patients praised the care they received and told us staff on the medical wards were kind and friendly. They told us the nurses always said hello and asked how they were when entering the ward bays. Patients told us nurses "tried to make [them] feel at ease" while they were in hospital and "realised it [wasn't] always a nice experience".
- Relatives were confident in the care provided by the critical care service and told us "the patients are safe here". They believed the patients were "well looked after" and that the nursing staff "care about the patients as if they are their own family".
- Most patients and relatives we spoke with told us there was nothing about the care given by staff on the medical wards that could be improved.
- Intentional nursing rounds were planned to be completed hourly. Patient continence, analgesia, position and environment should be assessed and patients should be assisted to the bathroom or made more comfortable if needed. Intentional round documentation we reviewed indicated these rounds were not completed on an hourly basis on most wards. Patients told us the nurses checked on them once or twice per day outside of the usual medicines and ward rounds.
- Patients told us their privacy and dignity had been maintained at all times during their hospital stay. We saw staff ensuring patients were suitably covered up when in bed and walking on the wards, however we observed some staff entering closed curtains without asking permission from the people inside which could compromise patient dignity.

- Board rounds and multidisciplinary meetings were completed behind closed doors to maintain patient confidentiality. On one ward, we saw visitors were asked to leave ward bays during ward round discussions so patient confidentiality was not compromised.
- Patient name and information boards were located within staff only areas and so were not visible to ward visitors. This meant patient confidentiality was maintained.
- We observed doctors on 10 South completing a ward round and checking the patient was comfortable and had everything they needed before moving on to the next patient.
- During our unannounced inspection, we saw patients on 8 West had been given handmade Valentine's Day cards signed by ward staff. Patients told us they appreciated the gesture and said it made the day feel "a bit special". Patients were also invited to a Valentine's Day tea party held by the hospital charity on the hospital premises and we spoke to one patient who attended who told us they received chocolates and flowers when they went and that it was a "pleasant afternoon".
- We observed that most patients had call bells left within reach and hospital audit data supported that this was usually the case.
- Posters around the medical wards advised that call bells should 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. On the wards under the TASS division, call bell audits were completed on a monthly basis and results showed all but one ward (9 North) achieved the target in January 2016. This was consistent with previous months, however it was not the same wards failing to hit the target each month.
- On one ward, we witnessed a member of nursing staff loudly reprimanding a patient for using the call bell too frequently. The ward manager witnessed this, however did not, to our knowledge, raise this with the staff member concerned.
- Staff were not always considerate of the restful environment on the ward, for example we observed a staff member on 8 North looking for a colleague and shouting the colleague's name into patient bays as she walked through the ward. We observed several patients were startled but the staff member did not acknowledge this.
- Patients told us staff were very busy and "seemed stretched" on some wards. One patient on 10 South told us her hair had not been washed for two months despite asking staff to help her with it. She told us staff were too busy to help. Another patient told us staff were too busy to have proper conversations with them which would have been helpful when the patient was first admitted.
- We were told of two occasions where patients on different wards had a "run in" with staff. Both times, the patients told us the staff members "held a grudge" and were rude to them in subsequent interactions.

Understanding and involvement of patients and those close to them

- We observed medical ward rounds on several wards and noted that most doctors introduced themselves before commencing the patient assessment. They gave clear explanations to patients and provided opportunities to ask questions and confirm understanding. Patients told us the doctors spent sufficient time explaining treatment options and side effects to them and they felt comfortable asking questions.
- Doctors across the medicine wards were available between 3pm and 4pm Monday to Friday to meet with relatives and provide explanations about the care of their loved one. Relatives told us they had usually been able to access doctors during this time although the doctors were sometimes late to meet them.
- During our unannounced inspection we observed a consultant completing patient bedside teaching with junior doctors. The consultant spoke over the patient and did not explain that teaching was taking place which led the patient to become worried and question whether there were serious concerns with her health. Instead of providing an explanation and reassurance, the consultant spoke sharply to the patient and said "it's fine" which did not aid the understanding of the patient involved.

Medical care (including older people's care)

- We observed therapists completing treatments with patients on the medical wards. Staff were encouraging and educated patients about the benefits of activities they had recommended.
- Patients told us they had longer than expected waits for their TTAs on discharge and they were not kept informed about when to expect them. One patient told us they were given their discharge letter at 9am but their TTAs were not available until after lunchtime.
- Relatives told us they had called out of hours to check on their loved one and ward staff had been helpful and reassuring. Relatives told us this made them feel better about not being able to visit late in the evening.
- Some relatives told us they did not feel involved in the care of their loved ones and were not included in discussions about treatment plans or scan results. However, most relatives spoke positively about the way they were engaged in discussions about the care and treatment plan of their family member.
- Signs identifying the nurse responsible for patient bays and side rooms were located in the corresponding area on the medical wards. This ensured patients and their visitors could easily identify who was taking care of them during that shift.

Emotional support

- Patients and relatives told us staff were supportive and empathetic when investigation results were communicated or treatment plans were discussed. Patients told us they felt supported to make difficult decisions and that they staff were "on [their] side".
- One patient told us a patient within their bay had died the previous night and told us staff checked that the other patients in the bay were not unduly upset. The patient described how the nurse held her hand when she spoke and showed genuine concern for their wellbeing.
- A multi-faith chaplaincy team were available within the hospital to support patients, relatives and staff members. The chaplaincy team held a weekly pattern of Christian and Muslim religious services within the hospital and were also available to visit patients and their families on the wards if requested. Patients told us the chaplaincy service was "invaluable" and had provided "great support at a difficult time".
- Protected mealtimes were used throughout the medical 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. A bell was also rung to highlight the start of the protected time. 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 on each ward so there were enough staff available to assist them. We observed this in practice and saw it was an embedded system which appeared to work well.
- Patients who needed assistance eating were offered bibs to keep their clothing clean whilst they ate.
- Food was presented with care and the temperature of hot food was checked to ensure it was hot enough before being given to patients. No hot food was available within the discharge lounge however sandwiches, other cold snacks and hot drinks were available if required.
- 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 appropriate, for example with a patient who was losing weight, and we saw these in use across the medical wards. Some wards completed these charts thoroughly for each meal and on a daily basis whereas the documentation on other wards was variable.
- A number of standards for mealtimes were identified by trust as areas for monitoring on a monthly basis. Audit results from November 2015 to January 2016 showed most wards were fully compliant with the standards identified or more than the target 81% compliant. There were two wards with a score below this target in the specified period which was 11 South (80%) and 9 North (75%).

Medical care (including older people's care)

Are medical care services responsive?

Good

We rated the responsiveness of medical care as Good because;

- We saw effective use of site management meetings to ensure suitable patient flow through the hospital and to ensure patients were on an appropriate ward.
- There were no mixed sex accommodation breaches and most services met the referral to treatment time target. The HLIU was accessible to patients across the country via a direct consultant referral. On the renal unit, an 'emergency' bed was kept free to accommodate patients who deteriorated quickly in the community and needed direct admission to the unit.
- Most patients accessed medical care via the accident and emergency department and were admitted directly to an appropriate ward; 72% of patients had no ward moves during their admission.
- Patients living with dementia were identified by staff and processes were in place to ensure patients were well supported. The specific needs of other patients groups, such as bariatric and end of life patients were met.

However;

- The support available for patients with a learning disability and those who are deaf or blind was unclear.
- Many ward moves took place out of hours (957 moves between May 2015 and January 2016) and 5% of medical patients were discharged from hospital out of hours.

Service planning and delivery to meet the needs of local people

- The trust identified the aging population and different types of demand this placed 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.
- Reviews of the inpatient processes were underway to make the patient journey more seamless and to ensure patient needs were met at all stages of receiving care.
- Patients were accommodated in single rooms or in single sex bays. Hospital data showed there were no mixed sex accommodation breaches on any of the medical wards from October 2015 to December 2015. However, the endoscopy recovery area did not separate male and female patients, other than by disposable curtains.
- Visiting times were 2pm to 8pm every day and visitors were limited to two per bed space. Some relatives told us they felt this was not long enough and wanted visiting in the morning too, however most were satisfied with this amount of access. Staff told us relatives who were unable to come during this allocated times could contact the nurse in charge and arrange for visiting outside of the designated times, provided it did not interfere with patient care, such as scans or physiotherapy.
- There were no facilities for private conversations with patients or their families, other than in endoscopy. Staff told us offices on the wards were used for this purpose if required and signs placed on the door to indicate that people inside the room should not be disturbed.
- There were limited facilities for relatives within the ward areas and only some wards had waiting rooms. There were no facilities for relatives to stay over if they lived a long way away.

Meeting people's individual needs

- 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 team of dementia specialist staff was available within the hospital which included a consultant geriatrician with a special interest in dementia and a dementia nursing lead. Where patients living with dementia had complex needs beyond the expertise of ward staff, the dementia team could be contacted for additional support. We saw evidence of the dementia team's involvement with some patients on the elderly medicine wards and staff were positive about their involvement.

Medical care (including older people's care)

- We saw evidence that more frequent intentional nursing rounds took place for confused or complex patients, which included increasing the frequency of checks to half hourly.
- An electronic flagging system was in place to highlight when patients with a learning disability were admitted. There was an acute liaison nurse based at the hospital who was available to support staff caring for these patients. Staff could also seek support and guidance from the community learning disability teams who frequently knew patients from their home setting. Staff on the wards were aware of the liaison nurse but none of the staff we spoke with suggested contacting the community teams for additional help.
- Staff provided examples where adjustments had been made for patients with a learning disability to improve their experience, such as allowing their visitors extended visiting hours.
- 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.
- Hospital volunteers were sometimes allocated to patients with a learning disability or living with dementia. The volunteer would spend time reading to the patient or completing activities.
- Staff were not aware if there was any support available for patients who are severely blind or deaf within the hospital. One nurse suggested there might be a sign language translator but was unsure if this would be organised via the usual translation arrangements.
- A range of leaflets were available throughout the medical wards for example information about cancer counselling, hand hygiene and falls. All leaflets we saw during our inspections were in English and staff were unsure if literature was available in other languages.
- A translation service was available for all patients if required and ward staff booked this when needed. Staff told us a range of languages was available and translators could be obtained at short notice if needed.
- Bariatric equipment was obtained on a hired basis and staff were aware of how to obtain these items. We saw evidence of staff discussing the need for bariatric equipment during a board round on 8 East.
- A variety of food was available to meet people's individual needs. This included special dietary needs such as gluten intolerance, Halal meat, kosher meals, Asian food and vegetarian options.
- Access to an alcohol liaison nurse was available for patients within the hospital. We saw evidence this nurse was contacted for patients on the acute admissions unit (8 North) and hepatology ward (10 North).
- Access to a psychiatric liaison team was available for patients within the hospital. Staff told us this team would be contacted for any patients with specific mental health needs, including delirium.
- Staff told us patients approaching end of life were moved to a side room if possible. They told us this allowed a more peaceful and dignified death. Staff also said that using a side room would allow relatives to stay with the patient for longer before and after they died.

Access and flow

- Four bed and site management meetings took place each day (8:45am, 12pm, 3:30pm and 5:30pm) to discuss patient flow into and out of the hospital. Representatives from each ward as well as more senior hospital management such as clinical directors attended these meetings. Any available beds as well as patients who need admission, awaiting discharge or on outlying wards were identified. From this information, the site management team decided which patients should be admitted to each ward and supported the discharge of patients to make more beds available.
- There were two patient flow coordinators who assisted with patient movement throughout the hospital. This involved liaising with families, organising care packages and collecting TTAs to accelerate safe patient discharges.
- The hospital at night team were responsible for patient movement overnight and was made up of two registrar doctors (one based in accident and emergency and one leading the medical wards) and two junior doctors.

Medical care (including older people's care)

- Patients were often admitted to the medical wards after becoming unwell at home and attending the accident and emergency department at the hospital. Patients would either be admitted directly to a ward or to the acute admissions unit (8 North) for further tests and assessment. Staff told us patients should be resident on 8 North for a maximum of 72 hours as they should be admitted to a long stay ward after this. They told us the 72 hour period was frequently extended. Hospital data from between November 2015 and January 2016 showed a mean length of stay of 2.3 days which was within the target timeframe although there were 238 (11%) of patients who stayed for longer than 72 hours, including one patient who was documented as staying for on the unit for longer than one year.
- On the renal unit (10 East), attempts were made to keep one 'emergency' bed free in case a patient in the community deteriorated and needed urgent admission for renal replacement therapy. Staff told us it was difficult to keep a free bed for this purpose due to the pressure on the trust for beds.
- Referral to treatment times (RTT) within 18 weeks were consistently above 90% in all specialities other than dermatology which was 87% within the RTT in October 2015.
- In September 2015, hospital data showed that 308 patients (40% of medical patients) were cared for on a ward dedicated to a different speciality than the one they required (known as medical outlier patients). This proportion was similar to data from previous months (37.8% in August 2015 and 38% in July 2015). There were high proportions of medical outliers for stroke medicine, neurology, infectious disease and clinical oncology. Additionally, 30% of geriatric patients and 36% of general medical patients were outliers.
- Between November 2014 and October 2015, most patients (72%) were not moved between different wards during their admission at Royal Free Hospital. Some patients (15%) were moved once and a small proportion (7%) were moved twice. 5% of patients were moved three or more times during their admission. This amount of wards moves was in line with the trust average.
- Between May 2015 and January 2016, there were 957 medical patients who moved wards after 10pm. Most of these were general medicine (27%), cardiology (19%), geriatric (18%) or medical oncology (14%) patients.
- Average length of stay across the general medical patients was 4 days in October 2015; this was in line with data supplied for previous months.
- Patients were booked to receive endoscopies by a dedicated administrator who liaised with medical consultants after their outpatient reviews. This administrator was also responsible for booking follow up appointments so patients could receive the results of their endoscopy in clinic with the consultant.
- Patients from across the country could access the HLIU via a telephone referral to the on duty infectious diseases consultant. Staff told us there were specific admission criteria for different conditions, for example a confirmed positive swab was required for patients referred with Ebola.
- Hospital data showed 496 medical patients were discharged out of hours between August 2015 and January 2016; this represented 5% of all medical patients discharged in this timeframe. The trust raised concerns regarding this data as they told us many discharges were not processed at the actual time patients were discharged. They felt it was more likely to be completed when staff got the opportunity to complete the necessary online tasks and this was usually out of hours due to reduced demand for patient care tasks. Staff on the wards told us the ward clerk was responsible for discharging patients on the computer system when they were discharged in daytime hours and so this information did not corroborate the trust's concerns.
- A discharge lounge was used to accommodate medically stable and independent patients while waiting for TTAs or transport prior to their discharge home. This allowed ward beds to become free more quickly.
- During a board round, we observed staff change an estimated discharge date because the date specified was a Saturday. When we raised this with staff, they told us they usually discharged patients starting a new care package or being discharged to a nursing home on a weekday rather than a weekend as the discharge "tends

to go more smoothly". Staff told us care packages were more likely to be unreliable over a weekend and not all nursing homes could staff their beds appropriately at late notice on a weekend.

Learning from complaints and concerns

- Data provided by the hospital showed there were 93 formal complaints made within the medical services between December 2014 and November 2015. The wards with the highest numbers of complaints were 6 South (8), 9 North (7) and 8 North (7). There were no clear trends to the complaints made in each area or across the medical services. We saw evidence of written complaint responses that contained apologies, investigation details and evidence of learning points where appropriate.
- One patient described raising an informal complaint with a staff nurse on 10 South. The nurse apologised immediately and did her best to rectify the issue. The ward manager then followed the issue up the following day to ensure the patient was happy and the situation had been rectified. An example of an informal complaint provided by a patient on 8 East demonstrated further management of informal complaints at ward level.

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 Hampstead site was under two divisions within the trust structure; the urgent care division and transplant and specialist services (TASS) division. Urgent care included cardiology, elderly and frailty medicine and acute, respiratory, neurology and stroke medicine. The TASS division included nephrology, medical oncology, haematology and infectious diseases. Within these divisions, care was led by five clinical directors and supported by clinical lead consultants. Each division had a head of nursing who was supported by matrons and ward managers in providing nursing leadership. Operational management was provided by senior operations managers, assistant operations managers and service managers for each clinical stream.

We rated the leadership of medical services as Good because;

- The service was led by experienced clinicians with autonomy in decision making and a clear strategy for the service in place.
- The leadership team identified the need to meet the needs of the patient population by developing the care provided for people living with dementia. Managers recognised the potential issues around patient discharge and flow and a review was underway to modify the patient pathway. We identified examples of service development and innovative practice, particularly in the HLIU.
- There were suitable governance arrangements in place and evidence of engagement with the public and staff members. There was a positive culture across the medical service and ward staff told us they were valued by visible and approachable management staff.

However;

- Some actions listed on the risk registers to address issues identified simply mitigated the risk, rather than addressing the cause.

Vision and strategy for this service

- A discharge and flow strategy was launched by the trust as part of the five year transformation strategy. There were four work streams relating to different stages of the patient pathway identified, for example admission, inpatient stay and discharge planning. Ward staff were aware of the aim to develop patient discharge strategies and acknowledged the patient flow coordinators as having a key role in achieving the relevant goals. Staff were also able to identify their own personal contribution to this strategy.
- The trust identified 24/7 working as an integral part of its quality strategy and staff within medical care were aware of this. Ward staff felt they already provided a full 24/7 service and so failed to engage in this as a trust-wide aim. Senior staff told us there were certain limitations to a full seven-day service that included aspects out of the trust's control, for example availability of new care packages over weekends.
- Senior staff described a desire to increase the availability of therapy staff over the weekends to accelerate patient rehabilitation during their inpatient

stay and improve flow through the hospital. They acknowledged that financial implications would limit this vision from developing further at present. 6 North was the only ward which demonstrated mitigation for lack of therapist availability through their multi-disciplinary "sitting out" list.

- 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 however staff we spoke with were not aware of this aim.

Governance, risk management and quality measurement

- Monthly governance reports were created within each area, such as stroke and neurology, where serious incidents were identified and learning points discussed. Trends in incidents were highlighted and discussion regarding duty of candour also took place. FFT results, compliments and complaints, the risk register and quality audits were also covered.
- We saw evidence of speciality meetings which were attended by various members of the multidisciplinary team and representatives from different clinical areas. Items discussed covered a range of governance and quality issues such as risks, serious incidents, complaints, infection prevention and control issues, clinical audit and FFT results. Minutes demonstrated constructive discussions and action points identified along with an allocated responsible person for the acute medicine meetings, however HSEP meetings appeared less thorough.
- 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.
- Mortality within the trust was monitored using 'Dr Foster' comparability tools.
- Deaths of elderly patients were audited and learning points such as communication issues and completion of death notes were identified as areas for improvement.
- Staff told us work was in place to harmonise some policies and procedures so they were used trust-wide rather than having site-specific policies. Senior staff felt having a "trust approach" would improve governance around specific activities and encourage cross site learning. Some cross site meetings already took place for certain departments, such as heart failure service at the Royal Free and Barnet sites, where complex cases were discussed and joint action plans identified.
- We saw evidence of speciality and divisional level risk registers which mainly reflected our inspection findings. Although it was usually clear what risks were being recorded and when these risks needed reviewing, it was not always explicit what was being done to address the risk identified. For example, one risk listed was "difficult to locate information within the clinical record, in part due to notes appear to be filed randomly", however the controls identified were "request physical notes" and "find clinical information by looking at alternative sources of information eg discharge summaries". Neither of these actions addressed the source of the risk identified.
- One member of the management team told us items on the risk register were no longer considered to be a concern because it was "on [their] radar".
- We saw evidence of trust-wide and site-specific audit programmes for the medical services however it was unclear when some audits were due to be completed and who was accountable, for example the TB cohort audit.
- Senior staff were able to identify learning and resultant changes to policies or procedures as a result of clinical incidents, for example a change to handover procedure between therapists and nursing staff after a patient fell during a transfer between their wheelchair and bed.
- Monthly staff meetings were held on wards and governance information such as dissemination of learning from incidents was passed on to ward staff. Some senior staff acknowledged the need to improve dissemination of information to ward staff.
- To address vacancies across the medical services, the service had introduced a direct student recruitment initiative where students who completed and passed clinical placements within the hospital would be automatically offered a permanent position. Staff told us this had been successful and a number of ex-students were due to start permanent positions later on in the year.

Medical care (including older people's care)

- Electronic rostering was being rolled out across the medical wards. The rostering package would enable a real-time review of the acuity and dependency of patients on each ward on a shift-by-shift basis, allowing for continual assessment of nursing needs. Staff told us this would help ensure the right numbers of staff were in the right places to meet patients' needs.

Leadership of service

- A recent change to make the trust a clinically led organisation provided the medical services leadership team opportunities to develop their services strategically and with greater autonomy, rather than receiving top down decisions.
- Senior staff within the medical service told us trust level management were very responsive to the views and concerns of clinicians working within each area. They told us the trust management was also proactive in seeking ideas from senior clinicians for service and trust-wide development.
- Ward staff were complimentary about the leadership of the medical services, from ward management level to clinical directors. Staff knew who their leadership were and where they fitted within the organisation as a whole.
- Staff told us the leadership team were often seen on the wards and were approachable for problem solving or sharing ideas. They told us the leadership team made them feel valued and appreciated the work they did. Staff told us there were good support mechanisms within the medical services management structure and they would feel comfortable speaking to various managers if their immediate manager was not available.

Culture within the service

- Consultants told us the level of peer support was "fantastic" and that there was always someone to speak to for advice and guidance. They felt comfortable approaching the clinical directors with service development ideas and believed their contributions were appreciated.
- We observed staff treated each other with respect and valued the opinions of their peers. We noted constructive challenge and negotiations during board rounds that were completed in a relaxed yet professional manner. Some patients reported "bickering" amongst ward staff however this was not observed during our inspection.
- Staff told us they mainly enjoyed their work and the opportunities for development they had. Some staff told us they felt they would be able to perform their jobs better if they had more staff on shift with them to share the workload but acknowledged the difficulties associated with this request.
- Sickness rates across the medical wards for nursing and medical staff were low, ranging from 0% to 3.6%. This was lower than the average sickness rate for nursing and medical staff nationwide.

Public and staff engagement

- An online patient forum was available for hepatology patients receiving care within the trust. The forum was created to allow patients opportunities to feedback about their experiences and to support one another throughout their treatment.
- Wards displayed "you said, we did" notice boards which highlighted negative feedback from patients and the actions taken to address the feedback.
- There was some evidence of staff engagement in the development of services. For example staff were involved in creating a "hub and spoke" model of care for liver transplant patients in collaboration with colleagues from Exeter, Bristol and Portsmouth hospitals.
- Staff were engaged in the development of the 8 East refurbishment. Building plans were available within the treatment room and staff were encouraged to annotate the plans with their suggestions and concerns. Staff told us they were confident that the newly refurbished ward would meet the needs of patients and "make life easier" for staff due to the more intuitive layout.
- Junior medical staff described raising a concern with their consultant about their lack of inclusion in weekly admission planning meetings within their specialty. They told us their comments were taken on board immediately and three days later a decision to modify the planning meeting to enabled their attendance had been made.

Innovation, improvement and sustainability

Medical care (including older people's care)

- Use of the HLIU patient pods meant staff identified shortcomings in the set up they were currently using and they adapted the pod each time a patient was discharged. This meant there were significant changes to the pod design to facilitate staff completing patient care tasks and interventions. For example a section of the pod was designed to allow an x-ray machine to be used on the contained patient without breaking the airtight seal and a physiotherapy area was built in for use when the patient was ready to start exercising.
- High level PPE was designed by staff working within the HLIU. This PPE was approved by Public Health England and made to be nationwide policy when caring for patients with highly contagious conditions.
- In 2015, the staff working within HLIU were given an award of recognition from the Nursing Times to acknowledge their work with three patients with Ebola.
- The consultant team working within the hepatology speciality were an integrated clinical and academic team who worked closely with NICE to develop clinical guidelines based on evidence-based practice.
- Staff on 10 West (cardiology) and CCU produced an information film for patients. The film answered some commonly asked questions about certain cardiac procedures.
- Plans for refurbishment were in place for some ward areas and we saw evidence of forward planning with regards to relocating patients affected by the refurbishment. For example 8 East was due to commence refurbishment in March 2016 and staff explained plans to relocate the ward temporarily to 6 East during the building works.
- Managerial staff from the urgent care and TASS divisions identified the main upcoming challenge to be faced by the service as being the introduction of a full seven day service within the hospital. They felt that recruiting the additional staffing this would require would pose a challenge and that reliance on agency staff would increase. They anticipated this would pose additional financial pressure on the service.

Surgery

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

Information about the service

Surgical services are managed by two divisions: surgery and associated services and transplant and specialist services (TASS).The trust provides a wide range of emergency and elective surgical services to the population of North Central London and Hertfordshire and specialist services to a wider catchment area.

According to trust data, the Royal Free Hospital is in the top 10% of acute trusts in England for number of surgical spells (60,461 in from July 2014 to June 2015). In addition, the Royal Free hospital is in the top 10% of acute trusts relating to the number of surgical admissions.

The Royal Free Hospital performed 66,841 surgical procedures during 2015.

Emergency, elective and day surgery is carried out at the Royal Free Hospital. The trust's anaesthetic departments are responsible for anaesthetic services across all sites.

The Royal Free Hospital is a national tertiary referral centre for complex aortic (the main artery of the circulatory system) disease specialising in endovascular (inside blood vessels) and open surgery for aneurysms (an excessive localised swelling of the wall of an artery) in addition to aortic dissection (a tear in the wall of the artery). The hospital offers a 24 hour vascular service at consultant level for all vascular and radiological emergencies.

Surgical services include breast, colorectal, ear nose and throat (ENT), gynaecology, hepatobiliary, liver transplant, ophthalmology, oral and maxillofacial, plastic and reconstructive, renal (including renal transplant), trauma and orthopaedics, urology and vascular.

Many of the trust's surgical services operate on a hub and spoke model (a network that is centralized and integrated), for example ophthalmology, plastics and vascular. There are five surgical adult inpatient wards in surgical and associated services at The Royal Free Hospital. TASS Division has two dedicated surgical adult inpatient wards. There are also a further two wards for transplant patients.

The Royal Free Hospital has 19 operating theatres including three day case theatres with associated areas for anaesthetics and recovery within the main theatre suite.

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

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

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

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

Surgery

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

Summary of findings

Overall, we rated surgery at the Royal Free Hospital as good because;

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

Departments performed frequent audits such as the theatre checklist and hand hygiene. Audits were analysed and the results cascaded to staff through staff meetings, notice boards and safety briefings.

The trust promoted and encouraged both local and national innovations to improve patient care and treatment.

The trust provided evidenced based care and generally adhered to national and best practice guidance.

The general environment was visibly clean and a safe place to care for surgical patients. We spoke to domestic staff who took pride in keeping their areas clean, they felt part of the team and we saw up to date cleaning schedules.

We saw emergency equipment and medicines were appropriately stored and checked in line with protocols.

We spoke with 30 members of staff who were passionate about working at the hospital and showed pride in their work. All staff said they felt supported and senior staff were visible.

All staff except one (recently started at hospital) we spoke to had undergone an appraisal in the last 12 months and had development opportunities.

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

There was an appropriate system of governance in surgical care services and arrangements to monitor performance and quality.

We found there were arrangements to ensure that staff were competent and confident to look after patients. All staff had competency documents.

Surgery

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

An interpreting service was available for both in-patients and out-patients within the hospital.

Arrangements were in place to support people with disabilities and cognitive impairments. However there was no electronic flagging system currently in place but a business case has been submitted for such a system.

There was an appropriate system of governance in surgical care services and arrangements to monitor performance and quality.

The surgery division kept an up-to-date and accurate risk register. The senior staff we interviewed were aware of items on the risk register and were able to explain how the risks were mitigated.

Are surgery services safe?

Good

We rated the surgical services at The Royal Free Hospital as Good because;

- Clinical safety was monitored throughout the service such as infection control, slips, trips and falls and manual handling.
- This included the five steps to safer surgery and the World Health Organization's (WHO) procedures for safely managing each stage of a patient's journey from ward through to anaesthetic, operating room and recovery.
- Regular audits were undertaken on compliance with the five steps to safer surgery, the latest WHO audit demonstrated 100% compliance in step 2, 90% compliance in step 3 and 100% compliance in step 4.
- Steps 1 and 5 was audited recently and data was unavailable at time of inspection, however we observed mandatory elements of the checklist.
- The theatre department had recently re-launched the WHO checklist following the occurrence of three never events which happened between January 2015 and December 2015.
- There was sufficient emergency resuscitation equipment available and we saw evidence of equipment checks.
- The trust used a combination of recognised tools to help ascertain safe nurse staffing levels within the surgical wards and theatre department
- Environmental safety was assured through regular monitoring and on-going checking of issues such as infection control, equipment and facilities.
- Identified concerns were closely monitored and actions taken to mitigate the risks to patients. For example, consistently staffing theatres to the required establishment was an acknowledged concern.
- Matrons discussed staffing levels at regular site meetings where the staffing level statistics were updated throughout the day.
- Although the majority of the surgical records and medical notes we reviewed were completed well, they did not always meet best practice, for example in the recording of risk assessments. It was noted by the inspection team there was a vast amount of paperwork to be completed and this may hinder completion.

- It was noted there was no specific surgical pathway documentation, a variety of separate assessments and documents was used instead.

Incidents

- Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There was three never events in theatres reported at the Royal Free Hospital site between December 2014 and November 2015, and one recorded never event at the Chase Farm site. These included a retained wire following a surgical procedure (June 2015),a retained needle post-surgical procedure (August 2015), and a retained swab post-surgical procedure (November 2015).
- There was an action plan in place to prevent similar incidents happening again and we saw evidence of an ongoing patient safety programme aimed to improve the five steps of safer surgery. The aim of the programme is to achieve zero harm from perioperative care by July 2016. The programme was launched in response to the three never events and the WHO checklist was re-launched across the organisation.
- We saw evidence of this programme in practice such as a new swab, needle and instrument policy awaiting ratification and radiographers checked laterality on consent forms. However, the inspection team observed that x-rays were not displayed during an operation, which involved laterality.
- As part of this programme, theatre staff were participating in an 'away day' programme to improve patient safety and reduce risks. There was significant work led by a consultant anaesthetist taking place in relation to WHO processes and improve communication within theatres. Staff said they were trying to improve culture in 'buy in' of the WHO and five steps of safer surgery and this was being audited.
- We observed a number of initiatives to improve the compliance with the WHO checklist such as the Stop, Quiet ,Listen, Please campaign. We saw posters displayed throughout the suite in an effort to raise awareness with staff of the importance of the team briefing prior to the start of an operating list and debriefing at the end of the list.
- A running debrief system was also being trialled, where positive and negative issues were recorded during the day by the whole team to ensure continuous learning. This was being audited by members of the patient safety team within theatres.
- Work was also undertaken to put greater importance and awareness on swab, needle and instrument counts and empowering staff to speak up when inaccuracies happened.
- We observed 'Time Out'counts in use and surgeons checked swab counts before proceeding to the closure of cavities and tissue layers.
- We were provided with a copy of the 'five steps to safer surgery' bulletin circulated to staff in January 2016. This provided shared learning from never events and changes in practice. We saw this policy in use and a vigorous checking process, prior to implantation of prosthesis.
- It is mandatory for NHS trusts to monitor and report all patient safety incidents through the National Reporting and Learning System (NRLS). If an incident is assessed as a serious incident it is also reported using StEIS (Strategic Executive Information System). Serious incidents can include but are not limited to patient safety incidents: for example loss of confidential information. Any serious incident which meets the definition of a patient safety incident should be reported to both StEIS and NRLS.
- Surgery reported 1,593 incidents between January 2015 – December 2015, 73.5% of incidents reported in surgery resulted in no harm.
- Patient accidents were the most commonly reported category of incident, accounting for 23% of incidents. However 74% of these incidents resulted in no harm and none of these resulted in severe harm or death.
- It appeared the timeliness of incident reporting had improved over the reporting period. All the incidents in September 2015 and all but one of the incidents in October 2015 were reported within 90 days. In November 2015a ll incidents were reported within 60 days.
- Surgery had the third highest number of incidents of any core service: 1,593 incidents which were about 17% of all incidents. There were three incidents resulting in death, and 11 resulting in severe harm.
- Trust policy stated that incidents should be reported through a commercial software system enabling

incident reports to be submitted from wards and departments. All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system.
- Staff described the process for reporting incidents and told us they were encouraged and felt comfortable using the system. They told us they received feedback which was disseminated by email, monthly ward meetings and safety briefings.
- We saw a root cause analysis (RCA) was completed as part of the investigation of incidents. Lessons learned from incidents were shared across teams.
- There was 10 SI's in surgery at the Royal Free Hospital between January 2015 – December 2015 and two of these were classed as never events. There was one other relating to surgical/invasive procedure and two grade three pressure ulcers.
- Learning from incidents across the trust was fed back to staff and had led to changes in practice to ensure patient safety.

We saw minutes of regular staff meetings, which contained evidence of discussing risks with the top three risks listed each month.

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.
- The trust did not require staff to attend specific training in relation to Duty of Candour (DoC), as the trust considered the Being Open policy was well understood and embedded, and the Duty of Candour merely enshrines these principles in law.
- However, the trust clarified DoC requirements within the DoC Policy and provided additional training in both an ad hoc context and specifically within a training programme lead by Head of Legal Services. The trust hadprovided three sessions in the training programme and 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 was accessible to staff.
- We saw that staff, patients and relatives were supported and informed of the outcome in accordance with the trust's Duty of Candour.
- The service kept appropriate records of incidents that had triggered a Duty of Candour response.
- While staff did not always understand the terminology, the process they described in communicating with patients and their relatives reflected openness and transparency.
- We spoke with consultants, managers and clinical staff who told us about the clinical governance, risk and mortality and morbidity (M&M) meetings, which were held monthly by directorate and were used to discuss any learning from incidents. Minutes of the M&M meetings were provided, which evidenced to us the learning from recent incidents.
- Staff in theatres told us when things went wrong it was used for learning and they were not shouted at. Staff were undergoing assertiveness training as part of improving the reporting and safety culture.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins). We found that the NHS Safety Thermometer information was available on all of the surgical wards we inspected.
- We saw evidence that safety thermometer data was routinely used to improve the quality of care. For example, the numbers of days since last infections and falls was clearly displayed in each area.
- We noted that the Patient Safety Thermometer data was discussed at the ward meetings and safety briefings.

Cleanliness, infection control and hygiene

- For 2015 - 2016 the trust had a limit of zero Methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus(MSSA) cases and 66 Clostridium difficile cases (infections per 10,000 bed days) for the twelve month period. As of 3rd February 2016, the trust was on course to meet all three limits. There had been three MRSA cases, none of which were attributable to surgery, 17 MSSA cases, three of which were attributable to surgery, and 54 Clostridium difficile cases, 54 of which were attributable to surgery.

Surgery

- There were infection prevention and control policies and procedures in place that were readily available to staff on the trust's intranet. We found the surgical wards and theatre department to be adhering to national infection control guidance.
- Infection prevention and control was included in the trust's mandatory training programme. Staff we spoke with all confirmed they had completed this training.
- 86% of staff had completed level one infection control training. The theatre team had a theatre specific level 2 infection control training, 70% had completed the level two training.
- We saw a high standard of cleanliness in all the areas that we visited.
- There were designated staff in wards and departments with infection control responsibilities. The hospital had a dedicated infection control team.
- We saw regular infection prevention and control audits took place in order to ensure all staff were compliant with the trust's policies such as hand hygiene and the use of personal protective equipment (PPE).
- Monthly hand hygiene audit results were displayed on notice boards within wards.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected.
- The 'bare below the elbows' policy was adhered to and PPE such as disposable gloves and aprons were readily available in all areas.
- Equipment was marked with a sticker when it had been cleaned and ready for use.
- We saw that the cleaning of commodes was a standard practice every morning and we also saw evidence of commode cleaning audits.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients.
- Cleaning equipment was colour-coded and used appropriately; we saw evidence of cleaning rotas and checklists.
- A member of domestic staff said she enjoyed working on the ward and that she loved talking with the patients and she tried to make their bed and surrounding area feel like it was their home.
- The trust monitored the use of antibiotics with regular audits. The last audit in September 2015 showed a compliance of 66% against six prescribing quality criteria.
- Decontamination and sterilisation of instruments was managed in a dedicated facility on site which was compliant with the EU Sterile Services Medical Devices Directive
- The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, wards, clinics and departments.
- Staff said there was a good working relationship with this facility.
- Audits took place to monitor standards of practice in relation to national infection control guidelines and to improve patient outcome related to surgical site infections.
- The service had a waste management policy, which was monitored through regular environmental audits.
- 83% of staff had completed waste management training.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- We noticed that although sharp safe cannulas (a thin tube inserted into a vein) were being used sharp safe hypodermic needles (hollow needle) were not being used.
- We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely, with posters displaying 'Your five moments for sharp disposal' and how to use sharpsmart containers.
- We noticed posters and information cards explaining waste segregation procedures and waste segregation instructions.
- Linen cupboards were clean and tidy with bed linen managed in accordance with best practices.
- The Royal Free hospital participated in mandatory surgical site infection surveillance for hip and knee replacements and patients suffering from fractured neck of femur.

Environment and equipment

- The Royal Free Hospital performed better than the England averages for the Patient-Led Assessments of the Care Environment (PLACE) from 2013 to 2015.

Surgery

- Surgical services had a comprehensive equipment record which allowed for the monitoring of equipment in addition the service provided evidence of an equipment replacement programme.
- We saw that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that it had been inspected and was safe to use.
- All equipment checked by the inspection team had up to date PAT labels.
- The inspection team noted signage within theatres could be improved, for example, signs indicating where emergency equipment was located.
- Medical gas cylinders should be kept in a purpose built cylinder store that should allow the cylinders to be kept dry and in a clean condition.
- We saw a purpose built cylinder storage was in construction within theatres.
- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate log books being kept and we saw evidence of these.
- The inspection team saw that log books had absent signatures on a number of days, staff confirmed the anaesthetic machines were in use on these days.
- We saw theatres and anaesthetic rooms were generally well organised, clutter free and single use items such as syringes and needles were readily available.
- Theatres had two 'Difficult Airway' trollies shared between 14 theatres, which were checked daily by the operating department practitioners
- We found that theatre trollies used for transportation contained emergency airway equipment and oxygen, there was processes in place to ensure these were checked daily.
- We saw that the lifts used to transport patients after surgery contained emergency equipment. The equipment was checked daily and recorded within the daily checklist completed by the night staff.
- We observed cables in the operating theatre which were not secured to the floor and which could pose a trip hazard.
- We saw that there were no wipe boards within theatres to record swabs, needles and instruments used intraoperatively,increasing the risk of surgical items being accidentally retained during an operation. For example, we observed when a swab was deliberately retained temporarily inside a cavity, a verbal record only was made. The theatre matron informed us that the wipe boards had arrived in the department and were awaiting installation.
- We found that resuscitation equipment stored on the resuscitation trolley was readily available and located in a central position. The trust policy identified the systems to ensure it was checked daily, fully stocked and ready for use. Daily checks should be recorded; we checked five different trollies and found all had been completed in line with policy.
- The staff we spoke with confirmed they had access to the equipment they required to meet people's care needs. Although wards held their own equipment there was also an equipment library, which staff could access for equipment such as infusion pumps.
- We saw the pre assessment department was extremely busy;11294 patients were seen in pre assessment between May 2015 – December 2015.
- The inspection team found the pre assessment department to be cramped and an inadequate environment.
- We saw that there was only one phone in the department which staff told us caused difficulties.
- There were no toilets with disabled assess.
- We found there were no emergency call bells in interview rooms. Staff told us a member of staff had collapsed in one of these rooms and had difficulty summoning help.
- Staff told us there are no refreshments available for patients, some of whom spent a considerable amount of time in the department.

Medicines

- The trust had a medicines policy which was issued on October 2015
- The medicines and safety group reviewed any medicine management incident that was reported on the trust's electronic reporting system. Themes and trends were identified and any learning shared through safety briefings, staff meetings and the medicines and safety group minutes.
- Latest results of trust wide audit of medicine management showed 100% of drug room doors and 100% fridge doors were locked and 100% of temperatures were recorded. Also, 100% drug cupboards and 85% intravenous fluid rooms were locked.

- We found that medicine cupboards were orderly, neat and tidy
- We saw that robust management controls were in place where drug rooms could only be accessed with a swipe card. Keys to controlled drug cupboards were held by the nurse in charge.
- We saw areas such as outside side rooms lockers which contained the patients own medication were secure.
- Staff told us drug stocks were checked weekly by pharmacy but not documented.
- We looked at controlled drugs (CD) (medicines liable to be mis-used and requiring special management) in wards and theatres. We checked order records and CD registers and found these to be in order. We saw evidence that ward staff checked stock balances of CDs daily.
- We saw that medicines were stored in dedicated medicines fridges when applicable.
- We noted the temperature monitoring devices were integral to the drug fridges and saw that daily records were correctly kept in folders. We noted one of the medicine rooms had a small 'traceable thermometer' affixed to the wall, however neither the ward nurse or ward pharmacist knew its function.
- We observed out of date needles stored in a plastic tray in the medicines stock room. Other sizes of needles were correctly stored in their original boxes.
- We reviewed 13 prescription charts and found them to be legible and completed appropriately. Patient allergies had been clearly noted on charts and on their identity band. The 13 charts we reviewed demonstrated that prescribing was in line with national guidance and that all were compliant with the National Institute for Health and Care Excellence (NICE) VTE guidance with a section in the front of the chart confirming a completed VTE assessment and that prophylaxis had been prescribed and administered.
- We saw a satellite pharmacy unit on one of the surgical wards, staff told us this provided support to the wards and helped with supplying patient medication on discharge. Staff told us this made discharging patients quicker and easier than using the main hospital pharmacy department.
- The satellite pharmacy is open until 5.30pm and is closed on weekends.
- Wards were visited daily by a pharmacist during the week.
- Pre packed take home medicines were available on wards to speed up patient discharges out of hours.

Records

- The WHO (World Health Organisation) checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre.
- Since the three never events in theatres the service had reinforced the importance of compliance with the WHO checklist with surgeons, anaesthetists and theatre staff. We were told regular and routine compliance was monitored through audit, peer reviews and feedback from patient safety staff.
- We observed demonstrations of the WHO checklist for each of the elective and emergency surgical procedures undertaken. They followed a standardised accurate approach.
- We found evidence of staff completing WHO checklist documentation when we reviewed patients' notes postoperatively. Staff told us compliance with the checklist was closely monitored and audits of compliance took place on a routine and regular basis. Staff told us there was a sense of checklist ownership to ensure it was fully completed.
- However we saw one postoperative patient's WHO checklist had not been fully completed; the time out section had not been completed.
- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- We looked at 16 medical and nursing records. The wards used a mainly paper based system of recording care and treatment and theatres mainly used an electronic based system which is printed off and placed in the paper notes. Requests for diagnostic procedures were undertaken via an electronic database. Patients were given a paper copy of their discharge summary and a copy was manually sent to their GP.
- We saw standardised pathways were followed for patients who underwent specific operations. These were personalised through individual risk assessments and notes made in the care plans. For example patients undergoing fracture neck of femur operations.

Surgery

- The surgical care pathways included pre-operative assessment such as previous medical history, social history, anaesthetic assessment, input from physiotherapy, discharge planning and allergies together with baseline observations.
- The care records included multidisciplinary input where required, for example, entries made by dieticians, physiotherapy and occupational therapists with referral to specialist advice, such as the dietician and tissue viability nurses.
- The inspection team felt there was a vast amount of paperwork for the nursing staff to complete which was all separate pieces of paper not streamlined into a pathway
- We found lapses in completion the documentation and it was felt by the inspection team that the vast amount of paperwork hindered completion.
- We observed that nursing staff did not record their grade when they signed documents. In general, medical records were accurate and fit for purpose and completed to a good standard.
- We reviewed the local guidelines related to assessments which were laminated to the top of a notes trolley was written in 2011 and may require review. For example the policy stated that a falls assessment only needed to be completed weekly, the inspection team felt this maybe too infrequent.
- Staff told us they carried out documentation audits which highlighted areas for improvement. Staff told us documentation completion was now discussed as part of the safety briefing to raise awareness.
- We saw photographs of a patient's pressure areas within the notes where no consent could be identified within the notes for these photos. We informed the nurse in charge who said she would ensure the correct action was taken.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on the trust local internet. We saw that staff found the policy easily and quickly.
- There were safeguarding leads in the hospital who acted as a resource for staff and linked in with the trust's safeguarding team.
- Safeguarding training was included in the trust's mandatory training programme.
- 80% of staff had completed level one adult safeguarding training and 87% of staff had completed level two adult safeguarding training.
- Staff we spoke with confirmed they had received safeguarding training as part of mandatory training. They told us they would report their concerns to the nurse in charge and contact the safeguarding team if needed. They were aware of the safeguarding policy and how to access it.
- Staff told us they received good support from the safeguarding team, there was a single point of referral and referrals were dealt with promptly.

Mandatory training

- Mandatory training was monitored and all staff were expected to attend on an annual basis.
- Staff told us mandatory training was a mixture of on-line training and face to face training and was always completed in work time.
- Mandatory training was monitored and compliance discussed during appraisal.
- Monitoring and compliance were managed by a computer database and staff told us that they received emails when training was due for completion.
- Staff told us there was a time lag between completion of training and the computer database and this sometimes affected overall percentage compliance.
- Staff told us that the clinical educators and ward managers supported staff in giving protected time to complete on line training away from the clinical setting usually in the library.
- We spoke with doctors of all grades; they told us mandatory training, such as safeguarding and infection control, was available.
- Junior doctors told us the induction programme was extensive and included mandatory training updates.
- Junior doctors told us consent training was mandatory for every doctor undertaking operations.

Assessing and responding to patient risk

- The trust was in the process of aligning physiological scoring systems, and was operating two separate systems at time of inspection.
- The Royal Free Hospital used early warning system (EWS) used single triggers rather than a cumulative score. The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support.

- The algorithm when a patient triggered was first to alert the nurse in charge and refer to the junior ward doctors. If response was delayed or the patient was not responding the next stage of the algorithm was to contact the risk and resuscitation team and the patient's registrar and the outreach team.
- The hospital carried out a review on the use of EWS .The wards reviewed were selected based on acuity of patients and gave a representative sample of hospital specialities.
- 238 patients reviewed, 10 (4%) were triggering at the time of review. All had been escalated and reviewed in a timely fashion. One patient was identified who had not had observations checked for 12 hours.
- Nursing staff told us medical support was readily available when required as the surgical team and consultants attended to patients quickly when required.
- We saw the situation, background, action, recommendation (SBAR) tool in use when patients were referred to other services.
- Daily operational meetings with representation from surgery took place. This ensured early escalation and early resolution.
- At the Royal Free hospital the day surgery service was provided in a 23 hour unit
- There were two incidents in November 2015 where patients were nursed overnight in recovery in periods of high bed demand.
- Staff we spoke with were unaware of whether there was an operational policy which identified patients suitable for the environment. Staff told us on average one or two patients a month are nursed in recovery overnight.
- Local preoperative assessment policies should ensure pregnancy status was checked within the immediate preoperative period in accordance with NICE guidelines. The check should be recorded on preoperative documentation used by staff performing final clinical and identity checks before surgical intervention. We observed evidence of this guideline being used in practice.
- We saw patients generally had a VTE assessment completed and patients undergoing surgery wore anti-embolic stockings.
- There were daily handovers, one at the beginning of the day and the other towards the end of the day. We observed two nursing handovers which were well organised and comprehensive. The handovers took place in the staff room in order to minimise interruptions and a qualified member of staff supervised the ward during the handover.
- At the end of handover a safety briefing checklist was used which identified patients with infections, medication, sick patients, patients at risk of falls, patients identified as potential absconders, same name patients, patients not for resuscitation, hand hygiene, pressure areas, cannula care, documentation assessments and care plans. We judged this to be a well imbedded practice throughout the surgical wards.
- We observed a medical hand over which was undertaken in an adequate environment, blood results were checked simultaneously whilst each patient was discussed. Inspection staff saw one handover which was not very interactive, with no nursing input and no formal review of patients with consultant after handover.
- Staff in theatres told us that regular scenario training was undertaken in relation to clinical emergencies.

Nursing staffing

- The sickness absence rate for nursing and midwifery at the Royal Free Hospital was 6% between January 2012 – May 2015 which was higher than the trust target of 3%
- The vacancy rate at the Royal Free Hospital was 21% within nursing and midwifery. The largest vacancy were within lower gastrointestinal surgery (43%).
- There were significant staffing vacancies within the operating department. There was a high usage of agency operating department practitioners (ODPs) within anaesthetics, which was consistent with other London hospitals.
- We reviewed staff rota's and observed that vacant shifts were covered with the appropriately trained staff bank or agency staff.
- Managers told us there was a problem recruiting due to competition with the other London hospitals. We were assured there was an innovative and active recruitment programme in place. An example of this was that every student nurse seconded to the trust had direct entry to a band 5 position on qualification. There was a variety of schemes to encourage retention of staff which included discounted gym membership and assistance with accommodation and travel loans.
- Hospital wide in November 2015 out of a minimum of 3000 shifts there were 9 (0.3%) reported occasions

where the registered nurse: patient ratio fell below 1:8 on a day shift or 1:10 on a night shift. There was one reported night shift where one registered nurse was on duty supported by nursing assistants.
- There were no reported patient safety incidents associated with these incidents.
- 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. Theatres did not display staffing guidelines but inspection staff saw evidence from staffing rotas and allocations that the guidelines where adhered to.
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients. We saw a safe staffing board that demonstrated planned staffing met actual staff ratios for each.
- All wards had planned v actual staffing displayed.
- The nurse to patient ratios were monitored and the trust supplied data which demonstrated that safer staffing rules were adhered to.
- The staff and patients we spoke with said there were enough nurses to provide safe compassionate care.
- Staff told us that understaffing would be reported on the trust's electronic incident reporting system.
- Agency staff usage was monitored on a monthly basis.

Medical staffing

- Within medical and dental staffing the vacancy rate at the Royal Free Hospital was - 3.6%.
- Proportions of consultants and junior doctors were both similar to the England averages.
- General surgery had a consultant on site Monday – Friday 8am – 8pm and a 2nd consultant on site 8am - 1pm Monday-Friday. Consultants were on call and non-resident after 8pm. There was a middle grade doctor and junior doctor on site 24/7.
- Trauma and orthopaedic surgery had a consultant on site Monday – Friday 8am – 8pm who also had elective duties. The consultant was on call and non-resident after 8pm.A consultant was on call at weekends with three hours on site on Saturdays and Sundays. There was a middle grade doctor and junior doctor on site every day 8am - 8pm with a Senior House Officer 8am – 11:30pm Monday – Friday and 8am – 8pm on Saturday and Sunday.
- Vascular hub had a surgeon of the week free from all other duties Monday - Friday 8am – 5pm. There were 2 consultants on call from home at night. There is a middle grade doctor freed from all other duties 8am – 8pm Monday - Friday with on call from home at night. A middle grade doctor is non -resident on call at weekends.
- The junior doctors we spoke with during the inspection told us they felt there was enough doctors to meet peoples care needs
- The Royal Free London NHS Foundation Trust submitted 253 revalidation recommendations to the GMC between 1st April 2015 – 27th January 2016.

Major incident awareness and training

- The trust had emergency preparedness, resilience and response policy issued in November 2015.
- Staff told us they did not take part in major incident training as a hospital or with other emergency services or health and social care providers.
- Staff were made aware of the trust's Major Incident Plan which was available on the trust's intranet.
- In theatres we saw action cards displayed as prompts should a major incident be declared.
- Staff in theatres were able to give a good account of what action to take in a major incident.
- Managers on the surgical wards were also able to give an explanation of what action to take in a major incident; however, some staff on wards were unsure what action to take.

Are surgery services effective?

Good

We rated the effectiveness of the service as Good because;

- Patient surgical outcomes were monitored and reviewed through formal national and local audits to ensure care was evidence based and adhered to best practice guidance.
- Supporting information such as trust's policies and guidelines were available to staff via the trust's internet.
- Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes.

- There were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists.
- We found staff had undertaken training to their specific roles and had completed competence assessments, new staff and newly qualified staff were well supported to ensure patient safety. The majority of staff received an annual performance review where their specific learning needs and development were discussed.
- Staff assessed the nutritional needs of patients, and trained volunteers supported patients to eat and drink with the assistance of a red tray system and protected mealtimes. Specialist medical, cultural, vegetarian diets could be catered for.

Evidence-based care and treatment

- Staff were able to access national and local guidelines through the trust's intranet, which was readily available to all staff. Staff demonstrated the ease of accessing the system to look for the current trust guidelines.
- The anaesthetics departments at the Royal Free Hospital was preparing for accreditation with the Royal College of Anaesthetists however, the accreditation had financial implications which were still under discussion.
- There was a range of clinical pathways and protocols for the management and care of various medical and surgical conditions which had been developed in conjunction with healthcare professionals from a range of specialties, for example the sepsis pathway.
- Nursing staff confirmed clinical governance information and changes to policies and procedures and guidance had been cascaded down by the matron and ward manager via emails, communication diaries, team meetings, and safety briefings.
- Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations. For example, patients who underwent surgery for fracture neck of femur (NOF) had their surgery fast tracked.
- Following surgery, patients were nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital.
- Within the theatre, we observed that staff adhered to the (NICE) guidelines CG74 related to surgical site infection prevention and followed recommended practice.
- National clinical audits were completed, such as the national hip fracture database, national emergency laparotomy audit and lung cancer audit.
- The hip fracture audit 2014/15 shows the Royal Free Hospital performed better than the England average for 7 indicators and worse for 2 indicators.
- In the national emergency laparotomy audit the Royal Free Hospital's self-reported data indicated that the provision of facilities required to perform emergency laparotomy was available for 19 out of the 28 measures reported on.
- The facilities not available included an emergency surgical unit (ESU), minimum four tier EGS rota at all times, policy for surgical seniority according to risk, explicit arrangements for review by care of elderly doctor, policy for deferment of elective activity to prioritise emergencies, pathway for enhanced recovery of EGS patients and single pathway for adult EGS patients.
- The trust had mixed results in the patient reported outcomes measures (PROMS) audit when compared to the England average.
- Hip-related PROMs were flagged as an elevated risk and knee-related PROMs as a risk in the May 2015 intelligent monitoring report. These related to comparison measures of function and pain of patients before and after their surgery.
- Royal Free Hospital participated in the bowel cancer audit 2015.The hospital had a good ascertainment rate of 10.9% and generally performed better than the England average.
- The trust took part in the lung cancer audit 2015. The trust met the 95% target for percentage of patients discussed at multi-disciplinary meetings. However, no patients received surgery.
- We observed that in areas where audit indicated a short-fall in service provision, or outcomes, we were aware of action plans in place, along with plans to re-audit in the future.
- Participating hospitals collect data relating to surgical site infections (SSI) for different kinds of surgical procedures over a minimum period of three months. From the data provided, the trust has generally performed better than the England average in surgical site infections in relation to hip replacements, knee replacements and fracture neck of femur operations. It

should be noted however that there were no patient questionnaires completed at this trust and the data has not been adjusted for patient type, which may affect overall results.

Pain relief

- Royal Free Hospital pain management service was nurse led with support from consultant anaesthetists with an interest in pain.
- There was a single point of contact to the pain team. Ward nurses told us pain nurses proactively reviewed patients daily and supported staff in managing patients' pain.
- Wards practiced a nurse rounding system (NRS) which meant checking on patients hourly and monitoring their pain.
- All the patients we spoke with who had recently undergone surgery told us there were no problems in obtaining adequate pain relief.
- Patients told us nurses responded quickly when extra pain relief was required and the effect checked by nurses.
- The staff we spoke with had been trained on the use of patient controlled analgesia (PCA) and epidural pumps, and the pain team provided support with these if required.
- There was no standardised trust wide pain tool and a 0-3 rating was used at the Royal Free Hospital whilst a 0-4 rating was used at Chase Farm. Barnet hospital was trying to standardise pain tools.
- There was four pain nurse specialists at the Royal Free site who would assist with training and giving expert advice where necessary.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of being under nourished.
- Generally the records we reviewed had a nutrition and hydration assessment undertaken.
- Staff advised us there was a quick response rate from dieticians and speech and language therapists (SALT).
- We saw evidence of a referral to the speech and language therapists (SALT)
- A SALT completed the initial swallow assessments on new patients who had swallowing difficulties and then provided advice to nursing staff.
- Specialist nutritional drinks were readily available for patients on enhanced recovery after surgery pathway(ERAS).

Patient outcomes

- Staff understood the National Institute for Health and Care Excellence (NICE) guidelines and stated these were referred to in discussions with staff about patients' care and treatment.
- Staff told us they were able to assess relevant NICE guidelines on the trust's internet.
- Mortality and morbidity trends were monitored monthly through Summary Hospital-level Mortality Indicator (SHIMI) and Hospital Standardised Mortality Ratio (HSMR)
- The Royal Free London was a positive outlier on both measures, a feature consistent across The Royal Free Hospital and Barnet Hospital sites and has been maintained over several years. Site level data was not available at the time of inspection.
- The trust monitored mortality using the Doctor Foster tools. Occasional alerts for disease or procedure codes 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 are taken to the clinical performance committee, a Non-Executive Director (NED) chaired board committee. We have seen evidence of meeting minutes from this committee.
- The service took an active role in clinical audit, with a robust programme of audit activity as well as clear post-audit follow up.
- The trust benchmarked their performance against national comparisons with other NHS trusts such as the national hip fracture database.
- In the fracture of neck femur audit 2015, the Royal Free Hospital performed worse than NHS Trusts in relation to Patients undergoing surgery on the day of or after day of admission, percentage of patients developing pressure ulcers and mean length of acute stay.
- However performance was better in admitted to orthopaedic care within four hours, pre assessment by geriatrician, bone health medication assessment, fall assessment and mean length of stay.
- We saw evidence in theatres that work was undertaken to ensure pressure areas in patients undergoing operations for fracture neck of femurs where thoroughly assessed and protected.

Surgery

- The trust reported low rates of pressure ulcers, falls with harm and catheter acquired urinary infections reported between December 2014 and November 15.
- At trust level, the average length of elective stays for patients was shorter than the England average and was longer than the England average for non-elective stays.
- The risk of readmission for elective and non-elective care was lower than the England average at trust level.
- The trust scored in the bottom 20% for 24 out of the 34 questions in the cancer patient survey 2013/14.
- Bed occupancy rate was lower than the England average from quarter four 2013/14 to quarter two 2015/16
- Theatre utilisation for the Royal Free Hospital was 65% (capped) and 64% (uncapped) for October 2015.
- Managers told us there was a project underway to improve theatre utilisation. One of the factors which affected theatre utilisation was availability of intensive care beds. Since some surgeries took up to 12 hours, if there was no intensive care bed available, the operation was cancelled which had a negative effect on theatre utilisation.

Competent staff

- The trust had in place appropriate job descriptions for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post.
- Staff members registration status was monitored by a local electronic database and managers received emails prior to a staff members registration expiry.
- In addition we saw a central electronic database which contained registration expiry dates of staff.
- Staff also received an email when the registration was due for renewal.
- New employees undertook both corporate and local induction with additional support and training when a need was identified.
- The agencies used to provide staff had been audited to check their compliance against NHS employment standards. This provided assurance that agencies ensured their staff met these standards.
- The hospital tried to use the same agency staff who were familiar with the trust. We saw orientation and induction packs which included training in the use of specialist equipment used.
- We saw evidence of a comprehensive induction programme for agency staff within theatres and the surgical wards.
- Due to the nature of some of the complex equipment in theatres, only regular agency staff were allocated to work within areas with this equipment, after they were trained and were deemed competent.
- Between April 2015 – November 2015 72% of nursing staff had an appraisal completed.
- Learning and development needs were identified during appraisal. Nurses were supported in their learning and development by their managers and practice educators provided department based training and individual support.
- In theatres there were electronic records of individual's equipment training.
- Staff told us the hospital was a good learning environment with access to mandatory training and further development.
- There was a preceptorship programme for all newly qualified band 5 nurses.
- There were leadership programmes available for band 7 and 8 nurses, and development programmes for band 6 and 7 nurses.
- We saw in theatres that a band 7 development programme was recently launched.
- We saw each area had clinical educators who were senior nurses who worked clinically with staff to support training and supervision.
- However a student nurse could not describe the correct phone numbers for reporting fire or a medical emergency.
- Staff told us that clinical educators were an invaluable resource to staff and students.
- 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

- Care planning took place at multidisciplinary team meetings where there was involvement from all members of the team including doctors, nurses and

allied healthcare professionals. We attended a multidisciplinary team meeting and observed positive and proactive engagement between all members of the multidisciplinary team.
- Overall, staff reported good multidisciplinary working with other services within the trust and with external organisations, such as local authorities and general practitioners.
- Staff in theatres and the day surgery unit planning meetings took place to discuss future theatre lists. The units worked closely with the pre-assessment, waiting list teams and service managers to co-ordinate and prioritise the admission of patients.
- On some wards there was a designated discharge co-ordinator who facilitated the discharge of patients and worked with external agencies to ensure timely safe discharges.
- The surgical wards were well supported by additional specialist services such as tissue viability and pain teams, posters with details of how to access the services were displayed. There was good multidisciplinary working with daily physiotherapy and occupational therapist ward rounds.
- We observed a good culture in multidisciplinary working and a good team ethos.

Seven day service

- The trust had identified the 24/7 working scheme as an integral part of its quality strategy. It had undertaken a preliminary self-assessment exercise to review the extent to which services are provided seven days a week in order to help assess the capabilities to provide going forward. 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 was identified that there was a need to clarify, strengthen and harmonise across sites key processes and capabilities that ensured they delivered 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.
- Some specialities, including vascular, operated a consultant of the week model.
- Consultant cover was available for the wards and theatres seven days a week. This meant that consultants were on site from 8:00am to 8.00pm and an on call system operated out of hours and at weekends.
- Staff told us that there was good support from allied health professionals and pharmacy seven days a week.
- The Royal Free Hospital provided no clinical pharmacy at weekends.

Access to information

- We spoke to clinical staff who told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for their patients.
- The Royal Free Hospital had an electronic system for recording the results of patient investigations. Clinicians could view the results from various locations and by remote access
- Staff told us at a focus group there was an issue with the electronic system across the hospital sites with different systems not communicating and being difficult to use. This could compromise patient safety through delay or missed results or diagnosis. They said it took time to log in under personnel logins to obtain results.
- Two junior doctors successfully demonstrated the hospital computer information systems they accessed as part of their role. Once on the system, they said programmes and scanned images loaded quickly. They demonstrated common tasks such as viewing clinic letters and patient notes; x-ray and medical scan images along with reports and laboratory results.
- Staff told us card readers were frequently faulty and we were shown an office containing four terminals, of which two computers "could not be used" as the readers failed.
- Consultants and junior doctors we spoke with told us they felt there was excellent communication between medical and nursing staff.
- There were notice boards around the hospital which gave information for staff about training opportunities, staff meetings minutes, and the results from audits and incidents.

- The trust produced a monthly GP Bulletin in order to ensure effective communication with GP's.
- Patients were given a paper copy of their discharge summary and a copy of this was manually sent to their GP.
- Theatre staff received information at theatre 'briefs' and 'debriefs' as well as at departmental meetings.
- Staff told us most clinical information and guidance was available on the intranet. They had access to information and guidance from specialist nurses, including diabetic, stoma and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.
- The Chief Executive of the trust ran monthly briefing sessions as a way of communicating with staff; these were recorded so staff could access the briefing.
- The Director of Nursing conducted monthly video conference calls with the matrons.
- The departments we inspected had regular monthly meetings and used a communication diary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Training on consent and the Mental Capacity Act 2005 was readily available and 87% of staff had completed MCA and DoL training.
- Staff were able to describe the legislative requirements regarding consent and confirmed that policies and procedures were available to ensure that informed consent was obtained from the appropriate individual.
- Consent was audited and the results of the consent audits were shared during educational study days.
- Patients we spoke with told us they had been given clear information about the benefits and risks of their surgery in a way they could understand prior to signing the consent form.
- Patients were given enough time to ask questions if they were not clear about any aspect of their treatment.
- The consent forms we reviewed identified all possible risks and complications following the procedure. The consent forms we reviewed were fully completed and contained no abbreviations so that patients could easily understand what had been written.
- Staff were aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were able to describe the arrangements that were in place should the legislation need to be applied.
- We were told that best interest decisions and deprivation of liberty (DoL) decisions were taken where indicated and these were formally documented.
- We did not identify any patients currently being treated under a DoL. The inspection team were told of a discussion held about one patient who may have fulfilled the criteria. It was decided that the patient did not need to be treated under a DoL, however there was no documentation of this discussion.
- We saw evidence of Best interest meetings, which included capacity assessments and dementia screening, discussed at multidisciplinary meetings.

Are surgery services caring?

Good

We rated caring for the service as Good because;

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

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. We saw FFT information was displayed on notice boards around the wards and departments.

- Wards 7 West and 7 East B at the Royal Free Hospital had the highest FFT ward response scores within the trust.
- In October 2015 97% of patients said they are extremely likely or likely to recommend day surgery unit at the Royal Free Hospital to their family and friends.
- The 7 surgical wards had an average response rate of 57.7% for November which is higher than the England average, in November 2015 an average of 74% of patients who would recommend the ward to friends and family, which is lower than the England average.
- The patients we spoke to were all very positive about the care they had received and said nurses had time to give compassionate care.
- We saw thank-you cards from patients displayed and 'You said, We did' posters which displayed patient's feedback comments and action taken on their comments.
- Throughout our inspection, we witnessed good staff interaction with patients. We observed how the nurses assisted patients, with compassion and skilled care.
- Patients said they were treated with compassion, dignity and respect. The Royal Free Hospital performed better in PLACE audits in 2013, 2014 and 2015 for treating patients with privacy, dignity and wellbeing.
- On the day surgery unit one patient told us how staff had learnt from a previous bad experience and had gone the extra mile to ensure a better experience the next time. One patient told us she could not fault the care she had received on this occasion.
- Another patient said the service was 'very good' and gave examples such as his rapid referral from his GP; the ward environment and the explanations he received from medical and nursing staff. He said the food was "good" and a "wide choice" was offered. He said he was a "fan of the NHS", which was "amazing" and they had "brilliant nurses here".
- All patients we spoke to gave positive feedback about the service, citing examples such as cleanliness; friendliness of staff, discharge planning and "breakfasts served at a sensible time".
- In theatres we observed staff delivering care with empathy and compassion. We saw theatre staff offered caring and compassionate care, safeguarding the patients' dignity including when they were not conscious. We saw theatre staff gave consideration to ensuring patients were not left exposed unnecessarily and that patient's dignity was preserved when opening theatre doors.

Understanding and involvement of patients and those close to them

- We spoke with patients at different stages of their surgical journey, they told us they felt involved in their care and in decision making about their treatment.
- We spoke to some patients relatives who said they has been involved in their relatives care and had been given regular updates.
- We were given an example by a relative when her husband's operation had been postponed the nurse had telephoned to inform her of the delay.
- The patients we spoke with told us they were given adequate information about the specific surgical procedure that applied to them.
- We saw that specific information leaflets were available which were given to patients at pre assessment therefore they had time to read the information prior to their operation. They felt they had time to ask questions and their questions were answered in a way they could understand.
- We saw in the day surgery unit relatives were able to wait with the patient until they were called to get changed.
- We spoke to one patient who attended the day surgery unit who's operation had been delayed until later in the day and was able to go home and come back later in the day.
- Patients in day surgery said they were kept informed of their approximate surgery time which helped to manage their stress and anxiety.

Emotional support

- Royal Free Hospital had arrangements in place to provide emotional support to patients and their families when needed.
- We saw posters giving details on a variety of support groups or services which could be accessed for example bereavement services and dementia support groups.
- Pre-admission staff told us that where it was identified that patients required extra support this was arranged where possible before admission and discussed with

the multidisciplinary team. For example patients with complex needs such as learning difficulties were scheduled first on the operating list to minimise waiting time and anxiety time.
- We were given examples of relatives attending the anaesthetic room with their relative to provide emotional support.
- Staff confirmed they had access to the End Of Life Team and previous referrals had been acted upon promptly.
- The trust has a weekly pattern of Christian and Muslim services which were held throughout the trust.
- There is a 24-hour emergency on-call chaplaincy service operated throughout all hospital sites.
- Staff told us the trust was committed to offering pastoral, religious and spiritual support throughout the trust. It benefited from a multi-faith chaplaincy team, supported by a dedicated team of chaplaincy volunteers.
- The trust hosted events recognising significant times, including, Remembrance Day, Holocaust Memorial Day, World Aids Day and a service of annual remembrance for those who had lost a loved one in one of the trust's hospitals.
- We saw a red tray food/water jug lid system in use highlighting patients who needed assistance with feeding.
- Staff confirmed meal times were protected and staff assisted patients with feeding when necessary.
- We reviewed a patient menu which included options for people with specialist dietary needs such as religious beliefs or vegetarians.
- The Royal Free Hospital performed above average for quality and choice of food in the Patient-led assessments of the care environment (PLACE) audits in 2013,2014 and 2015.
- A recent audit undertaken at the Royal Free hospital looked at the length of time patients were fasting prior to surgery. This showed that 62% of patients fasted over 2.5 hours, 47% of patients fasted over 4.5 hours and 27% of patients fasted over 6.5 hours.
- We saw posters displayed 'think drink' in pre-assessment which reminded staff to check how long patients had to wait prior to surgery and to ensure those patients waiting more than two hours should be given a drink if appropriate.
- We went to 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 patients we spoke with during the inspection said the food was good and there was a variety of choices available.
- Patients we spoke with said they were offered enough to eat and drink and were happy with the variety of food offered.

Are surgery services responsive?

Good

We rated the responsiveness of the service as Good because;

- The needs of local people, commissioners and stakeholders were taken into consideration when planning services.
- The day theatre recovery was rarely used for escalation beds, which reduced the need for cancellations for elective surgery.
- There were established surgical pathways of care through the hospital from admission to discharge.
- There was an escalation policy in order to manage peaks in demand and ensure that the care given to high-priority patients was not compromised.
- Complaints were acknowledged, investigated and responded to.

Service planning and delivery to meet the needs of local people

- The trust is in the process of consolidating services across sites, managers told us staff, local people, commissioners and stakeholders were involved in the process and had an opportunity to have their views heard.
- We were given an example of the current plan to consolidate orthopaedics services and how this had been communicated to people involved, and listening events had been held.
- Patients were offered a choice of appointment and treatment times either through 'Choose and book' or through personal contact.

Access and flow

- Daily bed occupancies were completed for the hospital which identified potential service problems and reviewed demand, capacity and workforce. Daily operational meetings with representation from surgery took place.
- Trust referral to treatment time performance was below the 90% standard from September 2014 to October 2015. Over the same period six specialty groups failed to meet the standard; ear nose and throat surgery, general surgery, ophthalmology, plastic surgery, trauma and orthopaedic surgery and urology surgery. The service had an action plan in place to address this issue. RTT data was captured at pathway level and was not split by site.
- Elective access to specialty surgical services was via a two week rule and urgent clinic slots. Patients were triaged where appropriate. The cancer referral data indicated that in October 2015 97% of all patients were seen within two weeks.
- The number of cancelled operations trust wide was mixed, dropping to its lowest of 63 in quarter one 2014-2015.
- 17 patients trust wide were not treated within 28 days after their operation was cancelled between quarter one 2013/14 and quarter one 2015/16.
- Emergency surgical services were in place for all specialities, with priority access to theatres via consultant led reviews. There was a dedicated emergency theatre available all day. In times of increased demand, emergencies would displace their own speciality. For example if there was a vascular emergency, it would be undertaken on a vascular elective list which could result in the cancellation of elective patients.
- We found that only seriously ill patients were operated on at night in line with the Royal College of Surgeons Unscheduled Surgery Guidance
- There was a formal policy in place to provide guidance for staff when cancellations had to be made on the day of surgery.
- We saw details of this policy displayed in theatres to act as a reminder and resource to staff.
- It was observed by the inspection team there was limited staggering of arrival times in the Day Surgery Unit for operations. This meant patients often arrived at 7:30am but did not have their operations until the afternoon.
- We saw the white board in day surgery unit was used to track the journey of the patients coming through for their surgery and through to discharge. Differing visual aids were used to show where the patient was in the assessment and preparation process.
- July 2015 – June 2015 57% of all operations undertaken at the Royal Free Hospital were day case procedures.
- From the information supplied to us, the recovery area was rarely used to accommodate patients overnight when bed shortages occurred.
- The matron told us on average two patients per month were cared for in recovery overnight and this was consistent with the data we were supplied.

Meeting people's individual needs

- We heard the hospital was generally able to meet patients' individual needs for example there were positive initiatives in place to support patients living with dementia.
- Staff told us one of these initiatives was the use of the hospitals volunteers who became 'dementia friends' to inpatients suffering from dementia.
- Staff told us of a number of activities undertaken by volunteers to help meet individual needs these included massage, reading to patients and feeding patients when they had undergone the relevant training.
- Staff told us they were proud of the care the volunteers provided and they were an invaluable asset to the hospital.
- We saw the hospital had a library service which enabled patients to borrow books during their stay.
- Theatres had bariatric equipment available to meet the needs of patients with a high BMI (Body Mass Index) although there was no high BMI policy.
- Staff had access to resource folders for patients admitted with special needs such as a learning disability.
- Staff told us prior planning took place for patients admitted with special needs, pre- assessment would notify ward managers of the patient's specific needs so adjustments could be made.
- Staff told us that translation services were available in a variety of forms, for example face to face or telephone translation.
- There was access to patient information literature however we noticed it was only available in English but staff told us it was available in other languages on request.

- All food at the Royal Free Hospital was provided by an outside contractor to a prescribed standard.
- The patients and staff we spoke with said the food was of good quality with a variety to choose from which catered for individual needs for example Kosher food and vegetarian options.
- Day Surgery had separate male and female waiting areas and separate male and female bays so there were no breaches of single sex accommodation.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints was readily available on all the wards and departments we inspected.
- Complaints were monitored and discussed at departmental clinical governance meetings. There were mechanisms in place for shared learning from complaints through the staff meetings, trust briefings and safety briefings.
- There were 99 complaints received in surgery between December 2014 and November 2015.
- The average (mean) time that complaints were open for was 42.50 working days.
- Top subjects for complaints related to all aspects of clinical treatment 58.6%
- It should be noted however that a large number of records relating to complaints could not be identified at site level 1,070 records of 1,354

Are surgery services well-led?

Good

The surgery department for the Royal Free London NHS Foundation Trust is led by two divisions, surgery and associated services (TASS) and transplant and specialist services (SAS). Each division is led by a divisional director, divisional director of operations and a divisional director of nursing. There are two heads of nursing for surgery across all three sites.

We rated the leadership of the service as Good because;

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

However;

- We considered clinicians were not so well led, we were told there was a 'them and us' culture between clinicians and discontent across the different sites. Clinical staff described feeling that there was little communication or involvement regarding changes to services, and that they were not encouraged to speak during divisional meetings.

Leadership of service

- The service was led at the site level by a tripartite model of Clinical Lead, Matron and Service Manager. This reported to the Divisional Surgical Director, Deputy Head of Nursing and Divisional General 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.
- There was clear leadership, and staff knew their reporting responsibilities and took ownership of their areas.
- Senior nurses undertook relevant leadership and management training. We observed high performing nursing teams, led by strong local nursing leaders, who led on embedding innovation into their clinical practice.
- Staff reported that collegiate working was encouraged within the Division, however cross-Divisional working was not encouraged and staff described the structure as encouraging silo thinking.
- Staff told us some members of the senior management team were visible and approachable.
- We spoke with the directors and clinicians with responsibilities for the surgical divisions, they told us that the Chief Executive was very approachable and they felt supported.

- We saw managers and clinicians monitored performance against key performance indicators or clinical outcomes.
- Staff reported the leadership culture made them feel valued, included and respected.
- Staff told us the nursing leaders and managers in their areas of work inspired them and encouraged them to work together in achieving enhanced patient care.
- All staff spoke with passion and pride about working at the Royal Free Hospital and all spoke enthusiastically about what the future held for the hospital.
- We saw that the nursing leaders and managers were able to respond to an ever-changing healthcare environment, organisational expectations and changes to local and national policies.
- We saw good examples of nursing leaders and managers nurturing others. For example, we spoke to a newly qualified nurse in theatres who said she felt well supported by local management and preceptorship program. She said she felt confident that her department would support her through developing her skills and undertaking further training.
- One nurse told us she had worked at the trust for 14 years and had been selected for nurse training as a health care assistant. She was very positive about her experience, quality of her local leadership and the opportunities afforded. She said her managers were "so approachable" and gave examples of protected time for courses and clinical supervision; effective personal development reviews and good communication within the unit
- Theatre staff told us about the monthly multidisciplinary meetings; weekly theatre meetings which alternated between training sessions and departmental meetings. We heard there was a strong culture of openness from junior to senior staff, clinical and non-clinical.
- We heard regular staff meetings were held in all the departments these were minuted and we saw evidence of these minutes.
- 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 matrons which ensured matrons across all sites could be included in these meetings.

Vision and strategy for this service

- The service had a variety of developments to further enhance the provision of surgical services in the future on the different sites.
- Some specialities had their own strategies: breast, vascular, urology, paediatric, elective orthopaedic, renal transplant, liver transplant, renal cancer and plastic surgery all had their own.
- Staff told us they were aware of and supported the trust vision and values, and they could tell us what the strategies, meant to them, which was to provide the best care for patients and to put patients first.
- We observed the trust's vision and values were prominently displayed in hospital corridors, on the wards, in literature, on key documents and on the trust's website for patients, visitors and staff to comment and understand.
- Staff told us they were proud to work at the Royal Free Hospital and were enthusiastic about the service they provided.

Governance, risk management and quality measurement

- There was a robust governance framework in place with responsibilities defined that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service.
- 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. We observed the risk register to be complete and in-line with our observations. There were patient safety and risk feedback bulletins including incidents and learning.
- The governance structure consisted on service specific governance meetings, which reported to a Divisional governance meeting, attended by nursing and clinical representative from the services. This structure was mirrored across the sites, and the location of the Divisional meeting altered across the sites on a rolling basis.
- Theatres demonstrated the three never events had been taken seriously and were committed to learning from these events and preventing them from reoccurring.

- Senior clinicians and managers told us they could raise issues for discussion and resolution through a network of performance, clinical governance and safety meetings which took place on a planned basis throughout the surgical division.

Culture within the service

- We considered clinicians were not so well led, we were told there was a 'them and us' culture between clinicians at the different sites.
- We observed a medical handover where a junior doctor asked a senior clinician about the management plan for a patient who had been transferred from Barnet hospital and the response was 'he is a Barnet patient speak to the Barnet doctors about the medical plan'.
- We were told that people were actively encouraged not to speak during divisional meetings and that decisions about services were not always well communicated or consulted on with staff.
- Surgeons told us it was unfair that some surgeons got to do more interesting and challenging operations than others depending on the site they worked at.
- We observed a lack of cohesive working between clinicians at different sites and a lack of knowledge of services provided.
- Conversely, we observed excellence in nursing leadership across the services, with staff reporting high visibility, nursing managers were described as supportive and nurturing.
- The staff that we spoke with were extremely proud to work for the organisation and felt that the care they provided was excellent.
- None of the staff we spoke with said they had experienced bullying from their colleagues or managers
- Staff told us they felt able to raise concerns and felt that the organisation was transparent with a "non-judgemental, no blame" culture.
- Staff told us the culture of the service was focused on meeting the needs of patients.

Public engagement

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

Innovation, improvement and sustainability

- We saw staff wanted to learn, develop and improve their skills, they were given protected time, resources and encouragement to do so.
- We were told of a new skin grafting technique and lung biopsy method used which reduced patients' recovery times.
- We saw an innovative nurse-led discharge medication system was being used in Day Surgery Unit which reduced delays to patients awaiting take home medication.
- We saw on 7 East ward an exercise regime was in use for patients who have had total knee/hip replacements.
- There were distances marked along the ward for patients to walk to and posters displaying exercises to be undertaken. This innovation has resulted in a reduced length of stay in patients who have had hip/knee replacements by up to 3 days.
- We found that innovation and improvement was recognised, shared and celebrated.

Critical care

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

Information about the service

The critical care unit at The Royal Free Hospital has capacity for 34 patients and can be flexibly staffed and configured to provide care and treatment for level three intensive care patients and level two high dependency patients and operates as one single intensive therapy unit (ITU). The unit is divided into three 'pods';

ITU East: 14 Beds, including 1 side room and a 2-bedded side room.

ITU South: 11 Beds, including 8 side rooms.

ITU West: 9 Beds, including 6 side rooms.

The unit treated 1032 patients between April 2014 and March 2015 and is part of the North East North Central London Critical Care Network.

Patients are mainly admitted following planned surgery but a proportion are also admitted via the emergency department and the hospital wards, either due to becoming more unwell, or after emergency surgery. The critical care unit admitted patients referred to the tertiary specialist Hepatobiliary (HPB) and vascular services provided at the Royal Free Hospital.

The Patient at Risk Response Team support ward staff to care for deteriorating patients prior to their transfer to critical care, as well as reviewing patients following discharge from the unit.

We visited the critical care unit over the course of three announced inspection days. During our inspection, we spoke with 25 members of staff including doctors, nurses, allied health professionals and ancillary staff. We spoke with the divisional leadership team within critical care at the trust. We also spoke with six patients and four relatives. We checked ten patient records and many examined the ward and it equipment.

Critical care

Summary of findings

Overall we rated critical care services at the Royal Free Hospital as Good because;

We found there were processes and systems in place which prioritised patient safety and allowed staff to deliver evidenced based care. Staff were proactive in reporting incidents and there was evidence that learning from investigations had taken place consistently with an effective system in place to ensure all staff were aware of updates to practice.

Critical care services was delivered in a newly refurbished modern and clean environment, with a large number of isolation rooms available. Staff adhered to infection prevention and control guidleines and rates of hospital acquired infection were low.

Staffing levels were reviewed continually using an established nursing acuity tool and there were enough staff to provide care and treatment in accordance with national guidance. The education team were providing in-house university accredited post registration training in critical care and ensured all staff received training prior to working independently on the unit. Agency staff underwent stringent induction and background checks before working on the unit.

The critical care team had access to multidisciplinary specialists who contributed to decision-making and ward rounds to ensure best care for patients. An established critical care outreach team supported patients across the hospital, pre and post admission to the critical care unit.

Clinical practice was benchmarked against national guidance from organisations such as the National

Institute for Health and Care Excellence (NICE), the Royal College of Physicians and the Intensive Care Society (ICS).Staff contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC) as well as a programme of local audits to evaluate the service.

The leadership team had identified access and flow on the unit as one of their main challenges and had taken steps to address this issue, such as better planning for elective surgery and a senior nurse appointed to facilitate access to and discharges from the unit.

Caring staff maintained patients' privacy and dignity and provided emotional support to relatives.

However;

There was a lack of written information available to patients and their relatives and patient engagement was limited. Staff had not achieved the trust target for most of the mandatory training modules, with some key training, such as resuscitation having low completion rates for medical staff.

Although data was currently being submitted to ICNARC, the unit had in the past been inconsistent with this data submission and it was unclear how the critical care service was benchmarked during that period.

Critical care

Are critical care services safe?

Good

We rated safety for critical care as good because;

- There were effective systems in place to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us about improvements in practice that had occurred as a result.
- The environment was fit for purpose and all staff complied with infection prevention and control guidelines. Staff had access to a wide range of equipment and all equipment was adequately maintained.
- Staffing on the unit was in line with national guidelines, although agency nurses were often used to achieve this. Patient records were comprehensive, with all appropriate risk assessments completed.
- The Patient at Risk Response Team reviewed all deteriorating patients and ensured patients received the appropriate level of care, while awaiting admission to the critical care unit.
- Medicines were stored safely and securely although we observed inconsistencies in the recording of drug fridge temperatures.

However;

- Staff had not achieved the trust target for most of the mandatory training modules, with some key training, such as resuscitation having low completion rates for medical staff.

Incidents

- One serious incident was reported for the period of January 2015 to January 2016. This was a Grade 3 pressure ulcer acquired on the critical care unit. This incident was fully investigated and we saw evidence of lessons learnt, actions taken and plans to share this learning in the investigation report. The matrons for critical care showed us a staff noticeboard, where the learning from this incident and changes implemented as a result was clearly displayed. Earlier referral to the Tissue Viability Nurse (TVN) for critical care patients was recommended following the investigation and we saw evidence of staff being prompted to refer all patients with a Grade 2 pressure ulcer in the records we reviewed. A tissue viability link nurse was also allocated following this incident. We also saw evidence of learning from a previous SI that took place in 2014.
- There was a second SI involving critical care. This was an incident when a patient had their surgery cancelled due to a lack of critical care bed. We saw that staff from critical care had been involved in the investigation and the learning had been shared amongst surgical and critical care staff.
- Staff reported incidents using an electronic reporting system. Staff we spoke with told us there was a good reporting culture on the critical care unit and they knew how to report an incident. Staff completing an incident form always received feedback via email of the outcome of the investigation as well as verbal feedback from the matrons. Learning from incidents was shared with all staff during 'safety huddles' at handover. This included incidents that happened in other part of the hospital but had the potential to impact on critical care patients.
- The senior nurses had also established a system of sharing important information with all staff groups, known as 'hot topics.' These were three items of information, ranging from learning from incidents, changes to pathology reporting or specific training for staff, which were discussed as part of the daily handover for a week. Staff we spoke with were able to tell us what the hot topics were for that week and felt it was a useful way of ensuring staff on all shifts received consistent information.
- There were 292 other incidents reported for critical care for the period January to October 2015, however the large majority of these were low harm incidents. The three main categories of incidents reported were pressure ulcers (acquired and admitted with), medication errors and skin trauma (not pressure ulcer).Other data showed a high number of delayed discharges but this was not reflected in the incidents reported. Senior staff acknowledged there was under reporting of delayed discharges as incidents.
- The critical care team informed us they held monthly mortality and morbidity meetings as part of their audit and training afternoon. We asked for minutes of these meetings but only received two sets of minutes for June and September 2015. These meetings were not always minuted, therefore staff not attending were unaware of

actions and learning from these meetings. However we saw that during these meetings, cases were discussed in depth and staff present had the opportunity to contribute and share their learning.

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 spoke to staff of various grades about the Duty of Candour and they all had a good understanding of the Duty of Candour requirement and were able to explain how it applied to their specific roles. We also saw evidence of 'being open' in incident investigation reports we reviewed, with a nominated individual responsible for keeping the patient and family up-to-date during investigation process and providing feedback as well as a copy of the report once the investigation was completed.

Safety thermometer

- The critical care unit participated in the NHS Safety Thermometer scheme used to collect local data on specific measures related to patient harm and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas. This data was collected electronically and a report produced for each area.
- For the period of December 2014 to December 2015, the critical care unit was providing over 75% of harm free care except for March where percentage of harm free care was 55%. This was due to six new pressure ulcers acquired on the unit. All patients had access to basic pressure relieving equipment on admission and for the more complex patients, specialist equipment was hired. Staff we spoke with did not report any delay in accessing these specialist equipment. Staff had access to the trust-wide specialist TVN service as well as a critical care specific Pressure Ulcer Prevention team.
- The senior nurses informed us the safety thermometer data highlighted pressure ulcers as an area of concern and the unit had therefore invested in more advanced oxygen tubes and masks designed to help prevent pressure ulcers and made other equipment such as boots more readily available to all staff. They have since noticed a downward trend in the number of pressure ulcers acquired on the unit, which is reflected in the data we reviewed.
- The critical care unit did not currently meet the requirement to display their safety thermometer data and staffing levels. We raised this with the matrons and were told this was because all patients on the unit were cared for on a 1:1 basis.
- The records we reviewed demonstrated all patients had undergone a Venous Thrombo-embolism (VTE) assessment on admission and were receiving the appropriate VTE prophylaxis treatment. The safety thermometer data also showed good compliance with VTE assessments. This assessment was reviewed at regular intervals or when there was a change in the patient's condition.

Cleanliness, infection control and hygiene

- There were dedicated staff for cleaning the critical care unit and they were supplied with and used nationally recognised colour-coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination. Cleaning staff understood the cleaning frequency and standards and said they felt part of the ward team. There was on site cleaning staff between 7.30am to 9pm and for out-of-hours and 'deep' cleans, a rapid response team was available via a bleep referral system and usually attended within 30 minutes.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required. Staff adhered to infection control precautions throughout our inspection such as cleaning hands when entering and exiting the unit and bed spaces, and wearing personal protective equipment when caring for patients. Side rooms also had signs displaying presence of infection and the doors remained closed. We observed bed space curtains were labelled with the date they were last changed.
- The clinical areas we visited were clean and all the patients we spoke with were satisfied with the cleanliness. Other areas within the critical care unit, such as the relatives' room, quiet rooms and nursing stations, were clean and tidy. However, on one morning of the announced inspection days, we observed the main waiting area at reception to be messy and the floor

was littered with empty food cartons and wrappers. We highlighted this to the cleaning staff and were informed this was due to absence of the member of staff assigned to this area. The other cleaners acted promptly to ensure this area was cleaned immediately following our feedback.

- We looked at the equipment used on the units, including commodes and found most of them to be clean. We did however observe a therapy hoist to be dusty and some blood on the blood gas analysis machine. On the first day of our announced visit, we noticed not all equipment had a label indicating they had been cleaned but on the second day, every piece of equipment we looked at had had a label applied.
- Alcohol hand gels were readily available at the entrances to the critical care unit and at each bedside. We observed staff and visitors decontaminating their hands when entering and leaving the unit.
- The critical care team restricted other medical teams reviewing patients on the unit to two members of staff. The matron told us this was to minimise infection risk and felt it was well received by all teams. We spoke to two visiting teams and they did not feel this impacted on teaching for other team members.
- Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed no concerns in relation to hospital-acquired infections, such as MRSA or C. difficile and performance in these areas was similar to comparable units.
- The critical care unit followed the trust isolation policy for the use of side room and staff worked closely with the infection control team in the management of patients admitted with infectious diseases.
- The cleaning audits we reviewed showed the critical care unit achieved over 97% consistently and actions were clear when an issue was identified. We requested data on hand hygiene audits but did not receive this.

Environment and equipment

- The critical care unit had recently been refurbished and was spacious and bright. Most of the areas had some natural light and space between beds was in line with Intensive Care Society standards. Each of the three critical care 'pods' had numerous side rooms and these were pressure controlled rooms to prevent the spread of infection. Each room also had a decontamination lobby in line with best practice guidance. On ICU north, one of these side rooms was a two-bedded room, which staff told was used to cohort patients or for patients without transmissible infections.
- Staff told us they were able to access equipment required to care for patients and each bed space had a computer terminal to allow staff to readily access pathology results and other policies and guidelines on the intranet.
- Needle sharp bins were available at each bed space and within the medicines preparation area. All bins we inspected were correctly labelled and none were filled above the maximum fill line.
- There was one arterial blood gas analyser available in each 'pod' and these machines were calibrated daily; we saw documentary evidence of this with no gaps evident.
- A dirty utility room was located on one 'pod' and contained facilities for disposing of clinical waste and cleaning equipment. There were large domestic and clinical waste bins stored with direct lift access from the room for the removal of these bins. On one of the days of our announced inspection, we observed the large clinical waste bins was unlocked, which was not in line with the trust's waste management policy. There were hand-washing facilities for staff available within this area.
- Access to the clean utility rooms was controlled via a key card system and we observed these rooms to be organised and well stocked. The critical care unit also had direct access to bloods and other blood products from a machine situated in this room, to enable the team to respond to major haemorrhage. This was implemented following a serious incident.
- Emergency equipment such as resuscitation trolleys and difficult intubation trolleys were available on each 'pod' and the contents of these were checked on a daily basis by the shift coordinator. Documentation found on the trolleys specified which items needed to be checked on which trolley and demonstrated these checks were happening on a daily basis. On inspection we found one item of equipment which was open and therefore no longer sterile; all other contents were stored appropriately and within their expiry dates.

- Medical equipment including ventilators and arterial blood gas analysers were maintained by the in-house equipment technicians. We saw evidence equipment servicing was up-to-date and items had recently been 'portable appliance safety' tested.
- The critical care unit had a dedicated equipment manager to oversee all equipment needs, servicing and repairs as well as 24 hours technician support.
- Therapy staff we spoke with told us they had access to all the equipment required to carry out rehabilitation, including specialist seating.

Medicines

- There was one full time pharmacist dedicated to critical care, who attended the morning ward rounds Monday to Friday and a second pharmacist was split between critical care and anti-microbial. There was also a full time pharmacy technician. Weekend and out-of-hours pharmacy support was available via the on-call pharmacist.
- We reviewed four paper-based prescription charts and saw they were fully completed, including details of any missed doses. Allergies were clearly documented and staff informed us the prescription charts were re-written every weekend.
- We observed nursing staff administering medicines followed correct procedures, including controlled drugs being checked by two members of staff and patient identification confirmed.
- Controlled drugs (CDs) were stored in lockable wall units and the authorised signatory list was available. Documentation showed the stock of CDs was checked once per day alongside the CD book. Incidents data showed a large number of medication errors relating to CDs and we discussed this with the matrons. They confirmed this issue had been picked up at the three monthly CD audits and discussed at the critical care safety meeting. The decision was taken, after consultation with pharmacy colleagues, to introduce a new way of recording CD which has led to a reduction in CD errors.
- Medicines were stored securely, including intravenous fluids and medicines required to be stored in a refrigerator. However we observed the temperature checking records kept on each fridge were not consistently completed. On one of the fridges, we saw the temperature had not been recorded for 20 days in the month of December 2015 and 17 days in January 2016.
- We also found a box containing ampules of local anaesthetic stored within an empty bed space and brought this to the attention of staff. Staff were not aware of these but immediately removed the box following our feedback.

Records

- We saw evidence of clear and comprehensive discharge summaries completed for patients leaving the unit. These included VTE risk assessments and VTE prophylaxis treatment the patient was currently receiving.
- In the 10 records we reviewed, all the nursing care plans and observation were completed fully. All ward round documentation were present, with clear plans communicated to the rest of the team.
- All records relating to the current critical care stay was kept separate from the main patient records. The folder contained some nursing, medical and multidicplinary team (MDT)notes and was kept with the main nursing charts at the bed space, making all records readily available to the clinical team.
- We observed some patient records which were stored in the reception office, while awaiting collection. The reception was mainly staffed by one member of administrative staff and volunteers. We saw the volunteers were sometimes left in that office unsupervised, which meant they could have access to patient confidential information from their records. We highlighted this to one of the matrons, who assured us immediate actions will be taken to remove the patient records.
- 78% of nursing staff and 53% of medical staff had completed the information governance training on critical care, against the trust target of 95%.

Safeguarding

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy. Nursing staff were able to give an example of the last safeguarding referral made on the unit and more junior staff reported they would seek advice from more senior

staff if unsure. Staff told us an incident report was completed when a safeguarding referral was made and we saw evidence of this when reviewing the incidents data on the unit.
- All staff we spoke with knew the safeguarding team members and we noted a member of the safeguarding team was on the unit on one of the days of our inspection and was assisting staff in making a referral.
- 98% of nursing staff and 78% of medical staff had completed the safeguarding adults Level 1 training and level 2 training rates were 94% and 72% respectively, against a trust target of 95%.
- Safeguarding children level 2 training was completed by 92% of nursing staff and 72% of medical staff.

Mandatory training

- Key aspects of mandatory training such as information governance and fire safety were undertaken as part of the induction process for new starters. Additional mandatory training such as infection prevention and medicines management were undertaken as e-learning modules and further classroom based sessions.
- Staff told us they were able to complete their mandatory training within working hours when they did not have a patient allocated to them or they would be given a designated shift during which their training was completed.
- Resuscitation training was delivered by the Patient at Risk Response Team (PARRT) and staff explained the level 1 training was an e-learning module and the level 2 training was face-to-face with scenario training and an assessment. 99% of nursing staff had completed the level 1 training and 84% had attended the face-to-face training. However the training rates for medical staff were low with 44% for the level 1 training and 17% for the level 2 training.
- 71% of nursing staff and 42% of medical staff had undertaken infection control training. This was below the trust target of 95%.

Assessing and responding to patient risk

- Patients' conscious levels were recorded using the Glasgow Coma Scale (GCS) and Richmond Agitation-Sedation Scale (RASS) was used to monitor agitation in sedated patients. We saw evidence of this in the records we reviewed.
- Staff told us the Confusion Assessment Method for the intensive care unit (CAM ICU), was used to assess whether patients were delirious while on the unit. This practice was in line with current best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. Staff showed us a quick reference flow chart that was designed to guide clinician in monitoring analgesia, sedation and delirium for patients on the unit.
- There was a well-established Patient At Risk Response Team (PARRT), staffed by specialist nurses and led by a nurse consultant. There was no critical care consultants attached to the PARRT team but the team worked closely with the consultants. The PARRT was responsible for reviewing all patients following discharge from ITU and the nurse consultant told us the team aimed to review patient prior to them leaving the unit and within six hours of being on a ward. ICNARC data for the period of January to September 2015 showed all patients were reviewed following discharge from critical care, with 98.2% of these reviews carried out by the PARRT team.
- For patients on the ward, a single parameter early warning system was in use and ward staff would contact the medical team and the PARRT team if patient triggered escalation. Ward staff were supported in managing deteriorating patients by the PARRT specialist nurse and critical care registrar as required.
- The PARRT team also reviewed all patients with tracheostomies in the hospital and the nurse consultant led a tracheostomy ward round weekly.

Nursing staffing

- Senior nursing staff used a acuity tool was used to determine safe staffing levels across critical care. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that all ventilated patients (level three [L3]) are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and for level two (L2) patients a ratio of 1:2. We reviewed patient allocation records and staffing during our inspection which showed the critical care complied with these required staffing levels.
- The critical care unit had five supernumerary shift coordinators on duty at all times who had completed training and specific competencies for this responsibility. Rotas we reviewed showed this was always the case and we observed these supernumerary staff members on the shift during our inspection.
- The matrons met with the shift coordinators each morning to discuss staffing and allocation and although

the unit currently had two nursing rotas for the three 'pods', staff were allocated and moved to other areas according to patient needs and staff competencies. All agency and bank nurse booking were done by dedicated administration staff, which allowed the matrons and shift coordinators to focus on patient care.

- Best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units suggests no more than 20% agency staff usage per shift. Nursing staff rotas reviewed during our inspection, showed compliance with this guidance.
- The nursing establishment was 206 qualified nurses and the critical care unit currently had 152 nurses in post. This meant there was a reliance on bank and agency staff to fill all shifts. The matrons explained recruitment was particularly challenging for senior critical care nurses and therefore the unit had recruited additional junior nurses and provided the critical care training in-house.
- Agency staff underwent a thorough induction to the unit and senior nurses told us they tried to use the same agency staff whenever possible to maintain the continuity of care and avoid repeated inductions to the unit, which can be time consuming for the shift leader. Agency nurses we spoke with confirmed they regularly worked on the unit and were invited to the critical care training days training days, when relevant.
- Nursing staff received an overview of all critical care patients from the shift coordinator at the start of their shift and then a thorough bedside handover once they had been allocated a patient.
- A handover took place at the beginning of each shift, which incorporated a safety briefing and discussion about 'hot topics' for that week. Nursing staff received an overview of all critical care patients from the shift coordinator at the start of their shift and then a thorough bedside handover once they had been allocated a patient.

Medical staffing

- At the time of our inspection, there were 11 critical care consultants who participated in the rota which covered the critical care unit. The trust had commissioned an external review last year, which highlighted the need for extra consultants. Active recruitment was taking place and the management team informed us two additional consultants had been recruited and were due to start.
- Consultants were allocated to cover the critical care unit in weekly blocks and did not have additional responsibilities within the hospital while responsible for critical care. This type of rota system ensured continuity of care and was in line with best practice guidance.
- Three consultants were based on the critical care unit during the day (one allocated to each pod) and were on site from 7.30am to 6pm, 8.30pm, and 9pm respectively. Each consultant was supported by a registrar grade doctor in training, with an additional registrar available as a 'float.' The additional registrar was responsible for reviewing referrals received from the wards and accompanying patients for imaging and other procedures.
- Overnight, patient care was led by three airway-trained registrars with support from a consultant on an on-call basis. Consultants were available to attend deteriorating or newly admitted patients overnight with a 30 minute response time. The 'float' registrar was also available overnight.
- At weekends, two consultants were on site between 8am and 8.30pm, with one consultant then covering the overnight on-call off-site.
- Doctors completed a formal ward round twice each day and decided upon a management plan for each patient. This was in line with recommendations by the Faculty of Intensive Care Medicine Core Standards for Intensive Care.
- Medical handover meetings took place twice each day, during which staff finishing their shift would handover patient details and any relevant updates to doctors starting work.
- We saw copies of the medical rota and staff we spoke with told us the level of cover meant there was always a doctor present on the unit in an emergency.

Major incident awareness and training

- All staff received fire safety training as part of their mandatory training programme; staff told us they had practiced drills as part of their training days and we saw evidence of evacuation equipment available next to the stairs.
- There was an up-to-date major incident plan for the trust with a specific action card for the critical care unit and senior staff we spoke with were aware of this and clear of their roles in the event of a major incident.

Critical care

Are critical care services effective?

Good

We rated the effectiviness of critical care as Good because;

- Care and treatment were delivered by a competent and experienced team of consultants and nurses and was based on a range of best practice guidance.
- Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently Medical staff received regular training as well as support from consultants.
- There was good access to seven-day services and the unit had input from a multidisciplinary team.
- Staff managed pain relief effectively and patients' nutrition and hydration needs were closely monitored.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.

However;

- Mortality and unplanned readmission rates were slightly worse when compared to similar units for 2015. Data was not submitted for the previous years so it was unclear how the services were being benchmarked during that period.

Evidence-based care and treatment

- Intensive care specific policies and procedures we looked at were up-to-date and referenced to current best practice from a combination of national and international guidance. References included National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations.
- Polices and guidelines were accessed by staff via the intranet, although some printed copies were available in folders at the nursing station for quick reference. We found these folders contained the most up-to-date policies, although staff acknowledged work was needed to harmonise all policies since the merger with Barnet and Chase Farm Hospital.
- The critical care unit contributed data to the ICNARC database for England, Wales and Northern Ireland during 2015.This meant care delivered and patient outcomes were benchmarked against similar units nationally. However data was not submitted to ICNARC for 2013 and 2015. It was therefore unclear how the service was being benchmarked during that period.
- IV lines and care bundles audits were completed on a monthly basis and staff were reminded of key aspects of care following audit-findings. The urinary catheter audit for the month of January 2016 showed compliance ranged between 80 to 100% for the eight criteria being looked at.
- All patients received daily physiotherapy as required by the National Institute for Health and Care Excellence (NICE) guidance and intensive care society standards. All patients were screened within 24 hours and their rehabilitation needs were identified at the time. Rehabilitation progress was measured using the evidence-based Chelsea Critical Care Physical Assessment Tool (CPAx), so patient progress could be monitored.

Pain relief

- Pain relief was managed primarily by consultants on critical care, although input from the specialist pain management team was available on request.
- The Critical Care Pain Observation Tool (CPOT) was used to assess pain in non-communicating patients. The CPOT assessment was completed in all records we reviewed for appropriate patients.
- A patient who was due for discharge from the critical care unit, told us their pain had been well managed and they were awaiting a review from the pain team prior to moving to a ward. The pain team would then continue to review this patient and ensure optimal pain management.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed on a daily basis by nursing staff and a dietician also reviewed high risk patients and those receiving enteral feeding on weekdays. We saw evidence of comprehensive assessments from the dietician in two of the records we reviewed, with clear feeding regimes in place. At weekends, nursing staff were responsible for initiating enteral feeding if required. Staff highlighted the enteral feeding policy on the intranet and explained they would refer to this policy to calculate feed doses.

Patient outcomes

Critical care

- The Critical care unit did not submit data to ICNARC between July 2012 and March 2014, and it was unclear how the unit was monitoring their outcomes and benchmarking against similar unit nationally, for that period.
- ICNARC data for the period of March 2014 to April 2015 showed the average length of stay of 9.7 days for all patients admitted to critical care was in line with other similar units.
- ICNARC data showed risk adjusted hospital mortality to be slightly worse compared to data submitted by other similar units. There was no action plan in place to review why this was the case.
- Unplanned re-admissions to critical care within 48 hours from unit discharge and after 48 hours were slightly worse when compared to similar units for the period of April 2014 to March 2015. Data showed 20 patients were readmitted to the critical care unit in the period of March to June 2015. During the inspection, the senior team told us all patients were now reviewed by their speciality team and the critical care team to determine if they were ready to be transferred to a ward.
- Patients discharged 'out of hours' between 10pm and 7am were associated with worse outcomes and ICNARC data demonstrated there were fewer patients discharged from critical care out of hours than in other similar units.
- The majority of patients returned to their pre-admission residence and previous level of independence on discharge from hospital.

Competent Nursing staff

- All new nurses working in critical care were allocated a six week period of supernumerary practice, during which they were expected to complete a series of competencies which had to be signed off prior to independent working. We saw evidence these competencies were being completed by supernumerary members of staff. Staff we spoke with were clear these competencies should be signed off once the skill had been consistently demonstrated, rather than just on a one off basis. We saw the National Competency Framework for Critical Care in place for nurses which had to be signed off before caring for patients with specific needs, such as patients with a tracheostomy.
- All new starters were provided with an induction booklet, according to their band, which provided information about the unit, who's who, expectations of the role and the day-to-day running of the unit. Nurses who had recently started told us this booklet had been very useful.
- A team of five dedicated Clinical Practice Educators (CPE) were responsible for all elements of training and education for the nurses on the unit as well as supporting student placements. The team were extremely proud of the in-house university accredited post registration course in critical care nursing they were currently delivering and felt this would help address some aspects of recruitment and retention.
- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post registration award in critical care nursing. The unit had not achieved this as only 45% of staff currently held this qualification. The CPE team informed us a cohort of nurses were awaiting their results from the in-house post registration course and the percentage of staff with this qualification would meet the required 50% very soon.
- All nurses we spoke with during the inspection spoke highly of the support provided by the CPE team and told us they also had an allocated mentor who were responsible for regular one to one sessions and appraisals.
- Allocated link nurses were in place for a number of key themes within critical care such as pressure ulcer prevention and infection control. This allocation meant nurses on the units could seek guidance from their colleagues around specific issues.
- The trust's target for appraisal was 95% but only 70% of nursing staff were up-to-date with their appraisal at the time of the inspection.
- The PAART team delivered various courses to clinician across the trust, for example advanced resuscitation training and simulation training based on recent serious incidents scenarios.

Competent Medical Staff

- We saw evidence showing new medical staff underwent a comprehensive induction programme on their first day.This included sessions on infection control, role of the PARRT team, computer systems training and simulation training for emergency situations in critical care.
- Scheduled teaching for trainees took place twice a week between 8am and 8.30am, as well as additional

radiology training weekly. The trainees were also expected to lead a journal club weekly and the trainees we spoke with told us these teaching sessions and teaching during ward rounds gave them confidence and equipped them to carry out their role on the unit.

Multidisciplinary working

- Doctors worked collaboratively with nursing and physiotherapy staff to plan and implement ventilator weaning programmes (when patients' reliability on breathing machines is reducing and they are able to do more breathing on their own).
- A MDT meeting took place every week to discuss treatment and rehabilitation plans for long stay patients. Medical and nursing staff and the wider MDT (physiotherapist, pharmacist, dietician, and Speech and Language therapist) as well as the nurse consultant for the PARRT team attended this. Staff told us these meetings were extremely beneficial in planning holistic care as well as longer term requirement for individual patients following discharge from critical care.
- The nurse consultant for the PARRT team also led a weekly MDT ward round for all tracheostomy patients in the hospital and worked closely with staff on the ward in caring for these patients.
- Therapist and nursing staff worked collaboratively to implement rehabilitation plans for each patients and we saw nursing staff and therapists working together to complete patient care tasks and rehabilitation during the inspection.
- The critical care unit did not have dedicated Occupational Therapist (OT) cover and staff told us the physiotherapists led rehabilitation on critical care and would usually make the referral to OT when needed.
- The clinical director told us of more recent meetings happening every Friday with the HPB and vascular team to discuss the following week's elective cases and critical care requirement. There was a close working relationship between the critical care and HPB team. Patients requiring critical care input were transferred from other hospitals, to access the specialist tertiary HPB service.

Seven-day services

- The PARRT team were available 24/7, to assess and provide support for deteriorating patients on the wards, with three nurses during the day and two at night.
- Staff ordered diagnostic imaging services via an electronic referral process. Staff told us the radiology department completed all imaging according to clinical need and there were very rarely delays to investigation for critical care patients, even out of hours.
- There were 4.5 staff providing physiotherapy on weekdays with other staff rostered to provide cover at weekends. The team provided a full respiratory and rehabilitation service, including an on-call respiratory service out of hours.
- A pharmacist was available to support critical care at weekend, although they also had responsibilities in other areas of the trust. Microbiology support was available via telephone within the trust at all times.

Access to information

- Staff obtained most of their in-house information via the hospital intranet site. This included links to policies, procedures, mandatory training, and emails from matrons. A computer terminal was available at each bed space, which allowed easy access to the information.
- When patients were admitted via A&E, theatres or the wards, a verbal handover was provided to the medical and nursing staff as well as written information in the patient records.
- The medical team kept ward round documentation in a separate folder, with clear tasks and objectives for the shift so this information was readily available during medical handover.

Consent and Mental Capacity Act

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

Critical care

- Staff held best interest conversations with family or independent advocates where appropriate. Staff described a situation when an Independent Mental Capacity Advocate (IMCA) had been appropriately used to support a patient.
- Staff had received training on the Deprivation of Liberty Safeguards (DoLS) and a DoLS checklist was in place for patients requiring mittens for short periods. We saw this checklist had been appropriately completed in the records we reviewed. For patients requiring mittens for longer periods, staff made a DoLS application to the local authority and we saw the safeguarding lead assisting staff with an application during our inspection.
- 94% of nursing staff and 81% of medical staff had attended training specific to mental capacity and DoLS.

Are critical care services caring?

Good

We rated caring in critical care as Good because;

- The critical care unit provided a caring, kind, and compassionate service which involved patients and their relatives in their care.
- All the feedback from patients and their relatives was positive. Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
- Staff provided emotional support and were also able to access the hospital multi-faith chaplaincy services, when required.

However;

- Patients and their relatives were not encouraged to provide feedback and some relatives felt they did not have enough opportunities to speak to the medical staff.

Compassionate care

- All the patients, families, and friends we spoke with were happy with the care and treatment they received on the unit. Some patients called the staff "fantastic" and ''gentle and caring.'' Another family said they "could not have wished for anything better" and they would not change anything.
- The relative of a patient with learning difficulties, who also has a phobia of needles and hospitals, told us how staff had been extremely understanding and the 'care and treatment had been excellent.'
- Other relatives told us they were always welcomed on the unit and staff spent time explaining 'all the machines and what they are for.'
- We observed several interactions between staff and patients, saw staff speaking to patients in a calm and reassuring manner, and listened to what patients had to say.
- The unit did not participate in the Friends and Family Test and the critical care unit did not currently have a way of continuously collecting patient feedback. Staff told us a questionnaire was used but this was not ongoing. We saw evidence of the results of that survey which showed over 75% of patients felt the care provided on the unit was excellent. The Friend and Family test was included as a question in the questionnaire and 80% of patients and relatives said they would recommend critical care unit.
- We noted many thank you cards and letters received from patients praising the care they had received throughout critical care.

Understanding and involvement of patients and those close to them

- Staff introduced themselves and their role to patients throughout critical care. Patients told us this was needed because it could be difficult to tell who was who due to all staff wearing the same colour theatre scrub uniforms on critical care.
- Patient told us staff always kept them informed of the treatment plans and staff explained any test they were due to have. During the ward round, we observed the medical team interacting with the patients who were awake and explaining their treatment. A few relatives felt they did not get enough opportunities to speak to the doctor as staff asked relatives to leave during the ward rounds.
- We observed staff interacting with patients and involving them in decisions, a nurse discussed dietary requirement with a patient and came to a joint decision he would try to eat as well as have the supplement drinks.

- We only saw one patient who had family pictures and cards within their bed space. Staff told us all relatives were encouraged to bring in personal items but not many did so.
- Staff told us they used patient diaries but during our inspection, we did not see any completed patient diary, even though some patients had been on the unit for a few weeks. The matron acknowledged the use of the diary had been very inconsistent and told us he will discuss this issue at the next critical care meeting.
- Staff told us they sometimes held meetings for families with relatives on critical care so that any questions about their relative's time in hospital could be answered. All family discussions were documented in the patient records.

Emotional support

- A multi-faith spiritual team was available to provide support within the hospital 24 hours per day.
- Feedback from patients and relatives was positive and they told us staff had been reassuring and comforting during difficult times and we saw in the patient questionnaire result that over 70% of patients and relatives felt the emotional support provided was excellent.
- The physiotherapy team arranged to take stable longer stay patients outside or to the coffee shop every two weeks. This is only done by suitably qualified therapy staff and the nurse who looked after the patient. Staff told us going out of the unit 'gave patient a boost.'
- Patients who were able to eat and drink were seen to be offered a choice of food and drinks. Drinks were observed to be within patients' reach when appropriate. The housekeeper was able to heat up microwavable meals so patient could eat whenever they requested rather than having set meal times.
- We observed fluid monitoring recorded on the patient records and staff told us it would always be highlighted during handovers if patients were on a fluid restriction.

Are critical care services responsive?

Good

We rated responsiveness for critical care as Good because;

- The senior staff had an understanding of the needs of the service and were clear of their plans to address recruitment issues.
- Staff had identified access and flow on the unit as a significant issue and had recently appointed a nurse dedicated to facilitate admissions and discharges from the unit. The critical care team were also engaging with other specialities to better plan admissions to the unit.
- Staff had access to communication aids and translators when needed, giving patient the opportunity to make decision about their care, and day to day tasks. Quiet rooms were available for staff to speak to relatives.

However;

- A considerable number of discharges were delayed, although this figure was improving.
- There was currently no follow up clinic for patients following discharge from critical, which was not in line with NICE Guidelines CG83 ' Rehabilitation after critical care in adults'.
- Although relatives had access to a large waiting area and relatives' room, those areas did not contain information about the critical care staff, the hospital chaplaincy service or other specialist charities offering emotional support. There was also no hot drink making facility.

Service planning and delivery to meet the needs of local people

- The critical care unit served a combination of specialities, including post-operative surgical patients and medical patients. However, the largest number of patients admitted to the unit were those with severe liver disease followed by vascular surgery. The trust was a tertiary referral centre for both of these specialities and patients were therefore transferred from other hospitals for specialist treatment. Staff told us this could make service planning difficult, as it could be hard to predict patient need at any one time.
- A large number of liver and vascular patients underwent planned surgery, which required a critical care post-operatively. The critical care team met with the HPB and vascular team every Friday to discuss the elective cases booked for the next week. This allowed the team to understand the post-operative needs of

these patients and plan staffing and capacity accordingly. Staff told us these meetings had helped reduce the number of elective surgery cancellations due to a lack of critical care beds.

- The environment on the unit had capacity for 34 patients although the staffing establishment was for 31 beds only. However, in response to the demand for critical care beds, a business case had been put forward to increase the critical care bed numbers to 34 beds and this had been approved. Additional staff had been recruited and the unit was functioning at 34 beds since November 2015, although we observed not all the beds were occupied during our inspection.
- The critical care team are currently undertaking a review of all patients receiving level 2 care outside of the unit and identifying any patient post-operative who should be receiving critical care but are not currently. This will enable the team to establish the need for a surgical HDU, located next to theatres.
- The PARRT team also had close links with the local hospice and provided input into the care of patients with tracheostomies at the hospice. The nurse consultant for PARRT informed us nurses from the team were able to outreach to the hospice for specific tasks such as tracheostomy change rather than hospice staff arranging for palliative patients to make the journey to the hospital.
- The CPE team had recognised nursing staff needed the skills to care for the large number of liver patients on the unit and are in the process of setting up an accredited post registration liver course for critical care nurses.

Meeting people's individual needs

- A mixed sex breach occurs when level one or zero patients are placed on an open ward area with a member of the opposite sex. There were no mixed sex breaches on the critical care unit despite the large number of delayed discharges as patients were mostly cared for in isolation rooms.
- There was open visiting on critical care, although staff advised relatives to refrain from visiting during the morning ward rounds. There was a large reception and waiting area at the entrance of the unit, with two vending machines selling drinks, snacks and some microwave meals. Reception staff were present during the day to direct relatives and at the entrance of each pod, relatives were able to dial the intercom and speak directly with the nurse in that bed space.
- There was a lack of information about staff and the unit in the main reception area. Information about how to make a complaint was also not very visible, although we observed this was available at the reception. However the matrons showed us the new interactive touch screen device, that was due to be installed a few weeks after our inspection, to provide relatives with a wide range of information about the critical care unit.
- Each of the critical care 'pods' had access to quiet rooms, where difficult or confidential conversations could be held with relatives.
- The hospital did not have accommodation on site for relatives who lived a significant distance away or who had difficulties accessing the hospital while patients were admitted. However, staff told us relatives were able to obtain a discounted rate at a local hotel. The relatives' room had a few recliner chairs and some relatives were able to spend the night there. The trust offered discounted parking fees for relatives of critically ill patients.
- The relatives' room was large and bright. Relatives had access to water, a fridge, and a microwave. The fridge contained a large number of food items but none of these were labelled or dated so it was unclear how the cleaning staff were able to monitor how long food had been in the fridge. Relatives were unable to make hot drinks, as there was no kettle in the room. The housekeeper told us relatives were asked to purchase hot drinks from the coffee shop situated in the hospital; however, the coffee shop was not open at night.
- The relatives' room contained a few patient information leaflets such as MRSA and Clostridium Difficile (C-diff) as well as information on the Royal Free charity. There was no other information available such as charities where relatives could obtain support or the hospital chaplaincy services. All the leaflets available on the unit were in English, although staff told us they could request leaflets in other languages, if required.
- A translation service was available for patients who did not speak English as their first language. Staff could access interpreters via the telephone or make bookings for interpreters to attend face-to-face meetings.
- Psychiatric support was available on request and we observed a psychiatrist visiting a patient on the unit during the inspection. Staff told us they could obtain support from the team quickly if needed.
- Staff on the unit worked closely with the specialist learning disability team when caring for patients with

learning difficulties. We saw evidence of this during the inspection whereby the specialist learning disability nurse had attended the unit and advised staff on how to manage some of the challenging behaviours the patient was displaying.

- The critical care unit did not currently offer a follow up clinic where patients could reflect upon their critical care experience and discuss anything they were unclear about. This was not in line with NICE guidelines CG83 'Rehabilitation after critical care in adults'. This was despite a survey of patients and relatives showing 80% of respondents felt a follow up clinic would have been beneficial.

Access and flow

- The critical care unit had a clear admissions policy and admission to critical care was usually agreed between the critical care consultant and the treating consultant.
- The bed occupancy levels were over 100% and the unit had a significant number of delayed discharge. Although this was a common issue in critical care, ICNARC data showed the number of delayed discharges was higher than comparable unit between April 2014 and March 2015.
- Staff told us they experienced difficulties in discharging patients from the Critical Care Unit due to a lack of bed availability in the rest of the hospital. The were 411 delayed discharges from critical care for the period of April 2014 to March 2015 compared to 339 the year before. However this did not impact on patients' admission to critical care as staff were able to open up an extra bed temporarily when urgent critical care admission was required.
- Senior staff on the unit had put a business case together to recruit an additional senior nurse in the role of operational nurse. This new post was designed to solely manage the flow of patients on the unit by attending bed meetings, liaising with other medical and surgical specialities and hence reduce the number of delayed discharges and improve access. Initially this post was funded only during the day but following extremely positive feedback from staff, the role has been extended to cover the night shift. Staff felt delayed discharges had reduced since the introduction of this new role nine months ago, ICNARC data was only available up to June 2015, so it was difficult to assess the impact of this role at the time of this inspection.
- Staff told us the bed managers would prioritise a discharge from critical care if a patient required admission. However the trust did not submit data on the percentage of patients who were admitted within 4 hours of referral. The PARRT team and the critical care registrar would review all deteriorating patients and would remain with the patient and provide the level of care required (level 2 or level 3) until the patient was transferred to the unit. The team had access to a fully equipped mobile trolley to intubate and ventilate in other areas of the trust when required. This system meant patients did not experience any delay in receiving the appropriate care.
- A higher number of patients were transferred out of the unit for non-clinical reasons in the same period than in comparable units.
- Staff told us patients were transferred out of hours only in emergencies when a bed is required and ICNARC data for the period of April 2014 to March 2015 showed fewer patients were transferred out of our when compared to similar units.
- Data provided by the trust showed 16 elective surgery cancellations due to unavailability of critical care beds since July 2015. Senior staff felt this number had improved considerably and they were continuing to work closely with their surgical colleagues to further reduce cancellations. Staff told us elective surgery would only be cancelled when patients on critical care could not be transferred out of the unit for clinical reasons.

Learning from complaints and concerns

- Relatives we spoke with were aware they could raise any issues with staff on the ward or seek assistance from PALS if needed. This was despite the lack of poster advertising PALS in the reception and relatives' room.
- There had been four complaints relating to critical care since January 2015. We noted the trust dealt with the majority of the complaints within agreed timescale. Senior staff we spoke with were aware of the recent complaints and explained their role in the complaints investigation process. They felt it was useful to reflect following a complaint and ensure the learning is shared with the rest of the team. Senior nursing staff fed back during the daily handover and as part of the 'Hot Topic' for the week.

Critical care

Are critical care services well-led?

Good

We rated the leadership of critical care as good because;

- The leadership team had a clear vision and strategy and staff were able to verbalise future plans. The team of senior nurses and doctors were engaged in their vision to harmonise clinical guidelines and practice across the three sites and improve cross-site working relationships.
- There was a robust governance structure, both within critical care and also within the directorate. The management team had a good oversight of the risks within the services and any mitigating plans were in place.
- We saw very good local leadership within the unit and this was reflected in the conversations with staff. We saw evidence of strong staff engagement and changes being made as aresult to improve the care provided to patients.

However

- Patient engagement on critical care was not well developed. There was no system to enable staff to collect patient feedback consistently and the lack of a follow up clinic further limited opportunities for feedback.
- The leadership team did not prioritise some risks, such as non submission of data to ICNARC and this was not included on the risk register.

Vision and strategy for this service

- The leadership team provided evidence of a local strategy document, which outlined their key areas for improvement and their vision for the service. Some of these had already been implemented such as increasing capacity to 33 beds. The critical care team identified the majority of delayed discharges were short stay surgical patients and therefore included creating a surgical HDU in their strategy.
- The strategy had been agreed locally but the strategy document was not a formal paper presented to the Trust Executive Committee (TEC) so it was unclear how this strategy was aligned to the trust's overall strategy.
- The leadership team were clear in their vision to harmonise clinical guidelines and practice across the three sites and improve cross-site working relationships. They planned to appoint staff to work cross-site in the future and felt this would further enhance the sharing of best practice and learning in the trust.
- The nursing leadership team were confident the recent recruitment success and in-house critical care training would help the service 'grow their own' experienced critical care nurse and reduce the use of agency in the future.
- Ward staff knew how their work contributed to the wider vision of the trust and were aware of the trust values. Staff told us values were discussed at their supervision and appraisal sessions and was embedded in their practice.

Governance, risk management and quality measurement

- Directorates held monthly business and speciality meetings within a coherent reporting structure. These meetings were well attended and chaired by the Chief Operating Officer and we saw in the October 2015 minutes, that current issues and risks such as delayed discharges from critical care was discussed and the group reviewed the impact of recent measures introduced to address this.
- The lack of ICNARC data for an extended period between in 2013 and 2014 meant the senior leadership team had been unable to benchmark the safety and quality of critical care services during that period. The senior staff told us the data submission to ICNARC had been an issue due to lack of staff but it was unclear why it took that long to rectify the staffing problems and resume data submission.
- There was a monthly governance meeting for critical care which was attended by members of the infection control and clinical governance team. Clinical governance and pharmacy expenditure reports were presented to the group and discussions at these meetings allowed the critical care multidisciplinary team to have an oversight of the service and meant that concerns and risks that needed escalation and action were dealt with. Discussions from these meetings were fed back to staff at ward level during handover meetings.
- The risk register was reviewed at the Risk and Review meetings and this ensured senior staff were aware of the risks recorded on the register. We reviewed the version of the critical care risk register submitted by the trust

and found the contents largely reflected our inspection findings, for example delayed discharges and the difficulty in recruiting senior staff. One item on the register, relating to paper based nursing rota, had been recorded as a risk since 2014 but staff we spoke with told us this risk had been addressed since the introduction of an electronic system in August 2015. Data not being submitted to ICNARC was not included as a risk.

- Operational management meetings were led by the head of nursing for critical care and senior nursing staff were able to discuss staffing and performance issues, concerns and complaints.
- An allocated consultant took the lead for patent safety and clinical risk. This role involved promoting safety throughout clinical process, reviewing all clinical incidents and educating staff about concerning incident trends. In addition, the nurse consultant for the PAART team was on the Serious Incident review panel and played a vital role in sharing the learning from other areas of the trust with the critical care team.
- Consultant meetings took place on alternate Wednesdays and provided another forum to discuss incidents and risks, review scorecards and audit outcomes and undertake mortality and morbidity reviews. These meetings were not attended by consultants from the Barnet site due to the travelling required and were currently not minuted.

Leadership of service

- Two matrons shared responsibility for the leadership of the critical care unit alongside the clinical director. The matrons were supported by the directorate deputy Head of Nursing. We noted these senior staff were visible on the wards throughout our inspection and knew ward staff across the service.
- A supernumerary shift coordinator was allocated to each nursing shift to provide immediate leadership and facilitate service delivery on every critical care 'pod'. Staff across critical care spoke positively about the shift coordinators, praising their supportive attitudes and open approach to management.
- The nursing and medical clinical leadership teams worked closely together to plan and deliver a safe and responsive critical care service. Two-way communication around safety and capacity issues occurred frequently and a good relationship between the teams was evident.
- Junior and middle grade doctors said they felt well supported by their consultants and other senior colleagues.
- The matrons and deputy director of nursing were visible and staff felt able to approach them with any concerns. Some staff did comment on the junior workforce due to difficulty in recruiting senior critical care nurses but felt they were being well supported by the leadership team during that period.

Culture within the service

- There was evidence of arrangements for developing staff with good support, including mentoring and training. Senior staff spoke of the strong commitment to equality and diversity on the unit.
- Staff commented that there was a culture of 'no blame'. Everyone was encouraged to learn from incidents and staff said the individual feedback they received after any incident was constructive and helpful.
- Staff had good working relationships with each other and told us they worked as a team across the three 'pods.' Agency staff who worked regularly in critical care felt part of the team and were included in social events.
- Staff at all levels were proud of the service provided on the critical care unit and felt their work was recognised by the leadership team.

Public and Staff engagement

- There was limited public engagement in the critical care unit. Although staff made every effort to engage friend and family in patient care while they were on the unit, there was no system in place to collect feedback to help improve patient experience. The lack of a follow up clinic further limited the opportunities available to gain patient feedback.
- Staff felt involved and listened to when they brought new ideas to the leadership team. For example, the senior nurses, who worked as shift coordinators, raised the issue that they were spending a large proportion of their time dealing with access and flow from the unit and suggested the role of operations nurse be introduced. The management team had taken on board this suggestion and funded the new role nine months ago.
- The critical care team held away days for nursing staff to reflect and identify areas for improvement to further

enhance the care provided on the unit and support each other's development. Staff we spoke with felt ideas idea discussed on these days were well received and acted on by the management team.

Innovation, improvement and sustainability

- The Critical care team developed a smart phone application which contained up-to-date critical care policies and guidelines and best practice recommendation. Medical staff we spoke with told us they have found this extremely helpful to access key information on the go.
- Staff were proud of the new refurbished environment on critical care and felt the trust management had engaged clinical staff in the design which has resulted in a unit that met the needs of staff and patients.
- The critical care team were preparing to adopt a new electronic prescribing and records system. Senior staff were currently involved in testing the system and ensuring compatibility with other medical devices used currently.
- The critical care had received specialist training to care for patients with Ebola in the high level isolation unit on site. This is the only such unit available in the country and the work of staff with Ebola patients was presented as the plenary speech as the 2015 British Association of Criical Care Nursing conference.
- In response to the difficulties experienced in the recruitment of skilled and experienced critical care nurses, the CPE team have developed an inhouse, university accredited, post registration course to 'grow their own' nurses. They are also in the planning stages of a specialist liver course to give nurses the necessary skills to care for HPB patients on critical care.

Maternity and gynaecology

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

Information about the service

- The Royal Free London Hospital NHS Foundation Trust provides maternity and gynaecology services at the Royal Free Hospital. In July 2014 the trust acquired responsibility for Chase Farm and Barnet NHS Trust. The maternity services were merged with those provided at Barnet Hospital and the Royal Free London Hospital NHS Foundation Trust now provides integrated hospital and community maternity services across both sites and at Edgware Birth Centre.
- This report focuses on the maternity and gynaecology services provided at the Royal Free Hospital. The services at Barnet Hospital and Edgware Birth Centre are reported on in separate reports.
- The maternity and gynaecology service at Royal Free London Hospital NHS Foundation Trust is part of the Women, Children and Imaging Directorate which also provides gynaecology, genito-urinary medicine, neonatal and paediatric and imaging services. A total of 2993 babies were born at the Royal Free Hospital between April 2014 and March 2015.
- The Royal Free Hospital has eight antenatal beds, 23 postnatal beds and four side rooms that are used for readmission on the Maternity Ward. There are four Day Assessment Unit (DAU) beds. The Labour ward has five beds, three low risk midwifery-led rooms, three close observation beds and two obstetric theatres.
- The maternity service at Royal Free Hospital offers: a consultant-led labour ward; alongside a birth centre; an outpatient antenatal and gynaecology clinic; a fetal medicine unit (FMU); a day assessment unit (DAU); a triage unit; and antenatal and postnatal inpatient wards. Women can also choose to have a home birth supported by community midwives. Four teams of community midwives provide antenatal care, parent education classes, home births and postnatal care in children's centres, GP surgeries and women's own homes. The maternity services also include specialist provision, for example for women with diabetes.
- The gynaecology services at the Royal Free Hospital offer inpatient care, outpatient care and emergency assessment facilities, including an Early Pregnancy Assessment Unit (EPAU). Outpatient care includes colposcopy, hysteroscopy, treatment for miscarriage, termination of pregnancy services and pre-operative assessment. A team of gynaecologists receive support from specialist gynaecology nurses, general nurses and healthcare assistants.
- Gynaecology in patient activity takes place on 7 North, a mixed surgical ward. This report focusses on gynaecology specific pathways. Other findings from the inspection are contained in the surgery report.
- We visited all wards and departments relevant to the services. For maternity services we spoke with eight patients, two relatives, 21 midwives and support workers individually, and three midwives in a focus group. For gynaecology services we spoke with four patients and six nurses. We also spoke with eight medical staff who worked across both maternity and gynaecology services.

Maternity and gynaecology

Summary of findings

Overall we rated this service as good because:

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

However,

- There were three never events involving retained swabs in 2014, 2015 and 2016.
- Record keeping was inconsistent and on-going risk assessment in pregnancy was not recorded in patient records.
- Patients' individual needs and preferences were mostly considered when planning and delivering services.
- The designated bereavement room was not always available for bereaved mothers and they were therefore sometimes cared for in the birth centre.

Are maternity and gynaecology services safe?

Good

Overall we rated safe as good because:

- The approach to incident management was timely and enabled quick mitigation of the risks relating to the health, safety and welfare of service users.
- Staff told us that they were able to raise concerns and were confident that their concerns were listened to.
- Sustained improvements in safety and continual reductions in harm were encouraged.
- We saw documentary evidence that 100% of women said they received one-to-one care in labour.
- The planned and actual staffing levels were displayed on all wards in the gynaecology and maternity units and were in accordance with national requirements.

However:

- Systems, processes and standard operating procedures are not always reliable or appropriate to keep people safe. There were three never events involving retained swabs following a procedure in November 2014, May 2015 and January 2016.
- Cleaning, checking and storage of clinical equipment was inconsistent. We found high level dust; inappropriate storage of clinical equipment in the sluice on the maternity ward and clean linen stored beneath the sink in labour ward; an unsealed delivery pack and out of date needles in one of the delivery rooms.
- Documentation was poor around antenatal risk assessment and cardiotographs (CTG) the machines used to monitor the baby's heart rate in labour)

Incidents

- Escalation of risk was identified through a computer based incident reporting system. Incidents were flagged on this system to clinicians and the executive team. This allowed them to question the clinical teams and review the incident to gather all information. The nationally recognised Royal College of Obstetricians and Gynaecologists (RCOG) trigger tool was used for incident reporting. We were told that all incidents were reported according to the Serious Incident Framework (NHS, March 2015).

Maternity and gynaecology

- There was a strong reporting culture in maternity and gynaecology. We saw that there were 846 maternity incidents and 173 gynaecology incidents reported between October 2014 and November 2015.
- Five serious incidents were notified to the serious incident review panel, two for maternity and three for gynaecology between October and December 2015. Of these, two were reported to the Strategic Executive Information System (STEIS), one for maternity and one for gynaecology. We saw a sample of completed investigations which were robust and demonstrated that lessons learned had been identified and duty of candour observed.
- We saw documentary evidence that action plans were drawn up in response to lessons learned. Action plans were kept under review at the monthly local risk management group/clinical governance meetings and reported to the quarterly Divisional Quality and Safety Board. We saw that there were 13 open actions including eight overdue that related to ongoing guideline development and clinical audit.
- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were three never events involving retained swabs following a procedure in November 2014, May 2015 and January 2016. A form to improve swab counting was put in place after the first and second incidents. The third incident occurred after implementation of the form. Lessons learned showed that there was a need to make the scrub nurse accountable for the swab count by integrating the scrub nurse into the maternity team. The scrub nurse began attending the daily morning handover on labour ward to support the new process.
- Staff told us about changes that had been made in response to lessons learned. A theme from serious incidents was the interpretation of cardiotocography (CTG) recordings of the fetal heart. For example the trust was part of the ongoing work of the North Central London Maternity and Newborn Network to introduce the International Federation of Gynaecology and Obstetrics (FIGO) consensus guidelines on intrapartum fetal monitoring that were published in October 2015. This was mitigated on the risk register. Biannual external CTG masterclasses were introduced to the trust and weekly CTG training was introduced.
- Changes in practice were introduced following the recognition of an increased number of third and fourth degree tears (damage to the perineum involving the anus and anal sphincter). Staff were supported in adopting a 'hands on' approach to delivery of the baby's head and Epi-scissors (specially adapted scissors that ensure episiotomy positioning is correct) were introduced to help staff perform episiotomy (a cut into the perineum to enable delivery of a baby) correctly.
- We were told by managers that when necessary women and those close to them were involved in reviews they ensured that requirements under the duty of candour were met. We saw from a root cause analysis report that parents had been given a verbal apology and that a duty of candour letter had been sent offering them the opportunity to participate in the investigation.

Safety Thermometer

- The Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care. It is intended for public display so that the public are informed about the level of harm free care they can expect. The Maternity Safety Thermometer measures harm from perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. It also records babies with an Apgar score of less than seven at five minutes and/or those who are admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.
- The trust did not display all the metrics of the national maternity safety thermometer. This meant that the public could not readily see the harm specific to maternity care that they may expect to experience.
- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism.

- We saw a 'productive ward' information board for January 2016 on the maternity ward that demonstrated that the unit had a caesarean section rate of 30% which exceeded the trust target of 28.5%. The trust subsequently told us that, excluding maternal request, the overall section rate year to date was 27.6%. The board also showed: there had been 240 births on labour ward and 40 births in the birth centre (a low risk area adjacent to labour ward); there had been one case of Clostridium difficile infection on unit in the previous 150 days and no reported cases of Methicillin-resistant Staphylococcus aureus (MRSA); there had been 135 plaudits and three complaints in the preceding month.

Acuity Tool

- Acuity tools are used to measure and respond to capacity on the labour ward and indicate to staff when the escalation policy should be used to ensure the safety of women and their babies. We did not see staff use an acuity tool, however the matron told us the labour ward coordinator and manager on call cross site used an acuity tool contained within the escalation policy. Each week one of the matrons carried a bleep in order to manage the response required to changes in acuity and activity.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were mostly visibly clean and well maintained. However we some some light dust at high levels. An external company was responsible for cleaning and we saw cleaning schedules on all wards. For example, we saw that the cleaning score for the maternity ward was 95% which was the same as the trust target of 95%.
- We saw that equipment was labelled with tags to indicate when it had been cleaned. Sluice areas were clean and had appropriate disposal facilities, including for disposal of placentae. We noted that drip stands and a glucometer were stored in the sluice which meant that this equipment posed a cross infection risk.
- We observed compliance with the trust infection prevention and control policy. We saw that staff used hand gel, protective clothing and adhered to the bare below the elbow policy. The 'productive ward' board on labour ward demonstrated that there was 92% compliance with hand hygiene and the 'productive ward' board on the maternity ward demonstrated that there was 95% compliance with hand hygiene in December 2015 in comparison to the trust target of 90%.
- We found clean linen stored beneath the sink in labour ward.
- We observed an unsealed delivery pack in one of the delivery rooms. This was not sterile and therefore not fit for use.

Environment and equipment

- An intercom and buzzer system were in use to gain entry to the labour ward and maternity wards. This meant that staff could identify visitors and ensure that women and their babies were kept safe.
- We found equipment was clean and fit for purpose. Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that it was safe for use.
- We saw that a diary was used to record when resuscitation equipment was checked. However, we found that checklists were not used for checking resuscitation equipment to ensure equipment and supplies were complete and within date; it was therefore unclear exactly what staff were checking.
- We found evidence of needles which had expired in 2009 in the labour ward.
- Maternity staff we spoke with knew the pool cleaning and evacuation procedures.

Medicines

- Medicines including controlled drugs were mostly safely and securely stored. We saw that lignocaine (a local anaesthetic) was stored in an unlocked drawer in labour ward.
- Records demonstrated that twice daily stock checks of controlled drugs were maintained and that these were correct.
- Temperatures of refrigerators used to store medicines were monitored daily to ensure that medicines were stored correctly and that women and babies were not at risk of the administration of ineffective medicines. We saw that the fridge on the maternity ward had not been checked 11 times in December 2015 and once in January 2016.

Records

- We saw that patient records were stored securely on the gynaecology and maternity wards. We reviewed 10 sets of maternity records. We saw loose leaves in records which meant that there was a risk of incomplete records and breach of confidentiality. We saw that initial risk assessments were made but not revisited in the antenatal period. Record keeping around CTGs was not robust. CTS were not signed and dated and maternal pulse was not recorded.
- Staff told us women only took postnatal records home if the woman was discharged to the Royal Free catchment area. We were told that this was because the notes were not returned if women lived out of area. This meant that postnatal records were not available to staff providing care in other areas. However, women who lived out of area were discharged home with a discharge letter which was copied to her GP.
- On the maternity unit we saw individual maternity records being reviewed as part of the women's care and the personal child health record (red books) were introduced for each new born. Red books are used nationally to track a baby's growth, vaccinations and development.

Gynaecology records

- We saw that the confidential waste paper bin was full and that papers could be pulled out of the container. This meant that confidential data was not disposed of in a manner that protected peoples' privacy.
- We reviewed five sets of records and saw that appropriate assessment, planning and evaluation was taking place.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and national and local policy.
- Staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process.
- We were told by senior staff that all midwives and maternity care assistants had access to level 3 safeguarding children training in line with the intercollegiate document (2015). Updates at level three were provided annually at the mandatory clinical skills update week. Safeguarding training compliance at level three was recorded at 95% which was equal to the trust target.
- There was a child and baby abduction policy in place to ensure the safety of babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984.
- Information regarding women with safeguarding concerns was kept on an electronic folder on the computer system. A flag showed on the maternity service information system for any woman identified with a safeguarding concern to alert staff to the concern.
- Training was ongoing to safeguard people at risk of and treat those affected by female genital mutilation (FGM). The trust provided evidence that 91% of staff had been trained compared to the trust target of 85% compliance to be achieved in line with the Training Needs Analysis by 31 March 2016.
- We were told of and saw evidence of systems in place to monitor the disclosure of Domestic Abuse by midwifery staff in line with NICE guideline [PH50] 'Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded.'
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). We spoke with senior staff about the provision of safeguarding supervision and were told that the trust did not provide this for staff working in maternity services. The trust commented that the lead midwife for safeguarding received safeguarding supervision from the trust lead for safeguarding and external approved institution, the lead midwife for safeguarding provided safeguarding supervision for the midwives in the vulnerable women's teams and maternity staff had the opportunity to attend group supervision facilitated by the lead midwife for safeguarding. Safeguarding supervision was reported quarterly to the trust integrated safeguarding committee.
- We saw that the CCG had commended the trust for excellent communication related to a complex midwifery safeguarding case.

Mandatory training

- Trust mandatory training covered subjects including adverse incident reporting, conflict resolution, equality

and diversity, fire prevention, infection control, learning disability awareness, load handling, and positive mental health. We saw that 50% of the gynaecology nurses and93% of midwives had completed mandatory training compared with the trust target of 95%.

- Specific maternity mandatory training took place over a week and covered subjects including: maternal and neonatal resuscitation, electronic fetal monitoring, and management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Maternity specific mandatory training and other learning and development was managed by the consultant midwife. We saw that 92% of midwifery staff and 84% of medical staff had completed mandatory PROMPT (Practical Obstetric Multi-professional Training) training.
- Staff told us that the content of the maternity specific study days were changed annually to reflect incidents that had taken place. For example training sessions on controlled delivery in the second stage were introduced in response to the high numbers of third and fourth degree perineal tears. We saw that 94% of staff had completed this training by December 2015 which exceeded the trust expectation of 85% by April 2016.
- Multidisciplinary 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breech presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse.
- The CTG (cardiotocograph) machine was used by midwives on the labour ward to measure contractions and baby's heart rate over a period of time. We saw that staff were required to undertake an online CTG learning package training annually and that 96% of midwives and 94% of medical staff had completed the training.

Assessing and responding to patient risk

- For women using maternity services the booking visit took place before 12 weeks of pregnancy and included a detailed risk assessment. An initial maternity booking and referral form was completed by community midwives at the booking visit. Between April and December 2015 96% of women were seen by a midwife by 12 weeks and six days gestation of pregnancy. We saw that on-going risk assessments were not documented at subsequent antenatal visits which meant that we were not assured that referral to the obstetric team, or other services would be made if risk factors were detected.
- Women who had problems in pregnancy were reviewed on the DAU. From here they could be admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording foetal growth, counselling women regarding foetal movements and smoking cessation, and monitoring babies at risk during labour. We saw that customised fetal growth charts were in use to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy.
- Women were offered vaccinations against influenza and whooping cough. We saw notices on the maternity unit advising people who may have travelled to South America to seek advice about the Zika virus.
- Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman. We saw that there was an extended MEOWS chart used when women required high dependency care. During our visit, we observed that use of the MEOWS identified deteriorating women and that appropriate clinical decisions were made.
- We saw evidence of a guideline for management of sepsis in the obstetric patient which helped staff identify women at risk of sepsis and initiate required treatment.
- Women requiring management of complications were cared for on the Close Maternal Observation Unit (CLOMA), a three bed bay on labour ward. Care was provided by a midwife trained in high dependency care. MEOWS triggers were acted upon by referral to the Patient at Risk (PART) team, an outreach service within the Trust. Any woman who needed additional support and care was transferred to the intensive therapy unit (ITU). The CLOMA was also used for recovery after caesarean section.
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health

Organisation's (WHO) Five Steps to Safer Surgery' guidelines. We saw documentary evidence that all the stages were completed correctly and that checklists showed that this was usual practice.

- NHS Safety Alert 1229: 'Reducing the risk of retained swabs after vaginal birth and perineal suturing states that swabs should be counted whenever they are used.' The unit had three never events concerning swab counting. We saw 100% compliance with an observational audit for WHO checklist and swab, needle and instrument count for labour ward theatre in February 2016 (five instrumental deliveries and 15 caesarean sections). Compliance with two person swab counting was 99% after a normal delivery (audit of 20 midwifery led birth notes).
- The senior midwives on duty provided CTG review known as 'fresh eyes'. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that is it was within normal parameters. We were told that this had been introduced in the past year and had not yet been audited.
- Midwifery handover took place at the change of each shift. Handover included a review of all women on the wards and allocation of work. We observed that the midwifery handover on the maternity ward was organised and systematic. However it was lengthy which meant that night staff did not get off duty on time.
- Formal multi-disciplinary handovers were carried out four times during each day on the labour ward attended by medical staff and the labour ward coordinator. We observed the 8.30am handover which was structured and included discussion on all maternity and gynaecology inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to the appropriate doctor.
- There was a Did Not Attend (DNA) policy that the trust adhered to. This meant that staff were aware of women who had missed appointments and could arrange follow up to ensure that women attended for care and safeguarding concerns were raised when they did not do so.

Midwifery staffing

- Birthrate Plus® is a midwifery workforce planning tool which demonstrates required versus actual staffing need to provide services. Birthrate Plus® is recommended by the Department of Health; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.
- The trust was in the process of conducting a reconfiguration of the maternity service and management told us they planned to conduct a Birthrate Plus® assessment once this was completed.
- Trust data showed that the midwife to birth ratio was between 1:28 and 1:29 for December 2015 to January 2016. This was close to the national average of 1:28. However, the ratio shown on the 'productive ward' board at the time of inspection was misleading for patients and staff as it stated the ratio was 1:33.
- Midwives worked a mixture of 8 hours and 12 hour shifts. Labour ward coordinators were responsible for the management of the activity on the ward and required constant oversight of the ward so that decisions could be made regarding care and treatment and flow of patients. Trust records showed that the band 7 labour ward coordinator was supernumerary for December 2015 and January 2016. However, staff we spoke with felt they were not supernumerary.
- The planned and actual staffing levels were displayed at the entrance to each maternity ward. The labour ward required eight midwives and one maternity support worker (MSW) on each shift, this included staffing for the CLMU and birth centre. We saw that required and actual staffing was met on this ward during our inspection.
- Staffing requirements for the maternity ward was five midwives and two MSWs on the day shift and three midwives and one MSW on the night shift. We saw that required and actual staffing was met on this ward during our inspection. We noted that patients had left comments about staffing on the ward. One said 'During the day the care is excellent. At night, very busy, with little staff present' and another said 'Overall midwives were helpful and offered good care. However, we felt that some of them could be better organised and that at times the ward was understaffed'.
- Staffing requirements for the DAU was two midwives and one support worker.
- We saw documentary evidence that the vacancy rate was 6 WTE; the sickness rate was 4% WTE and maternity leave rate was 6%WTE.

- The maternity unit used agency staff and had its own bank of temporary staff which was made up of permanent staff who undertook extra work to cover shortfalls. Bank midwives undertook the same mandatory training as substantive staff. However, the trust relied on agencies to provide training for agency midwives. We saw that agency staff were required to report to the labour ward coordinator who had access to a register of agency staff. An induction sheet was used to provide a systematic induction to the unit for those who had not worked at the unit before. If problems were identified with agency midwives staff told us they would escalate their concerns to the matron or supervisor of midwives on call.
- We were told that the trust had a direct employment scheme which meant that they were able to retain student midwives on qualification.
- Birthrate Plus® recommendation is that community midwives have caseloads of 1:96. The trust was using a team model and therefore could not provide individual caseload numbers. Community midwives could be called into the hospital as part of the staffing escalation policy. They told us that this happened occasionally and that when they were called in they typically stayed for the whole of a shift. This could impact upon their workload the next day and meant that visits and appointments were rescheduled.
- There was only one midwifery support worker to support five teams of community midwives. Staff expressed the need for more such support. We saw evidence that the trust planned to allocate a midwifery support worker to each team.
- There was a lone worker policy which community midwives adhered to.

Nursing staffing

- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients. We saw a safe staffing board that demonstrated planned staffing met actual staff ratios for each shift.
- We were told that where possible a trained gynaecology nurse was on duty. We saw that gynaecology nurses were not identified on the off duty for 7 North.
- Staff on the ward reported that they were often short staffed. The trust informed us that the staffing vacancy had been identified and active recruitment was in progress.
- Specialist gynaecology nurses worked in outpatient clinic s to provide colposcopy, rapid access cancer and vulval services.

Medical staffing

- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations.
- The trust employed 90 WTE medical staff in the maternity and gynaecology services. The level of consultant cover was 33% which is similar to the national average of 35%. The percentage of registrars 60% which is greater than the national average of 50%. The percentage of middle grade doctors was 1% which is fewer than the national average of 8%. There were 6% junior grade doctors which is similar to the national average of 7%.
- There were 72 hours of consultant cover per week on the labour. At the time of the inspection the consultant staff stayed on the labour ward every day from 8am until 8pm, Monday to Friday and from 8am until 10.30 am on Saturdays and Sundays. Out of hours cover was provided by the consultant on call. A second consultant attended labour ward for elective caesarean sections.
- A consultant anaesthetist provided cover for labour ward between 9am and 5pm weekdays. Out of hours cover was provided by the on-call consultant.
- We saw that Deanery senior house officer posts were not fully filled. The trust employed locum staff to meet this shortfall. However, it was difficult to source sufficient staff. Staff told us that there were unfilled shifts at registrar level. The trust informed us that they were in the process of recruiting to senior house officer and registrar level posts. There was a cross over between those working notice and those starting.
- The gynaecology service was covered by a dedicated hot week consultant, a registrar and a junior doctor. Out of hours cover was provided by a registrar and a junior doctor between 5pm and 8.30pm and a registrar and a consultant from 8.30pm to 8am.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) by consultants and/or middle grade staff.

Major incident awareness and training

Maternity and gynaecology

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

Are maternity and gynaecology services effective?

Good

We rated effective as good because;

- Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care. However, some of these guidelines were out of date. The trust was in the process of standardising maternity and gynaecology guidelines across the two sites. At the time of our visit 50 out of 125 guidelines had been standardised.
- Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care. However, the results of monitoring were not always used effectively to improve quality. For example we saw little progress or learning from Barnet hospital site for the reduction of the caesarean section rate.

However;

- Women we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24-hour period.
- Staff were competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working in the maternity service. Staff worked collaboratively to serve the interests of women across hospital and community settings.
- Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.

Evidence-based care and treatment: Maternity

- Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and procedures via the trust intranet. Hard copies were also available in ward areas.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- One to one care in labour was audited one week a month which demonstrated 100% compliance. A questionnaire was used to survey postnatal women. Outcomes were presented at directorate governance days and were sent to the Clinical Commissioning Group (CCG). Women told us that they were not left alone in labour.
- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- The trust offered screening in line with the National Screening Committee (NSC) recommendations. Patients were supported to make decisions around screening and were provided with the NSC leaflet at booking. We saw documentary evidence to show that the 10 week KPI for haemoglobinopathy screening was 52% and the uptake for Down's screening was 73%.
- Women with high risk results were invited into the FMU for ongoing management and tests such as choronionic villi sampling (CVS).
- We found evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, and care of the new born baby. However, staff described a medicalised approach to care.
- All labouring women were assessed on triage and admitted to the birth centre or labour ward. There was not a default pathway for low risk women to be admitted to the birth centre which meant that they could be cared for in the high risk environment on labour ward. Medical staff told us that they would like to develop a different approach so that low risk women were not on labour ward.
- We saw RAG rated guidance for the assessment of women in triage. This included anticipation that the majority of non-labouring women be sent home after review.

- The latent phase of labour is the early stage of labour before contractions become regular, longer and stronger. Best practice (NICE, 2014) is that women who are not in established labour have better outcomes if they stay at home. The trust policy for latent stage was to encourage women to go home if not in established labour following a discussion with the woman. If the woman declines as she feels unsafe or lives too far away then they are supported with admission to the antenatal ward. They are actively reviewed and if not in established labour they are discharged home. We saw that five women in the four days before our visit who were not in established labour were admitted to the antenatal ward.
- The fetal monitoring guideline was not compatible with NICE (2014) recommendations for categorising fetal heart rate monitoring during labour and the trust was still using the 2007 NICE guidance. They had mitigated against this by clearly stating in the guideline that this was the case and that they were working with the North Central London Maternity and Newborn Network to introduce the International Federation of Gynaecology and Obstetrics (FIGO) consensus guidelines on intrapartum fetal monitoring that were published in October 2015.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was mostly managed in accordance with NICE Quality Standard 132.
- The caesarean section rate for April to September 2015 was 30.8%, which is higher than the national average of 25%. The trust's trigger on the dashboard was 26%. The trust mitigated against the high rate of caesarean sections by publishing data for elective caesarean section (ELCS) due to maternal request which was 2.8% for the same period.
- The senior team told us that the difficulty in reducing the caesarean section rate was poor uptake of vaginal birth after caesarean section (VBAC) and the numbers of women requesting ELCS.
- We asked the management team for the strategy to reduce the caesarean section rate. We were told, and saw, that this is part of the Maternity and Neonatal Action Plan developed when the two trusts merged. The plan included an improved pathway for external cephalic version for breech presentations; monitoring of ELCS; daily caesarean section case reviews and reviewing practice and training around CTGs
- We saw that there was a VBAC pathway aimed at reducing the caesarean section rate. There was a weekly VBAC clinic led by the consultant obstetrician working in conjunction with the consultant midwife and a supervisor of midwives.
- The consultant midwife also worked one day a week on labour ward and the birth centre to support normal birth.
- We noted that Barnet Hospital had reduced the caesarean section rate from 32% in October 2015 to 24% in December 2015. It was not evident that learning was being shared across the trust in order to reduce the caesarean section rate on the Royal Free site.
- Changes in practice were introduced following the recognition of an increased number of third and fourth degree tears (damage to the perineum involving the anus and anal sphincter). Staff were supported in adopting a 'hands on' approach to delivery of the baby's head and Epi-scissors (specially adapted scissors that ensure episiotomy positioning is correct) were introduced to help staff perform episiotomy (a cut into the perineum to enable delivery of a baby) correctly.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect of postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) 'Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors.' This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Evidence-based care and treatment: Gynaecology

- Minor gynaecological surgery was undertaken on a day case basis. The expectation was that the woman went home on the day of the procedure.
- There was evidence from information reviewed and from discussion with staff that the service adhered to The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of necessary forms; HSA1 and HSA4.

- Surgical and medical terminations were performed up to 20 weeks of pregnancy. Choice was offered in line with RCOG Evidence-based Clinical Guideline Number 7: The Care of Women Requesting Induced Abortion. Women could choose to have early medical abortion (EMA), late medical abortion or surgical treatment under local or general anaesthetic.
- Manual vacuum aspiration (MVA) performed under local anaesthetic was available for the termination of pregnancies up to nine weeks. This procedure was carried out in a weekly clinic on the EPAU.
- Women whose pregnancies were between 10 and 14 weeks were offered surgical treatment with general anaesthetic as a day case. Women whose pregnancies were between 14 and 20 weeks were admitted to 7 North for treatment and Women whose pregnancies were between 16 and 20 weeks were cared for on labour ward.
- Consent was appropriately and correctly obtained in line with Department of Health RSOP 8: consent. Consent was obtained at the assessment visit and again on the day of treatment.
- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful. We saw that this happened.
- RCOG Clinical guideline No. 7 advises that information about the prevention of sexually transmitted infections (STI) should be made available. All women under 25 were tested for Chlamydia infection prior to any treatment (Chlamydia is a sexually transmitted bacterial infection). Women with positive test results were referred to sexual health services. Women were also referred to sexual health services for further screening for other STI and treatment.
- We saw documentary evidence that blood was tested at the initial assessment to determine Rhesus factor and Anti-D immunoglobulin administered to women who were found to be rhesus negative.
- We saw documentary evidence that contraceptive options were discussed with women at the initial assessment and a plan was agreed for contraception after the abortion. These included Long Acting Reversible methods (LARC) which are considered to be most effective as suggested by the National Collaborating Clinic for Women's and Children's Health.
- Women who underwent medical abortion were asked to ensure that a pregnancy test was completed after four weeks post procedure to ensure that the procedure had been successful. Staff report that there was one failed medical procedure in the last year. Surgical treatment was offered to complete the termination.
- A discharge letter was given to women providing sufficient information to enable other practitioners to manage complications in line with DH RSOP 3: Post procedure.
- Women were advised of an emergency number to call if they experienced complications.
- We asked about the care of people under the age of 16. A safe contact number was provided to younger patients and they were required to bring someone over the age of 18 with them when they attended for treatment. All people under 16 are referred to the safeguarding team. Children under the age of 14 are referred to the paediatricians.
- We saw that there were policies in place for the disposal of pregnancy remains that took account of women's wishes. Staff told us that there were issues with the storage and disposal of fetal tissue. Fridges were available on 7 North and the EPAU for this purpose. We were told that staff did not always adhere to this policy.

Audit

- The trust provided us with the clinical audit plan for 2015/16 which showed two site specific and 20 cross site obstetric audits and 10 cross site gynaecology audits listed. Audits were presented and discussed at the Clinical Governance and Audit meeting which was open to all staff. we found that there was learning from audit and related development plans.
- The trust actively participated in national audits including the National Screening Committee Antenatal and Newborn Screening audit, the National Diabetes in Pregnancy Audit and Mothers and the national report for perinatal mortality for births: Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE).
- The two site specific obstetric audits were two person swab count and vaginal birth after caesarean section

(VBAC). There was 99% compliance with two person swab count after delivery of the baby (audit of 20 midwifery led birth notes). The VBAC audit commenced in December 2015 and will report six monthly.
- Examples of obstetric audit included induction of labour, postpartum haemorrhage, pain relief in labour, instrumental deliveries, VTE and record keeping.
- Examples of gynaecology audits included colposcopy patient survey, postoperative complications of surgery, medical management of miscarriage and MVA.
- We were told and shown the 'Matron Portal' where matrons entered information regarding audits of meal times, call bell response rates, comfort rounds, respect and dignity and hygiene.
- The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report made 44 recommendations for the trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon.
- We saw documentary evidence that the supervisors of midwives team had monitored its performance against the recommendations of the report for supervision of midwives using the Local Supervising Authority (LSA) benchmark tool and assessed that it was compliant with all recommendations. We did not see documentary evidence that the trust had carried benchmarked against the recommendations related to trusts. However, senior managers told us the 'maternity integrated action plan', which we saw, was based on the recommendations of the Morecambe Bay report. The action plan fed into board assurance that the trust complied with the recommendations.

- All gynaecology audits were cross site and were planned for later in the year, we could not therefore report on outcomes. Audits for colposcopy patient survey, heavy menstrual bleeding, consent for gynaecology surgery and ectopic pregnancy re-audit were planned for September to December 2016. Hyperemesis (excessive sickness in pregnancy), outpatient hysteroscopy, manual vacuum aspiration, post-operative complications in surgery and medical management of miscarriage were planned for January to March 2017.

Pain relief

- Women we spoke with in maternity and gynaecology felt that their pain and administration of pain relieving medicines had been well managed.
- On the maternity ward we saw a variety of pain relief methods available including Tens machines and Entonox, a ready to use medical gas mixture of 50% nitrous oxide and 50% oxygen that provides short term pain relief. Epidurals were available 24 hour a day.
- A birth pool was available in the midwifery led rooms in the Heath Birth Centre so women could use water immersion for pain relief in labour.

Nutrition and hydration

- The Infant Feeding midwife was responsible for the oversight of infant feeding. The trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby.
- The trust had been awarded UNICEF Baby Friendly Initiative stage two accreditation and was preparing for stage three validation in March 2016. This meant that the trust supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- Women told us that they received support to feed their babies. We saw that the initiation of breast feeding rate was 95% across site in 2015. which was better than the national average of 75%. However, some women reported conflicting advice about feeding their babies which caused confusion.
- Babies with tongue tie (a condition where the string of tissue between the baby's tongue and floor of the mouth is too short and affects the baby's ability to latch onto the breast causing feeding problems) were referred to a neonatal clinic where the doctor could divide the tongue tie if required. This meant that women and babies received timely intervention when feeding was complicated by tongue tie.

Patient outcomes: Maternity

- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The Maternity Dashboard serves as a clinical performance

and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.

- The trust used a dashboard that had been developed by the North Central London Maternity and Newborn Network. This enabled comparative data to be used across the trust and across the maternity units in North Central London.
- Information on the dashboard from April to September 2015 demonstrated that:
  - The induction rate was 20% which was less than the trust target of 26% and below the national target of 22%.
  - The caesarean section rate was 31%, worse than the trust target of 26% and the national average of 25%.
  - The elective caesarean section rate was 16%, which was more than the trust target of 13%, compared to the national average of 11%
  - Emergency caesarean rate was 15%, which was similar to the trust target of 15.2%, compared to the national average of 14.7%.
  - The instrumental delivery rate was 11%. The differentiation between Ventouse and forceps delivery was not recorded. The national average for Ventouse delivery is 7% and the national average for forceps delivery is 5.8 %.
  - The third or fourth degree tear rate was 2% of patients.
  - The trust recorded postpartum haemorrhage above 1.5 litres on the dashboard and there were 38 such haemorrhages which equated to 3% of patients.
  - There were two maternal deaths due to indirect causes. Indirect causes of maternal death are those relating to pre-existing medical conditions that may be aggravated by the physiological demands of pregnancy.
- The normal delivery and home birth, stillbirth and unexpected term admissions to the neonatal unit rates were not recorded on the dashboard. The trust provided information which demonstrated the normal delivery rate was 55% in 2015, which is below the RCOG recommendation of 60%. The homebirth rate was 0.4% (n=10) which was lower than the national average of 2.3%.
- The stillbirth rate and number of unexpected term admissions to the neonatal unit rates were not recorded on the dashboard. We saw documentary evidence that 31 babies were still born between April 2014 and March 2015 and 439 term babies were admitted to the Neonatal Unit across both sites.
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) audit stillbirths in the UK. The latest report (December 2015) demonstrated that the stillbirth rate was 3.6 per 100 births across the trust, which is more than 10% lower than the average for similar sized trusts.
- The latest CQC Intelligent Monitoring report (May 2015) found no maternity outliers for this trust.
- The trust did not meet any of the five standards in the National Neonatal Audit Programme 2013. Two standards relate to maternity care, the remainder to neonatal care. The hospital did not have a level three neonatal unit. Babies born between 27 and 34 weeks gestation were transferred to Barnet Hospital. Babies born before 27 weeks gestation were transferred to other neonatal units. It was not measured against the standard for the percentage of babies having their temperature taken within the first hour of birth. The percentage of mothers who receive a dose of antenatal steroids was 81% compared to a target of 85%.

Patient outcomes: Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the gynaecology outpatients during the week. A team of professional staff supported patients in investigative procedures, giving advice as necessary. Emergency scans and assessments were available out of hours. We were told that there was a gynaecology operation scheduled on most days.
- Patients were offered a choice of medical or surgical treatment for termination of pregnancy. We saw that consent forms were completed appropriately. The patient's GP usually signed Part 1 of the HSA1. Alternative systems were in place for obtaining a second signature if the GP had not completed the form.

Competent staff

Maternity

- Maternity specific mandatory training and other learning and development was managed by the

consultant midwife. We saw that 92% of midwifery staff and 84% of medical staff had completed mandatory PROMPT (Practical Obstetric Multi-professional Training) training.

- An induction period of two weeks orientation was offered to newly appointed staff.
- In addition, all newly qualified midwives undertook a nine month preceptorship period prior to obtaining a band 6 position. This meant that they were competent in cannulation and perineal suturing and had gained experience in all areas of the maternity service.
- Appraisal rates for staff were provided for us and these demonstrated that 95% of midwives had been appraised. The consultant appraisal rate was 80%.
- Staff told us that they were 'impressed' with the professional development opportunities available to them. They were encouraged to apply and attend study courses outside of mandatory training.
- Staff described the duty of candour study day that they were encouraged to attend called 'Speak Up'.
- We were told that 12 midwives were qualified in newborn and infant physical examination (NIPE).
- Midwives rotated throughout the service which meant that they were competent to work in all areas in times of escalation.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The NMC sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:15 which confirmed that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.
- We spoke with three patients on the postnatal ward who all reported they felt cared for by skilled staff and felt safe in their care.

Gynaecology

- We were told that 7 North was staffed by one full time and two part time nurses with gynaecological experience. The matron for gynaecology ran a training programme for surgical nurses that included the management of termination of pregnancy.
- Junior doctors reported very positive feedback on training and the support they received from the obstetrics and gynaecology consultant team.

Multidisciplinary working

- A multidisciplinary handover took place twice a day on the labour ward. The handover used an SBAR (Situation-Background-Assessment-Recommendation) handover sheet and included an overview of all maternity and gynaecology patients. We observed the 08.00 hours handover on labour ward and noted that staff arrived late. We saw that the lesson of the week was discussed which was swab counting. The use of the new sheet for recording swab counts was demonstrated and the scrub nurse from theatre attended handover to support the new process.
- Following handover, a caesarean section review took place to provide peer review of care and decision making. This was not multidisciplinary as midwives were not present. A 'daily caesarean section review' proforma was used for the review. We saw that the proforma was systematic and thorough and required a review of Robson Criteria (a nationally accepted classification of urgent caesarean sections). It was unclear form our observations that the tool was being used as intended for peer review. For example, we saw that discussion of the rationale for performing a caesarean section rather than a process of review took place because care and management provided was not assessed. This was interrupted during our observation and abandoned because a deteriorating patient required clinical treatment.
- Communication with community maternity teams was efficient. In the community we were told of effective multidisciplinary team work between community midwives, health visitors, GPs and social services.
- The ward informed community midwives and GPs when a woman had suffered a pregnancy loss. They informed the obstetric office so that ongoing appointments could be cancelled.
- We were told of multidisciplinary links with external trusts. For example, the trust was a member of the North

Central London Maternity and Newborn Clinical Network which enabled the trust to develop shared polices to ensure consistency of quality across the region.

Seven-day services

- Access to medical support was available seven days a week. The early pregnancy service ran weekday mornings but if necessary early pregnancy scans could be done at weekends by the on call consultant or a radiologist could be called in by the on call consultant.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are maternity and gynaecology services caring?

Good

We rated caring in the service as Good because;

- Feedback from patients and those close to them was positive. Patients told us that they felt safe. Staff treated patients with dignity, respect and kindness during all interactions and patient-staff relationships were mostly positive.
- Patients were involved and encouraged to be partners in their care and were supported in making decisions.

Both maternity and gynaecological patients told us that they felt well informed, understood their care and treatment and were able to ask staff if they were not sure about something.

- Midwifery responded compassionately when patients needed help and supported them and their babies to meet their personal needs. Staff helped patients and those close to them to cope emotionally with their care and treatment.
- Patient's spoke highly of the nursing staff on the gynaecology ward and told us care had been 'really good'.

Compassionate care

- Maternity services were added to the Friends and Family Test (FFT) in October 2013. In December 2015 a high percentage of patients recommended the antenatal services, postnatal ward and birth services. The scores were similar to the England average:
  - 91% of women would recommend the antenatal service
  - 95% of women would recommend the labour ward
  - 88% of women would recommend the postnatal ward
  - 93% of women would recommend the postnatal community service
- The CQC maternity survey of December 2015 surveyed women who gave birth in February 2015. A total of 23 women, a response rate of 41%, returned a completed questionnaire. It showed that most outcomes were similar to the national average. The trust scored better than other trusts' in two areas:
  - Women were given a choice about where antenatal check-ups would take place
  - Decisions about how women wanted to feed their babies respected by midwives
- The trust had significantly worse scores compared to most other NHS trusts in England for four areas:
  - Women were not able to move around and choose the position that made them most comfortable during labour.
  - Women were not spoken to in a way they could understand when receiving care during labour and birth.
  - Women were not able to get a member of staff to help them within a reasonable time if they needed attention while in hospital after the birth.

- Provision of help or advice from a midwife or health visitor in the 6 weeks after the birth.

- Patients told us that the staff were kind, compassionate, respectful and treated them with dignity.
- One patient told us that she felt her privacy and confidentiality had not been respected when a social worker allowed the cleaner into her room during discussions.
- We saw that thank you cards were displayed in ward areas; an indication of appreciation from women and those close to them.

Understanding and involvement of patients and those close to them

- Women told us that they felt well informed and able to ask staff if they were not sure about something. One patient told us that she felt the staff took her pregnancy complications 'seriously' and involved her in all reviews of her care.
- Gynaecology patients told us that they felt informed and that 'things were explained step by step'.
- Partners of maternity patients described feeling involved in the care provided. One father told us that he was involved in all decisions. He cut the cord at the birth and 'felt part of the team'.

Emotional support

- A bereavement midwife provided care and support to women who suffered pregnancy loss at any gestation, including termination for fetal abnormality and miscarriage. A cold cot was available which meant that babies could stay longer with parents. Memory boxes were made up for parents who suffered pregnancy loss. Chaplaincy support was available.
- Counselling for termination of pregnancy was provided by the women's health counselling service at the Royal Free Hospital. The counselling service covered all termination clinics and 527 new appointments were attended in 2014-2015.
- Patients told us that food was available outside of set meal times if they did not feel like eating or were unable to eat at set meal times.

Are maternity and gynaecology services responsive?

Requires improvement

We rated responsive as required improvement because:

- Services were not delivered in a way that focused on people's holistic needs. Gynaecology inpatients were cared for in a mixed gender, mixed speciality surgical ward. However, 7 North ward was divided in two: one male side and one female side, separated by a dividing door which was kept closed. All gynaecology patients were cared for on the female side of the ward. Staff told us the side rooms were often used for patients with infections and were always oversubscribed which impacted on women requiring side rooms for termination of pregnancy or miscarriage management. Staff told us that a dedicated gynaecology ward would improve patient care.
- The lack of gynaecology beds meant that patients were admitted to other wards. We saw that gynaecology patients were admitted to 5 North and 5 East the day before our visit.
- There were shortfalls in how the needs of different people were taken into account. For example the antenatal clinic and gynaecology outpatients had a shared waiting room, which some women could find insensitive.
- The trust told us a designated room on labour ward was reserved for women suffering a pregnancy loss. However, the room was not always available for this purpose, for example it was in use by a patient who required isolation due to infection at the time of our visit.
- Patient flow was affected by delay in attendance by doctors. For example waiting for the paediatrician to examine babies prior to discharge and medical review of gynaecology emergency and obstetric patients in triage and DAU.
- The trust policy was for low risk women to follow a default pathway to the Heath Birth Centre. However, staff told us that women assessed as low risk at booking did not consistently default to a low risk pathway. All labouring women were risk assessed by triage staff who decided if women were suitable for the birth centre or required care on labour ward. Managers had merged the birth centre and triage teams to strengthen compliance with trust policy.

However:

- The maternity service was flexible and provided choice and continuity of care.
- The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support people with particular needs.
- There was a specialist midwifery team for vulnerable women.
- Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

Service planning and delivery to meet the needs of local people

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

Access and flow:

Maternity

- The maternity unit had not closed between January 2014 and June 2015.
- Women could access the maternity service via their GP or by direct referral. NICE guidance recommends that women are seen by 10 weeks of pregnancy so that the early screening for Downs Syndrome, which must be completed by 13 weeks and six days of pregnancy, can be arranged in a timely manner. We saw that 96% of women were seen by a midwife by 12 weeks and six days of pregnancy between April and December 2015.
- We were told about and saw written documentation which confirmed women were supported to make a choice about the place of birth. However, we saw that women were risk assessed at booking and that low risk women did not default to a low risk pathway. The consultant midwife told us that the triage and birth centre teams had been merged to increase the flow through the birth centre. Women requiring transfer to labour ward were not always moved due to capacity and therefore remained on the birth centre for ongoing management for example for epidural or augmentation of labour. Staff told us that they do not view the birth centre as a 'real' birth centre.
- The day assessment unit (DAU) provided an assessment service to women over 16 weeks of pregnancy between 07:45 am and 6pm Monday to Friday and 10am and 6pm on weekends on an appointment basis or self-referral drop in. Women could be referred to the DAU by community midwives, GPs, or they could self-refer. Day care was available for women with concerns such as hyperemesis (excessive sickness in pregnancy) and reduced fetal movements. Pre-operative assessment and outpatient induction of labour were also managed on the DAU. The DAU was run by one midwife and a support worker. Medical cover was provided by obstetricians from the on call team and staff told us that delay in medical review impacted on timely management and treatment for patients. Women were seen on the triage unit out of hours.
- Women for induction who were considered low risk were given the prostin pessary used to induce labour on DAU and were then sent home to return six hours later for assessment and onward treatment.
- There was a designated triage room on labour ward where women with urgent complaints could be reviewed and assessed. Women were provided with the telephone number for labour ward and a midwife was allocated to work the triage room on a daily basis.
- The Heath Birth centre was located adjacent to labour ward and separated by double doors. The birth centre had its own entrance and consisted of three rooms, one with pool birth for women to use for pain relief in labour and for birth. Low risk care was supported by a variety of trust policies aimed at promoting normality. The birth centre staff had been merged with the triage team to encourage flow of low risk women to the birth centre rather than labour ward.
- Elective caesarean section lists ran each weekday and there were typically two operations on each list.
- We were told that there were problems with discharging women to areas outside of the trust. On the postnatal ward one midwife was responsible for completing discharges each day. Staff told us that there had been an improvement in the time taken for women to be discharged since this was introduced. However, on the

day of our visit we observed that there were delays in the paediatrician attending the ward to examine babies prior to discharge. This was causing a backup of women on the labour ward waiting for transfer to the postnatal ward. A member of the midwifery team with the NIPE qualification was redeployed to meet the needs of the postnatal ward and commenced the baby checks.
- We were told that women could be diverted between sites in times of increased activity. We saw that four women had been transferred from Barnet Hospital in 2015, three for induction of labour and one for augmentation (speeding up) of labour.
- We noted that quarterly bed occupancy was 63% between June and September 2015. This was similar to the England average of 62%. This indicated that women were having similar length of stays in hospital in comparison to the other trusts.

Access and flow: Gynaecology

- A community gynaecology clinic was located next to the main hospital where family planning, menopause, pre-menstrual syndrome and termination of pregnancy services were provided.
- Gynaecology patients were cared for on 7 North, a mixed surgical ward. Staff told us that they considered it would be safer for the gynaecology ward to be located near the rest of the gynaecology services where staff with gynaecology expertise are based. We saw documentary evidence that the staff had written a formal letter of concern to the Clinical Director.
- One patient told us that she had waited for a long time for a bed on the gynae ward after her surgery. The lack of beds also impacted upon patients admitted with gynaecology emergency who at times were admitted to other wards. We saw that gynaecology patients were admitted to 5 North and 5 East the day before our visit.
- Staff told us that the side rooms on 7 North were used for patients with infections and that this impacted on women receiving treatment for termination of pregnancy or miscarriage. Trust policy was that if a side room was not available such women would be cared for in a closed bay. Staff said there had been meetings about capacity on 7 North but there was no resolution to this situation at the time of our visit.
- Staff told us that the inpatient termination of pregnancy service was 'managed badly' and was dependant on one staff member. They expressed the view that a separate area would improve the TOP service and provide more dignity and privacy for women.
- An early pregnancy assessment unit (EPAU) offered appointments between 7.30am and 8pm weekdays and 9am to 5pm on Saturdays. The EPAU service offered care on both the Royal Free and Barnet sites on alternate Sundays which meant that the EPAU service ran seven days per week. Referrals for investigation and treatment into bleeding in early pregnancy were accepted from midwives, GPs and the emergency department. There was access to scans and medical opinion was accessible from the on call registrar.
- Staff told us that waiting times could be lengthy when waiting for senior review in gynaecology emergency and obstetric triage because the registrars were busy on labour ward.
- We saw that the numbers of patients that required admission and were admitted within 18 weeks ranged between 91% and 99% from May to December 2015. A total of 19 breaches of the 18 week RTT occurred.
- Consultant led hysteroscopy was offered on an outpatient basis. There was rapid access clinic for the two week cancer pathway, a nurse led colposcopy clinic and a nurse led vulval clinic.
- We were told that there were high DNA rates for follow up following colposcopy. This was on the risk register and the trust had an action plan in place. It was identified that education was an important factor in follow up but women chose not to attend despite this.

Meeting people's individual needs

- We saw that the antenatal clinic and gynaecology outpatients shared accommodation.
- A designated room on the labour ward was reserved for women suffering a pregnancy loss. However, this room was in use by a patient who required isolation at the time of our visit. We asked where bereaved women would be cared for if the room was not available and were told that they would be cared for on labour ward. Staff expressed dissatisfaction with this arrangement and told us that alternative space off the birth centre or labour ward was being investigated.
- Gynaecology inpatients were cared for in a mixed gender, mixed speciality surgical ward. However, 7 North

ward was divided in two: one male side and one female side separated by a dividing door which is kept closed. The trust told us that all gynaecology patients were cared for in the female side of the ward.

- The consultant midwife held a Birth Options Clinic for women requesting home birth when risk factors were present. A birth plan was made in discussion with the woman to support labour ward staff.
- A birth centre was located on labour ward. We saw told that three rooms offered specialist equipment such as beans bags and birthing balls to promote the comfort of women in labour. A birth pool was located in one of the rooms for women who wished to use water immersion for pain relief in labour.
- A midwife from the Heath birth centre ran a 'birth centre' clinic every Friday for women who wished to birth in the Heath Birth Centre.
- The trust ran a joint antenatal and endocrine clinic to support women throughout pregnancy. Specialist midwives for diabetes, screening and fetal medicine, and safeguarding who, having successfully completed additional training, gave advice and support to women and midwives.
- There was a specialist midwifery team for vulnerable women. Staff told us that funding had stopped for the perinatal mental health team and that work was ongoing with the North Central London Maternity and Newborn Network to consider provision for perinatal mental health across the network. However, senior managers told us that funding had been obtained for a team.
- We saw that there were effective processes for screening for fetal abnormality. The FMU ran two sessions per week where fetal abnormalities could be investigated. We were told that the trust were planning a cross site fetal medicine service and would increase sessions.
- Women identified with a high risk of fetal abnormality, such as Downs's syndrome, were invited into the FMU for on-going treatment and referral to specialist centres if appropriate.
- Partners could visit between 8am and 9pm. Other people could visit at fixed times. This enabled new parents to spend private time with their babies. Staff told us that fathers were welcome to stay overnight. One patient told us that she appreciated the fact her mother could stay overnight.
- We saw a variety of patient information leaflets available for both maternity and gynaecology patients.
- Information leaflets were available for women suffering pregnancy loss outlining the choice of expectant (awaiting events) or surgical management.
- We saw that there was an interpreter service available by telephone.
- Privacy and dignity was enhanced by the use of privacy screens around beds and at the entrance to rooms on labour ward.
- Telemetry CTG machines were available which meant that women were able to be mobile in labour.
- Counselling was provided to gynaecology and maternity patients by the Women's Health Counselling Service.
- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, there was on-site NNU.
- Supervisors of Midwives (SoMs) were available to help midwives provide safe care of the mother, baby and her family. SoMs are experienced midwives with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met women's needs.
- The Supervisors of Midwives provided a 'Listening Service'.
- Gynaecology patients told us that call bells were answered promptly and that they 'wanted for nothing'.
- We saw that there were policies in place for the disposal of pregnancy remains that took account of women's wishes. Staff told us that there were issues with the storage and disposal of fetal tissue. Fridges were available on 7 North and the EPAU for this purpose. We were told that staff did not always adhere to this policy.

Learning from complaints and concerns

- A complaints manager was responsible for complaints which were handled in line with trust policy. If a woman or relative wanted to make informal complaints, they would be directed to the midwife or nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns. PALS used a closure form for informal complaints so that themes could be identified. Patients would be advised to make a formal complaint if their concerns were not resolved.

- We saw a trust information leaflet for patients and those close to them informing them of how to raise concerns or make complaints. Complaints were reviewed weekly and distributed to responsible officers for investigation and response within 25 days. A quarterly report was submitted to the Divisional Board.
- We discussed learning from complaints with the management team who told us that care issues and staff attitude were common themes.
- Information from the trust indicated that there had been 10 maternity and three gynaecology formal complaints made between October and December 2015.
- We saw evidence that Duty of Candour was observed.

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecology department was led by a clinical director, a director of operations and the director of midwifery and gynaecological nursing, a head of midwifery and a service line lead.

Overall we rated well-led as Good because:

- There was a robust approach to risk and governance.
- There was a statement of vision and strategy and staff we spoke with demonstrated an awareness or understanding of it.
- There were good clinical multidisciplinary working relationships. Leaders were described as visible and approachable.
- An integrated action plan was approved following the merger with Chase Farm and Barnet Hospitals NHS Trust. Changes made included enhanced recovery for women having caesarean births, outpatient induction of labour and the implementation of an Anti-D clinic.
- We saw examples of innovation in maternity to improve patient outcomes. For example, scissors specifically designed to prevent excessive damage to the perineum.

However,

- Whilst some good practice from the integrated action plan had been embedded at the Royal Free, we were informed by staff that the site had not made the same improvement on the caesarean section rate compared with Barnet Hospital.

Vision and strategy for this service

- Following the merger with Chase Farm and Barnet NHS Trust in July 2014, the trust commissioned an assessment of the maternity services to seek assurance about the quality and safety of the maternity services. An integrated maternity and neonatal integrated action plan was approved by the trust to address clinical governance, maternity dashboard triggers, themes from serious incidents, antenatal and newborn screening, leadership structure and midwifery establishment. It also included staff experience, education and training, patient experience, service redesign, community and neonatal and integration and midwifery supervision.
- The action plan was reviewed at the monthly Clinical Governance and Clinical Risk Committee meetings and quarterly by the CQRG which is attended by commissioners. We saw documentary evidence that 108 actions had been completed since July 2015, and 37 actions were in progress and on track to meet their deadline. Actions that were behind schedule were identified and monitored through a dashboard and there were 14 such actions.
- We observed that the Women's and Children's directorate had a vision and strategy. However, this was not underpinned by detailed, realistic objectives and plans and staff could not articulate the content.

Governance and risk management

- A Divisional Director of Midwifery and Nursing managed the maternity and gynaecology service trust-wide. The gynaecology services were managed by a matron cross-site. Locally, a Head of Midwifery managed the maternity services.
- A quality manager led a team with responsibility for patient safety and risk, compliance, audit and guidelines and complaints.
- The risk and safety manager reviewed all electronic reporting system submissions. These were discussed at a weekly risk meeting and allocated to an incident manager if it was considered that further investigation was required.

- The NRLS template was used to identify serious incidents which were reviewed by a multidisciplinary panel and a three day report produced. Serious incidents were uploaded to STEIS twice a week and were reviewed at the trust wide serious incident review panel (SIRP). A triage process was used to decide whether an internal investigation or an external RCA was required.
- Following investigation or root cause analysis the serious incident was discussed by the SIRP who made a judgement and decided on recommendations and actions.
- The weekly multidisciplinary perinatal meeting reviewed adverse events in order to identify the causes so that steps could be taken to prevent recurrence.
- Staff told us that they received feedback in various ways including at weekly meetings, 'lesson of the week' board and a quality and risk newsletter called Risky Business. If they submitted anelectronic reporting system form, staff received personal feedback on the incident reported. Performance issues were taken up with the individual staff member.
- We reviewed the minutes of the risk management meetings for both maternity and gynaecology and the obstetrics and gynaecology governance group for March 2015 to November 2015 and saw that the meetings followed a standing agenda. Issues were identified and actions were planned and reviewed.
- The maternity and gynaecology risk register was reviewed monthly at the risk management meeting. We saw that the risk register contained 35 risks, nine risks related to maternity and two risks related to gynaecology on the Royal Free site. We saw that risks were RAG rated, that progress was noted, that the risk register was discussed at the monthly obstetrics and gynaecology governance group meeting and reported on a quarterly basis to the Divisional Quality and Safety Board.
- The trust used the North Central London Maternity and Newborn maternity dashboard. Quality data was recorded monthly and reviewed at the obstetrics and gynaecology governance group to identify trends and to aid forward planning.
- Guidelines were kept under review by the compliance, audit and guidelines manager. A guideline implementation plan was in progress tostandardise guidelines across the merged services. We saw that 50 guidelines were out of date. When asked, a midwife showed us the Infant Feeding Policy that was dated 2009. We saw that 80 out 125 guidelines had been harmonised across the merged sites. They were discussed at the Women's Health Guidelines group and ratified at the Obstetrics and Gynaecology Governance Group meeting.
- A Labour Ward Forum and Maternity Services Forum met monthly to identify areas of good practice and new evidence based practice.

Leadership of service

- Midwifery staff spoke positively about matrons at departmental level and their support in general. We saw good examples of leadership and teamwork at ward level.
- Staff said that senior managers were visible, approachable and supportive. This meant that they were easily accessible to staff.
- The clinical director (CD) reported a good working relationship with the Divisional Director of Midwifery and the Head of Midwifery (HOM), the business manager and the medical director. The CD could also go directly to the chief executive officer (CEO) and felt able to access him as necessary.
- We saw that the Director of Midwifery had direct access to the trust board. This meant that the board could be readily sighted on issues relating to maternity.
- Members of the trust board were visible. There was a nominated non-executive director with the responsibility of maternity services.
- Staff assimilated into the management structure from the merger with Chase Farm and Barnet NHS Trust told us they 'know what a good executive team looks like now'.
- Whilst some good practice from the integrated action plan had been embedded at the Royal Free, the site had not made the same improvement on the caesarean section rate compared with Barnet Hospital.

Culture within the service

- Midwifery and nursing staff all had a strong commitment to their jobs and displayed loyalty to senior staff.
- Staff described a very supportive team culture and told us that there was a 'real sense of team work within the maternity services'.

- From our observations and discussion with staff we saw a strong commitment to meeting the needs and experiences of people using the service.
- We saw that monthly 'speak up' sessions were held for directorate staff where staff could attend and raise concerns. These were initiated in response to complaints of bullying and harassment and staff told us that there had been a change in culture.

Public and staff engagement

- The local Maternity Service Liaison Committee (MSLC) focus groups were organised and led by the team of supervisors of midwives. Women were invited to attend this drop in group to share their experience and make suggestions for improvements to the service.
- 'You said we did boards' were visible in the clinical areas which demonstrated that the trust listened to patient's views and acted on them. For example we saw the following comments:
  - You said there were broken chairs in the waiting room and the room needed refurbishment
  - We purchased new chairs, repainted the room and put up a welcome board with staff names and pictures.
- We were told that the trust worked with Jewish and Somali user groups to ensure that services met the needs of members from these sections of the community.
- A 'Maternity Star' was peer nominated each month and the successful member of staff was displayed on a notice board along with all nominees.

Innovation, improvement and sustainability

- A 'fetal pillow' had been designed to aid delivery of the baby at caesarean section. The fetal pillow was used to elevate the baby's head making operative delivery easier.

Services for children and young people

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

Information about the service

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

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

Children's services within the Hampstead site of the Royal Free Hospital provided care to children and young people between the ages of 0-19 years of age. The children's ward at the Royal Free Hospital had 20 beds with 12 single rooms, all with en-suite facilities and reclining chairs so that one parent could stay overnight with their child. The special care baby unit at the Royal Free Hospital provided special care for babies born at 34 weeks or over. There were 14 special care cots, including two emergency care cots to enable staff can to stabilize and treat critically ill babies before transferring them to another unit. Two external organisations provided retrieval services for children and neonates.

During our inspection we spoke with one advanced neonatal nurse practitioner, two practice educators, two second year child field of practice students, one junior doctor, four consultants, one neonatal sister, two band 6 nurses, one medical student, one outpatient sister, one recovery theatre practitioner, two matrons, one play specialist , one school manger, one teacher and one learning support assistant, one band six charge nurse, one CAMHS team sister, three junior doctors, one middle grade doctor, one safeguarding nurse, one nursery nurse, two ward sisters, two bank physiotherapists, two staff nurses, one hospital chaplain, 11 parents, one child, one head of nursing, one head of community nursing.

We attended a senior management team meeting with four consultants, one site manager and two senior nurses, and attended a psychosocial meeting with six multidisciplinary staff. We conducted one theatre visit and a meeting with one plastic surgeon. We attended one neonatal handover with three junior doctors, one advanced neonatal nurse practitioner, and one physician assistant.

Services for children and young people

Summary of findings

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

The trust met the Royal College of Paediatrics and Child Health (RCPCH) standards for paediatric consultant staffing levels.

The special care baby unit generally met the British Association of Perinatal Medicine standards (2011) for staffing neonatal units, apart from very few occasions.

There was good access and flow within the children's service. Patients received evidenced based care and treatment and good multi-disciplinary working existed between the children's services, external providers and the child and adolescent mental health service.Training provision to staff was good and recording of mandatory training was enhanced by the implementation of an electronic system to monitor staff compliance.

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

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

The service was well-led and a clear leadership structure was in place. A governance system was in place and we saw that clinical risks were identified. Feedback from staff, parents and children and young people was good.

However,

We saw that although services provided evidenced based care as identified within evidenced based clinical guidelines, many of these were out of date posing potential risks to patients.

Nursing levels on the children's ward were not always compliant with the Royal College of Nursing (2013) standards.

There was an over reliance on agency nurses, however there was a recruitment programme in place.

Post-operative recovery facilities were not child friendly and children had to share the post-operative recovery area with adults.

Are services for children and young people safe?

Good

We rated safe as good because:

- Children's services at the Royal Free Hospital had reliable incident reporting systems that the various staff members we interviewed were able to describe in significant detail.
- Staff were aware of their responsibilities to report incidents and lessons were learnt where incidents had taken place and cascaded to staff.
- The clinical areas were visibly clean and there were robust systems in place to ensure that children and their families were protected from the risk of harm associated with hospital-acquired infections.
- Staff undertook regular training to ensure they could recognise and respond to the needs of vulnerable patients.

However,

- There was an over reliance on the use of agency nurses, however all agency nurses received induction and many had worked at the Royal Free for a significant period. Medical staffing within the neonatal unit sometimes relied on general paediatricians from other disciplines to provide out of hours cover. However, there was also an on call arrangement with Barnet Hospital and the paediatricians were trained in advanced paediatric life support (APLS).

Incidents

- Systems were in place to ensure incidents were reported, investigated and lessons were learnt. Incidents and significant events were discussed at ward meetings, mortality and morbidity meetings and governance meetings in association with the risk register.
- Staff we spoke with confirmed that safety alerts and lessons learned from incident reporting were circulated via email, and were discussed at various meetings appropriately.
- We spoke with a range of medical, allied health professionals, school teachers, play specialists and

nursing staff. All were able to describe the hospital incident reporting system, and were able to explain their roles and responsibilities with regards to the reporting of incidents using the trust's electronic reporting system. The software application allowed staff members to report adverse events and near misses and facilitated initial recording through to investigation and subsequent root cause analysis.

- The nurses and doctors we interviewed explained to us and cited examples of how lessons learnt had been formulated from reported incidents using the incident reporting system.
- At the meeting with the senior executive team we were told about a serious incident involving a child and the resulting investigation had been appropriately recorded via the incident reporting system. The lessons learned from that incident had been appropriately escalated and cascaded to staff.
- A senior nurse from the neonatal unit told us that the incident reporting system was robust and that the processes involved in incident reporting ensured that timely feedback was given to whoever raised an incident on the system. We inspected a copy of the risk newsletter from January 2016. The unit had implemented an "improvement of the week", which was discussed at the weekly morbidity meetings. The newsletter gave details of incident reports from May to December 2015 and included incident case studies highlighting key areas of good practice.
- We saw and inspected the children's safety and quality bulletin with hypertext links to more detailed information for readers. The bulletin was emailed to all staff in children's services.
- We inspected the outcome of all paediatric incidents dated October to December 2015.There were a total of 87 incidents, 69 of which caused no harm with 5 near misses and 13 where harm occurred. We also examined the data from trends in paediatric incidents prepared by the trust and saw that the top category of incidents related to documentation including paper records and drug charts, treatment, procedures and admission and discharge.
- A neonatal sister we spoke with told us that the trust had rigorous policies and a culture of patient safety. Other staff we spoke to were able to give examples of how the incident reporting process operated in the trust and we were shown samples of patient notes where incident reporting had been documented. We saw that there was a low level of incidents but all staff we spoke with were confident that they were fully able to utilize the incident reporting system. Staff we spoke with told us that the trust had rigorous policies and a culture of patient safety
- Junior doctors we spoke with fully understood how to report an incident using the incident reporting system and confirmed that the email response to incident reporting was good. Doctors we spoke to in the neonatal unit confirmed attending the weekly perinatal meeting.
- We ascertained from the staff members we interviewed that training in the use of the incident reporting system was part of the induction process and the student nurses we spoke to were also aware of the reporting system.
- The nurses working in the day surgical unit were confident in being able to escalate a concern or make an incident report. The student nurses we interviewed were familiar with the process of reporting incidents.
- We noted that there were regular morbidity and mortality meetings held throughout children's services and we inspected the minutes from the perinatal meetings dated Monday the 16th December and the 21st December which detailed the management of individual neonates.

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 examined a serious incident which had occurred in the trust some weeks prior to our inspection and were reassured by the medical and nursing staff we spoke with that all procedures had been followed in dealing appropriately with the incident including applying the 'duty of candour' and being open with the child's guardians.

- The lessons learned from that incident had been appropriately escalated and cascaded to the multi disciplinary team and the outcome of the investigation into this serious incident resulted in new moving and handling procedures.
- A duty of candour flowchart was available for staff to access. We saw that there were laminated notices about the duty of candour in prominent places around the ward
- A parent told us how a student nurse had made a mistake in selecting the correct baby milk and that she had received a full and frank apology from the student when she realised her error.

Safety Thermometer

- Between December 2014 and November 2015 there were no incidents of pressure ulcers, falls with harm or catheter acquired urinary tract infections reported.
- Clinical performance data was reported monthly and displayed on the children's and young people's safety thermometer dashboard. During our inspection we examined a range of these dashboards in the various areas we inspected and we saw that the data was prominently displayed.
- The junior doctors we spoke with were aware of PEWS (Paediatric Early Warning System), SBAR (situation, background, assessment, recommendation) and sepsis six and believed that the organisation was safe. Similarly nurses we spoke with were familiar with how to observe a deteriorating child. We inspected the sophisticated PEWS assessment proforma which had been specially designed for children's services.
- We noted that a protocol for sepsis six was cited in the trust annual report for the assessment of feverish children. Senior staff we spoke with told us that aspects of sepsis six would be incorporated within assessment documentation.
- The official launch of the sepsis six pathway in the emergency department at the Royal Free Hospital was in January 2015. The trust reported that the paediatric department had achieved a 100% compliance rate in the first hour of identifying infection in an infant using the sepsis six pathway.
- Although the staff used PEWs and SBAR to monitor deterioration, no formal patient acuity tool for staffing levels was in use at the time of our inspection.

Cleanliness, infection control and hygiene

- Staff at the Royal Free Hospital who worked within children's and young people's services including the neonatal unit had a good understanding of their roles and responsibilities in relation to cleaning and infection control processes and practices.
- We spoke with an infection control link nurse and we inspected the inspection control procedures and noted that each clinical area had an infection control 'link' staff member.
- Staff told us that they could easily contact the infection control team, which meant appropriate professional advice was available. We saw that the "Freenet "data base contained a range of Infection Prevention and Control (IPC) policies and we inspected a sample of these.
- All staff received IPC training and we inspected the database for attendance and saw that it was 89% compliant for staff across children's services.
- Parents and staff members we spoke with told us that compliance to IPC procedures such as hand washing and the use of hand sanitisers hand was good across children's services. We observed staff frequently using the hand sanitizers and washed their hands. We noted that all staff carried personal containers of alcohol gel. Parents we spoke with told us that they had seen staff members frequently washing their hands and some of them had also been given instructions about hand washing and the use of hand sanitizers.
- We saw that some of the clinical areas were in need of refurbishment with some tiled areas in need of re-grouting. We noted that the hand sanitiser was broken in one of the cubicles we inspected.
- We saw that there were "six steps of hand washing" poster prompts to encourage hand washing and the use of hand sanitisers.
- A mother and a father we spoke with told us that they had witnessed the staff engaged in hand washing procedures but that they had never been taught how to do it themselves.

Services for children and young people

- We inspected breast milk storage facilities on the neonatal unit and found it complied with recognised national standards including fridge and freezer monitoring. We also inspected the fridge and freezer logs which were up to date.
- The drug fridge temperatures had not been checked daily in the day surgical unit
- Staff on the neonatal unit told us that the unit employed a technician to maintain its equipment
- We observed medical and nursing staff adhering to hand washing protocols and procedures. We saw cleaning schedules in place, which identified the tasks and frequency of cleaning in each area. These cleaning schedules were completed with signatures and dates to confirm the respective tasks were completed.
- Discussions with staff confirmed that nursing and ward assistants had specific roles in relation to cleaning duties. Staff received infection prevention and control training as part of their induction and as part of the annual mandatory training and we inspected the mandatory training data base data base to confirm this.
- We inspected two commodes and one set of weighing scales and all were visibly clean and had appropriate I am clean stickers applied. We saw that the dirty utility rooms were very clean and tidy.
- We inspected the neonatal unit and observed that overall cleanliness was good. We examined a parent accommodation room which was also clean and equipped with hand sanitisers. The corridors and clinical areas were all visibly clean.
- We visited an the anaesthetic room of the theatres and saw that it was visibly clean.
- The clinical areas of children's services had their own regular cleaner. We examined the cleaning schedule and the differing coloured mop heads which were used for specific cleaning duties and which followed the national colour coding for cleaning equipment. We saw that the correct colour coded disposable mop heads, disposable cloths and appropriate buckets and mop handles were used.
- We inspected the sluice areas of children's services which were tidy and clean and saw that waste management was compliant with national standards and that all waste receptacles were colour coded appropriately.
- We inspected the sharps bins throughout children's services and all had been dated. We also inspected the linen storage areas and noted that there was sufficient clean linen available.
- We inspected a range of patient equipment such as blood pressure cuffs throughout children's services and these were all clean and had been appropriately labelled with clean stickers.
- There were monthly hand washing audits carried out throughout children's services. Audit results were communicated to the staff of the children's services by email and were discussed at the meetings. We inspected the cleaning protocols used throughout children's services saw them in place in the sluice areas.
- We inspected the Trust annual report and saw that during 2014/15 PLACE monitored the care environment in the Royal Free Hospital, which performed well compared to other similar trusts.
- We saw that staff followed the personal protective equipment (PPE) protocol and the link nurse we spoke to told us that PPE advice was freely available from the central infection control department. A trust PPE poster was displayed in the sister's office.
- The play specialist we spoke with told us that toy cleaning schedules were in place.
- We inspected the trust annual report for 2014/15 and noted that the number of cases of clostridium difficile infections had fallen by 16% during the year from 69 to 58 cases across the whole trust. The trust reported having the lowest MRSA bacteraemia rate among London hospitals
- Apart from seasonal respiratory syncytial virus there were no specific infection control issues noted during the inspection and we observed that there were notice boards within the staff rooms detailing both infection control bulletins regarding future meetings and issues such as clostridium difficile rates.

Environment and equipment

Services for children and young people

- The care environment was child friendly although the children's services accommodation was quite old and in need of refreshment. The children's outpatient clinics took place in a specially designed children's hospital suite on the first floor of the Royal Free Hospital which had recently been refurbished and was based on a life-size animal and natural world theme.
- We examined the resuscitation trolleys and resuscitation equipment throughout children's services and the trolleys were clean, secure, but not all were updated and one had not been checked and logged on a daily basis. We saw that the resuscitation trolley was not checked daily in the day surgical unit and noted that the expiry date on 3 pairs of latex gloves had expired and that a copy of the BNF was out of date.
- We checked the resuscitation trolley on the neonatal unit and noted that it was compliant. However, when we inspected the neonatal transfer trolley we saw that one of the masks was out of date. We checked the drug trolley and the resuscitation trolley in children's outpatients and saw that both were compliant with standards.
- Equipment suitable for babies, children and young people was seen in all clinical areas and staff on the neonatal unit told us that the unit employed a technician to maintain its equipment. All the medical equipment was up to date and the neonatal intensive care equipment managed by one of the equipment companies and all equipment was PAT tested with EBME (Electro-biomedical Engineering) on site.
- We inspected the checking of fridges for breast milk storage for cleaning and temperature monitoring and found them to be up to date.
- Appropriate measures were in place to maintain security throughout children's services and security cameras were located throughout the building and people had to ring a bell to enter the clinical environment. We also noted that tailgating prevention posters were displayed. However, some mothers found the wait to get in quite lengthy.
- During our time in the children's ward a fire alarm was activated and we saw that all fire procedures were well managed.

Medicines

- Medicines management was in line with trust policy, for example medicines were locked in cupboards and the nurse in charge carried the controlled drug keys. We reviewed three drug charts and saw that all were legible and dated and signed appropriately with all relevant information including allergies, dosage and route of administration.
- Medicines and controlled drugs were secured safely and appropriately accounted for in the records we inspected.
- A paediatric pharmacist we spoke with told us they were invited to the children's ward huddle to discuss any pharmacy or medicine issues.They confirmed that advice was available 24 hours a day, seven days a week via on call arrangements. Otherwise dispensary was available from 9am to 5pm Monday to Friday and in the mornings on Saturdays and Sundays.
- We inspected drug storage facilities across children's services and all aspects were seen to be compliant to recognised standards with the exception of the drug fridge temperatures which had not been checked daily in the day surgical unit.

Records

- We observed that records were stored securely.
- We reviewed a mixture of three sets of medical and nursing notes of children and found both the storage and completion of the records was good, with weight and height recorded, PEWS recorded and the use of pain scales evident.
- We inspected the paediatric anaesthetic care pathway which was comprehensive and included the World Health Organisation (WHO) surgical safety checklist. We saw that this was used in the operating theatre we visited, and saw evidence in patient records.
- We saw that doctors and nurses did not have name stamps for record reporting.

Safeguarding

- We saw that a number of safeguarding procedures for vulnerable children were in place. The safeguarding children's advisor told us that safeguarding was a whole trust service and that mandatory and statutory training (MAST) ensured that everyone was up to date with their level three safeguarding training. They told us that "I am

very happy that we learn from serious case reviews and serious incidents and what I like about this trust is that they have allowed me to access courses on sexual exploitation"

- The children's services had a dedicated children's safeguarding team who worked closely with the adult safeguarding team. The named nurses were supported by named doctors.
- Mandatory training records showed that compliance for safeguarding training was 87% for the 398 staff who worked in children's services.
- Staff we spoke with on the neonatal unit told us that they used "red folders" as an alert for safeguarding issues
- Safeguarding reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide.
- Staff we spoke with demonstrated knowledge of the safeguarding processes. They knew what to do and who to contact should a concern be raised.
- The National Institute for Health and Care Excellence (NICE) safeguarding guidance recommends that qualified staff groups be trained to a level three standard in safeguarding and we were told that staff attended child safeguarding training, initially at trust induction and then subsequently during annual mandatory training.
- Children who failed to attend an outpatient appointment were monitored and were usually sent an another appointment, and safeguarding procedures were implemented where necessary .
- We saw that posters on how to deal with issues of female genital mutilation were highly visible in staff rooms.

Mandatory training

- Overall mandatory training compliance within children's services at the Royal Free Hospital was at 87%. Compliance for appraisals was 99% and infection control was 100%.
- The trust had recently appointed a lead practice educator for paediatrics and neonates and this appointee had introduced a new electronic system for recording mandatory and statutory training (MAST). Individual staff were monitored for compliance through the electronic staff record.
- The electronic system for recording MAST appeared comprehensive and captured system and saw that it captured all nursing and HCA staff training and was linked to appraisals. It was scheduled to incorporate nurse re validation, paediatric immediate life support (PILS), equipment and medicine competencies, mentorship and staff development days.
- Additional training in FGM and sexual exploitation was available.
- Staff we spoke to in the outpatient department told us that their mandatory training and other training such as FGM and sexual exploitation were up to date.
- We saw that a nurse revalidation quiz for nurses to complete had been developed and we also noted that the trust has invested in post qualifying education.
- We spoke with members of staff of all grades, and confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, paediatric resuscitation, fire safety, manual handling, infection control, and safeguarding.
- A theatre practitioner we spoke with told us that the majority of staff in theatres were PILs trained and data supplied by the trust showed that PILS compliance at the Royal Free Hospital Recovery was 85% with 15% of anaesthetists being PILS trained. The Resuscitation Council (UK) Paediatric Immediate Life Support (PILS) course was launched in 2007 for healthcare professionals who may have to act as first responders and treat seriously ill children or children in cardiac arrest until the arrival of a cardiac arrest team.
- Staff said training on the duty of candour was included in their mandatory training.
- Medical and nursing staff confirmed attendance and satisfaction with their corporate and local inductions. Corporate and local inductions were in place for new staff throughout the service.
- Bank and agency nursing staff completed an induction when new to the service.

- The trust provided health care assistants with training known as the 'five-day fundamentals of care programme' from April 2015. This care certificate incorporated both the common induction standards and the national minimum training standards, underpinned by the trust's values. The care certificate is a national education certificate which aims to provide clear evidence to employers, patients and people who receive care and support that their health care assistants have been trained and developed to a specific set of standards.

Assessing and responding to patient risk

- The service had guidelines and protocols to assess and monitor patient risk.
- The paediatric early warning score (PEWS) and the neonatal early warning score (NEWS) monitoring systems were used to monitor children and babies who may be at risk of deterioration.
- We were told that 'sepsis six' information (introduced earlier in 2016 to the emergency department) was to be integrated into the paediatric documentation.
- Sick children were monitored for signs of deterioration through the use of PEWS and SBAR. This structured method for communicating critical information contributed to effective escalation and helped ensure child safety.
- Generally the NEWS tool was not used for babies receiving level one care within the neonatal unit as these babies were subject to continuous monitoring. This monitoring process ensured that vital signs, pain levels (if any) and potential risks were fully identified. Risks to babies on the neonatal unit were identified during their initial assessment and identified within care plans. These risks were reviewed daily or as required and at handover. Any deterioration in a baby's condition when identified were communicated to the primary care giver.
- Nurses told us there were always nurses on duty with PEWS training. The nurses we spoke with told us they were fully confident in using PEWs and SBAR to determine the status of a deteriorating child. The student nurses we interviewed told us that they regularly witnessed the trained nurses carrying out patient safety checks using PEWS and SBAR.
- Retrieval services (to transfer sick babies and children to level three tertiary paediatric intensive care or neonatal units) were provided by an external organisation. Children and babies requiring intensive care management prior to retrieval were cared for by staff in the neonatal unit or the high dependency unit until the retrieval team arrived.
- One of the neonatologists we spoke with told us that the neonatal transfer system was exemplary but that they had concerns about out of hours neonatal care at the Royal Free site.
- During a visit to the operating theatre with a child and parent we saw the WHO patient safety poster detailing the 5 steps to patient safety and we observed theatre staff using the WHO checklist. The WHO checklist is a tool developed to decrease errors and adverse events, and increase teamwork and communication in surgery.
- Following handovers, safety huddles were initiated. Safety huddles were designed to heighten awareness of individual staff and sick children's needs that could be anticipated at the beginning of, or throughout a shift. Safety huddles were held three times per day.
- We saw that subjects such as staffing levels, bed occupancy and social issues were discussed at each handover.

Nursing staffing - Children's service

- There were 45WTE (whole time equivalent) nurses for the 20 bedded unit, the nine day surgical beds and the outpatient department. The vacancy rate was 17% at the time of inspection. Vacancies were covered by bank and agency nurses.
- One of the matrons we spoke with discussed the 17% vacancy rate and we inspected the off duty roster for December/January (2015/16) and noted that the risk was addressed through the scheduling of agency staff all of whom were trained children's nurses.
- The children's ward at The Royal Free Hospital did not always meet the 2013 Royal College of Nursing (RCN) staffing guidelines. The matron and ward manager we spoke with confirmed this. The RCN guidelines are a series of standards which detail the minimum essential staffing requirements for all providers of services for babies, children and young people.

- One of the sisters we spoke with told us that staffing could be better and they frequently had to use agency staff to fill gaps, especially for night duty on the 20 bedded unit. The workload was high but they said they felt able to escalate concerns about staffing without fear of recrimination. They said it was a "time consuming effort" to get agency nurses but that all agency nurses received induction and many had worked at the Royal Free for a significant period. The trust said a recruitment programme was in place.
- We inspected the minutes of the sisters' meeting and saw that the matron was encouraging staff to escalate concerns about staffing levels.
- The matron we spoke with had raised an incident report about staffing levels in December 2015 and encouraged staff to do likewise as necessary. This escalation had resulted in a new recruitment drive but the matron told us it was difficult to recruit staff and that many had to travel long distances because of house prices in London. Staffing ratios were the issue which worried the matron most and they told us they covered meal breaks for nurses as a way to manage risk.
- A matron we spoke with told us team meetings sometimes had to be cancelled because of staff shortages.
- A senior nurse on the children's ward said there was always a nurse with advanced paediatric life support (APLS) training on duty at any one time.
- Staff in the day surgical unit told us that nurse staffing levels there were not adequate and that there was a reliance on the matron or the practice educator when transferring or escorting patients to theatre. They told us that this was because staffing of children's services was 17% below establishment.
- Staff we interviewed in the outpatient department told us that staffing levels had recently improved.
- A mother we spoke to on the neonatal unit told us that there was sufficient skilled staff to care for her baby.
- Although staff told us that a formal patient acuity tool was not used to determine staffing needs, they mitigated any potential risk by reviewing patient acuity and staffing at each of the safety huddles and used SBAR to ensure that staff were placed in the most appropriate clinical area.
- We inspected the database to assess compliance to neonatal life support training and saw that it was 85%.

Neonatal staffing

- The special care baby unit was a level one unit and was staffed with a 1 to 4 ratio in line with British Association of Perinatal Medicine staffing levels. There was a minimum of two 'qualified in service' staff per shift, the third staff member was a nurse or junior staff nurse, and the fourth when required was a nursery nurse or band five staff nurse. There two high dependency cots were staffed 1 to 2 when required.
- We examined the nurse staffing board which was very transparent in the way it detailed staffing of the neonatal unit. We examined the patient data management system for recording neonatal data and saw that staffing met the BAPM standards apart from very few occasions. For example in November 2015 the data base showed that the unit was only non-compliant to the BAPM standards for three shifts and in October 2015 for 12 shifts. BAPM produces benchmarked standards that help all those involved in perinatal practice to improve the standards of perinatal care delivery.
- A neonatal sister we spoke with told us that all first level nurses had completed a high dependency course and all band six nurses had completed the neonatal intensive care course (formerly ENB 405) which was designed to give nurses the competencies for managing, promoting and delivering safe evidence-based care that addresses the physiological, psychological and cultural needs of neonates and their families.

Medical staffing

- Members of the senior executive team told us that the neonatal service at the Royal Free was primarily consultant led as there were no deanery funded middle grades. This posed some risk as out of hours babies might be seen by a paediatrician and not a neonatologist. However they believed that risk was controlled as and the paediatricians were APLS trained and were able to stabilise the child. There were effective cover arrangements with the neonatal medical staff from the Starlight neonatal unit at Barnet Hospital. The doctors we spoke with on the neonatal unit told us that

neonatal transport arrangements worked well for transfer of babies to either the Barnet level two unit or to tertiary level three units as required. We saw that the unit had a fully operational travel incubator.

- Consultants from children's services at the Royal Free confirmed that they were compliant with 'Facing the Future' standards for acute general paediatricians (2015).
- The Royal Free children's service across all sites employed 104 WTE medical staff of which 41% were consultant grade,1% middle grade 54% registrar group and 5% junior grade. Middle grades and junior grades fell short of the English average .This was attributed to the way in which the London deanery has allocated junior doctor trainees to trainee posts at Barnet but not at the Royal Free Hospital site.
- Staff we spoke with told us that there was a good medical presence and support throughout the service across 24 hours each day. The out of hours support provided by consultant level staff was described by staff as supportive. Parents we spoke with told us that medical cover was available 24/7 and that there were always doctors and nurses who they could ask questions of at any time.
- Anaesthetic consultants and intensivists were available out of hours to provide anaesthetic advice and support for children's services.

Major incident awareness and training

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

Are services for children and young people effective?

Good

We rated effective as good because:

- Auditing systems had informed practice, introduced changes and lessons learnt to improve outcomes for children and young people.
- The neonatal service had achieved stage two UNICEF Baby Friendly accreditation.
- Multi-disciplinary team working within and outside of the children's service resulted in positive outcomes for children.
- Trust appraisal statistics confirmed an improvement in staff yearly appraisal uptake in the last twelve months influenced by the robust structures which had been implemented to record mandatory training and other training by the practice educators within the service.
- Staff members told us their training needs were supported and they had received development appropriate to their needs.
- The children's service identified they had transition arrangements in place for young people entering adult services. These included areas such as diabetes, oncology, and diabetes services. We saw effective working relationships between all children's services staff.

However,

- We saw that although services provided evidenced based care as identified within evidenced based clinical guidelines, many of these were out of date, posing potential risks to patients. This was because the trust was still integrating clinical guidelines after the takeover of Barnet and Chase Farm Hospitals.

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) were used to inform care.
- We reviewed a selection of evidenced based guidelines but many were out of date. Senior staff told us this was because of the ongoing project to reconcile the database of clinical guidelines within the trust intranet service for staff. This was confirmed by a senior nurse we interviewed who told us that the trust was currently amalgamating the databases from the merger and that there remained some problems in updating all the policies and procedures

- We witnessed medical staff at handovers discussing evidence based practice and during the handovers they referred to the use of NICE guidelines.
- Despite some being out of date the nurses we spoke with on the day surgical unit told us that the guidelines on the trust intranet were easily accessible.
- Staff told us they were able to use other sources for guidance such as NICE via the internet and thus mitigate risk.
- We inspected the dashboards in the children's outpatient department and saw that audit results were clearly displayed and dated. The results for January 2016 showed that hand hygiene compliance was 83%, cleanliness 96%, privacy and dignity 100%, appraisal 63%, and staff training 89%.
- The special care baby unit had level two UNICEF accreditation for the 'baby friendly' initiative with the aim of promoting and improving breastfeeding uptake. The level two standards state that all health care staff must be trained to support a mother to express her breast milk for her baby.

Pain relief

- Children's services offered a pain service to provide help and advice on pain management issues and were contactable by bleep.
- Staff told us that pain management for children was assessed using a variety of assessment tools and that a variety of analgesia agents were used.
- We saw that a pathway to theatre was in place for children and we inspected the associated paediatric anaesthetic care pathway which was comprehensive and included the WHO surgical safety checklist, both of which highlighted pain management.
- Pain management within the neonatal unit utilized a range of strategies including skin to skin kangaroo care. This is a method of caring for a premature baby in which the infant is held in skin-to-skin contact with a parent, typically the mother, for as long as possible each day.
- We reviewed a sample of children's pain charts and saw that children's pain scores were escalated as per trust guidance. A range of pain assessment tools were used by staff to monitor pain in children. The assessment tools used to assess children's and young people's pain responses included the Wong-Baker smiley faces pain rating tool and a 1-10 visual analogue scale tool. Reassessments of children's pain had taken place following medication given to relieve the child's pain to ascertain whether the medication had provided effective relief. The Wong-Baker tool was developed to help children more effectively communicate their pain relief needs with health care staff.
- A mother we spoke with on the neonatal unit told us that her baby's pain management was well managed by the staff there.
- Pain protocols were available for staff to access.
- The play specialists we spoke with told us that they had a significant role in offering play activities for children in pain or who might suffer debilitating fears such as needle phobia workers used in pre assessment. We noted that Starlight distraction boxes were available to provide distraction throughout children's services. Starlight Distraction Boxes are filled with toys, games and puzzles to help children cope with various medical procedures. The boxes were used by the nurses and play specialists to provide effective technique's and pain management.

Nutrition and hydration

- The neonatal unit was supported by a group of specialist midwives from the trust's infant feeding team. They saw any mothers and babies who were breastfeeding and offered support and advice. We were told that the neonatal unit had been awarded level two UNICEF (United Nations International Children's Emergency Fund) Baby Friendly accreditation. The Baby Friendly Initiative was set up in 1992 by the World Health Organization and UNICEF to recognize hospitals that enable mothers to make an informed choice about infant feeding and to be supported in that choice.
- Junior doctors told us that there was good emphasis on breast feeding within the neonatal unit .The trust was working towards stage three baby friendly accreditation.
- A mother we spoke to on the neonatal unit told us that she had been fully involved in her baby's care plan regarding nutrition and a father we spoke to told us that his son had enjoyed the food provision in the children's ward. However, one parent said there was poor food choice for children.

- We inspected the menu for children and saw that a wide variety of food choices was available to children and young people. Special diets, for example diabetic, gluten free, renal, textured and allergy diets were available. Specialised milk formulae were provided in the neonatal as required. Breast feeding advice was seen to be good and non-judgemental.
- Paediatric dietitians were involved in undertaking nutritional assessments in children. We saw dietetic involvement in some children's care had taken place when we reviewed medical notes. Nutrition plans were developed and reviewed by the dietician where required.
- We saw that all children were weighed on admission and STAMP (screening tool for the assessment of malnutrition in paediatrics) assessments to determine malnutrition status were carried out. STAMP is a validated nutrition screening tool for use in hospitalised children aged 2-16 years.

Patient outcomes

- The children's diabetes clinic was run by a multidisciplinary team which included paediatric nurses, paediatricians and dieticians. Regular clinics were held where children under age 16 years were seen quarterly. The median HbA1c of child diabetic patients was 8.6% against the target of 8.4% or better, set by National Paediatric Diabetes Audit 2011-12 (December 2013). HbA1c is a measure of diabetes control. Good diabetes control can prevent the onset of diabetes-related complications.
- Emergency readmission rates for children and babies was less than the England average across the trust. However, multiple admission for children with asthma and diabetes was higher than the national average but not for epilepsy.

Competent staff

- Formal processes were in place to ensure medical and nursing staff received role specific training and an annual appraisal. Nursing staff told us they received yearly appraisals and training specific to their needs. Trust records showed that 88% of staff had completed their annual appraisal.
- The electronic tracking system introduced by the practice education team for mandatory training and other learning outcomes enabled mangers to easily track rates of compliance.
- Staff told us that training was provided for them and investment in staff training by the trust was perceived by them to be good. For example, a play specialist we spoke with told us that the trust had supported them to undertake training in the use of guided imagery from a specialist children's hospital. This is a non-invasive a method of relaxation which aims to concentrates the child's mind on positive images in an attempt to reduce pain or stress.
- Nursing staff on the neonatal unit were supported by the trust to attend neonatal intensive care courses at local universities, and staff were enabled to attend for example PILS (paediatric immediate life support) and APLS (advanced paediatric life support) courses. Data from the trust showed that recovery staff had completed PILS training.
- Staff on the neonatal unit told us that study days they attended were funded by the trust.
- A nurse told us that the preceptorship programme they were following was very effective but they felt that that there was insufficient time allowed in the programme for study.
- The trust annual report for 2014 showed that it provided all staff with opportunities to support their continuing personal and professional development. The report showed that the education team had commissioned a wide range of courses and projects from local universities and training organisations based on needs identified by ward managers and matrons and which reflected organisational needs and objectives.
- We were shown the mentor database and mentor annual updating and triennial review data for mentors and sign off mentors by one of the practice educators. This showed compliance with Nursing and Midwifery Council (NMC) standards and that there were sufficient mentors in post for the student allocation to the clinical areas.

- Student nurses we spoke with told us that they were supervised by their mentors according to NMC regulations. We inspected the student nurse notice boards and saw that special packs had been developed for students to read on arrival in their placements.
- Five nurse specialists were in post for oncology, allergy, diabetes, enuresis and epilepsy. Nurse specialist meetings were held monthly.

Multidisciplinary working

- Senior nurses told us that the rapport between children's services at the Royal Free Hospital site and the Barnet and Chase Farm sites was good.
- Staff we spoke with told us that there were effective working relationships between child and adolescent mental health service (CAMHS) professionals and paediatricians.
- Staff we spoke with within children's services told us that multidisciplinary team (MDT) working was good. For example, a nurse told us that there was good MDT working with the CAMHS team, the safeguarding team and the psychology team.
- The teaching staff we spoke with in the hospital spoke highly of their involvement in MDT working and the school manger we spoke with told us that the hospital school was very effective and that the teachers were able to attend the MDT ward rounds and the safety huddles.
- A neonatologist told us, "we are very good on team working – we are part of a team looking after a baby".
- Junior doctors said there were good MTD relationships and that "the nurses are brilliant – it's a two way relationship".
- We attended an MDT psychosocial meeting where we saw good MDT collaboration and matrons we spoke with said they had good relationships with the medical staff.
- A physiotherapist told us that a comprehensive physiotherapy team operated seamlessly across both the community and inpatient areas of children's services within the trust, and was led by two senior paediatric physiotherapists. The physiotherapy team worked with a well-established occupational therapy team.
- The chaplain we spoke with told us that they were invited to MTD meetings.

Seven-day services

- Staff told us that CAMHS support was available out of hours.
- Twenty-four hour paediatric and neonatal consultant support was in place.
- Staff said they could access out-of-hours investigations, for example, urgent laboratory tests. On call pharmacy support, radiology services and pharmacy access was available during specified times at the weekend.
- Parents we spoke with told us that medical cover was available 24/7 and that there were always doctors and nurses who she could ask questions of at any time.
- The Royal College of Paediatrics and Child Health standard that at least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent) was being met.
- Children requiring intensive care management and ventilation were stabilised by the resuscitation team in the high dependency unit before being retrieved as appropriate by the external retrieval service team, as were neonates needing transfer to Barnet Starlight unit or a level three unit via the external neonatal retrieval service.

Access to information

- Patient records were available and accessible to relevant staff members when needed.
- Weekly multi-disciplinary handover meetings took place to discuss children currently receiving support.
- Safe care assurance huddles were held three time speed ay to discuss individual sick children.
- All safeguarding referrals of children and young people were discussed and attended by members of the multi-disciplinary team.
- Staff had access to evidence base guidance, policies and procedures via the trust intranet.

Consent

Services for children and young people

- Staff we spoke with told us that they were informed of and understood the consent process. Staff explained the consent process was completed by surgeons for children requiring surgery and that written consent was obtained prior to this.
- The WHO safety checks prior to surgery included checking that consent had been obtained.
- Staff members told us that they fully understood Gillick competence in relation to consent processes for children and young people. "Gillick Competence" refers to any child who is under the age of 16 who can consent, if he or she has reached a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring a decision.
- We reviewed children's and babies' notes for evidence of consent processes and saw completed consent forms for specific investigations such as prior to surgery.
- In the day surgical unit we observed that there was no consent form available for a child who had an MRI scan.
- Matrons said there was good emphasis on consent and additional assessments were undertaken for children with learning disabilities.

Are services for children and young people caring?

Good

We rated caring as good because;

- Children, young people and their parents received compassionate care with good emotional support.
- Parents and young people were informed and involved in decisions relating to their treatment and care. A family centred care philosophy was practiced within all aspects of children's services. This approach was based on a belief that health care staff and the family are partners, working together to best meet the needs of the sick child or baby.
- Support for families was provided by the multidisciplinary team during the child's admission and in preparation for their discharge home.

Compassionate care

- Throughout our inspection, we observed that members of staff of all levels and specialities provided compassionate and sensitive care that met the needs of babies, children, young people and their parents and carers. Staff had a positive and friendly approach and explained what they were doing to both the child and carer.
- During our inspection of the day surgical unit we saw that children were involved in decision making and that the doctor and nurse clearly explained all aspects of the forthcoming procedure, including the anaesthetic, using pictures.
- We observed a surgeon in the operating theatre getting down to a child's level and speaking to the child in a caring manner, using language the child could understand. The mother had been able to accompany the child to the theatre and the anaesthetic room.
- We spoke with 11 parents of children using the service who told us they had generally been happy with the care and support they and their children had received. Parents we spoke with told us that doctors and nurses fully involved them in their children's care and that they were fully involved in decision making about their children's care
- Staff told us that the care team was enthusiastic and empathetic.
- The handovers we attended were demonstrably caring towards the children and their families.
- We read citations from parents in the ward comment book all of which were complimentary. For example, "Nursing fabulous and faultless" and "kind, caring, yet professional and knowledgeable".
- The play team staff showed us letters from satisfied families which praised the play specialist and the paediatric anaesthetists "the lovely/helpful understanding anaesthetists were so brilliant at cheering up our daughter and putting us at ease".
- Whist visiting the neonatal unit we were shown the bereavement packs supplied by the still birth and neonatal death charity (SANDS) which contained a variety of memorial objects such as cards for foot/hand prints and cards for locks of hair, and a SANDS booklet entitled 'Support for you when your baby dies'.

- Parents we interviewed on the neonatal unit were highly complementary of the care their babies received. There were shower and bathing facilities for parents on the neonatal unit.
- The neonatal unit had curtains to provide privacy for breast feeding mothers. There were facilities for parents to put their belongings in lockers. We observed posters detailing how resident parents could order lunch and dinner on the neonatal unit.
- A mother we spoke with told us that that communication with her by the staff was very good and that the staff were caring and compassionate.
- A parent we spoke to in the children's ward told us that the staff were very attentive towards their sick child and that they were kind and compassionate. Even when the ward was very busy they still felt that help was always available. They also told us that the play specialist staff were especially good at their job. He told us that privacy and dignity procedures within the children's ward were very good and that the staff were very kind.
- Mothers we spoke with told us that doctors and nurses fully involved them in their children's care and that they were fully involved in decision making about their children's care.
- Because of staff shortages parents on the day surgical unit were not routinely escorted to the recovery room by the day surgical team and we witnessed an anxious parent being given directions to the theatre recovery which was some considerable distance away.
- The recovery area in the theatres was not child friendly and was shared with adults. There was no chair for a parent to sit on in recovery. However, we observed a doctor coming to see a parent and child on arrival in recovery and the communication with the recovery nurse was good.
- The hospital chaplain said they believed the hospital school was exemplary and that the organisational values of the trust were embedded within the ethics of the organisation.

Understanding and involvement of patients and those close to them

- The parents and child we spoke with told us that they had been involved in and were happy with their care and treatment.
- Satisfaction surveys were carried out and staff told us that parents, adolescents and children had completed satisfaction surveys. We saw good results from the NHS friends and family tests and we examined an email note to staff members praising their contribution to care in the outpatient department. We inspected the friends and family test results from the children's outpatient department dated January 2016. There were many positive comments, for example: "the nurse was lovely and understood my autistic child".
- The clinical educator we spoke with told us that children were involved with service planning through the friends and family test. Results from this have led to an initiative to address waiting times in outpatient clinics.
- New parents to the neonatal unit were given a 'baby welcome pack', which contained useful information about aspects of care such as breast feeding support. Information about the service was displayed throughout the clinical areas children and their parents. Parents from the neonatal unit confirmed that they had been given written information such as information on breast-feeding and baby hearing tests.
- Parents told us help was available when they had required additional support and teaching, such as for breast-feeding.
- A senior nurse told us that a 15 step challenge audit had not been implemented, although the nurses were aware of its philosophy in promoting family centred care. The 15 step challenge is a series of toolkits to help look at care in a variety of settings through the eyes of patients and service users.
- Feedback cards and comment boxes for parents to use were available throughout the service.

Emotional support

- The parents we spoke with told us that the doctors and nurses kept them well informed with information about their babies and sick children.
- The needs of new mothers were re-evaluated regularly, demonstrating that appropriate emotional support was

available for both mother and baby. Mothers who experienced mental health problems received additional emotional support through the multidisciplinary team. Health visitors and social workers would be involved in their care. To ensure sufficient support was in place, discharge planning would commence on admission to the neonatal unit.

- Parents and families could access spiritual support through the multi-faith service provided by the chaplaincy within the hospital
- We saw nurses giving families information leaflets and using the leaflets to explain elements of care to the family members and we noted a range of information leaflets within the outpatient department and the day surgical unit.
- We noted that the children's survey data showed that the trust scored better than other similar trusts to the question "Do you feel that the people looking after you listened to you?".
- We saw that a range of well-produced leaflets were available within the clinical areas for example with information about a Jewish helpline and a child death helpline.
- The chaplaincy provided prayers for individual children when requested. However, the chaplain we spoke with told us there was a limited awareness within the nursing team of the role of the chaplaincy within the organisation.

Are services for children and young people responsive?

Good

We judged responsive as good because;

- The children's, young people and families' service was responsive and met children's needs.
- There was generally good access and flow to services, which met most children's and young people's needs. The 18-week referral to treatment performance data for incomplete pathways confirmed that during the 12-month period children's 'weeks waiting' over 18 weeks was from six to 28 weeks.
- Parents and staff told us that care had been delivered in a variety of settings including outpatient clinics at times that met their needs. The play and school service was especially responsive to children's needs.

Service planning and delivery to meet the needs of local people

- Parents could access free parking. Additional support in the form of meal vouchers, snack boxes and access to information and associated social care support was provided to families whose child or baby received long-term health care.
- The service has a reciprocal agreement with the children's and adolescent mental health service (CAMHS). If there was an immediate concern about a child, an urgent review wold be requested within 24 hours, which would be precipitated by a referral from the child's consultant. A senior nurse told us that admissions of young people with self-harming behaviour was increasing. We were told that ligature risks had been addressed through citations on the risk register.
- Services for babies and children in the trust had been developed to work in conjunction with adjacent larger tertiary children's and neonatal services in other hospitals, mainly in London.
- A paediatric dietician told us that a five day service was available to children's services each week. No on call service was available. A dietician visited the neonatal unit and the children's ward each day and responded to approximately 35 referrals per month.
- Parents told us that the "you're welcome packs" they were given were useful with maps and phone numbers.
- There was limited adequate accommodation for parents in the children's ward.
- We perceived that signage to the children's services area was poor across the hospital.
- The play specialist we spoke with told us that there were four members of the play team including one play assistant. The play rooms were closed at weekends but a full team of volunteers provided weekend cover. The

play team had good links with the hospital school. The play specialists carried a bleep and were able to provide cover to the emergency department as required. The team also liaised with the Barnet Hospital play team

Access and flow

- Patient flow and bed occupancy was responsive to local demand for paediatric services from local primary care physicians. Children's services also catered for the needs of the local paediatric population through the provision of clinics.
- A parent of a child with diabetes told us that they were impressed with the organisation of the diabetes service who had arranged for a diabetic nurse specialist to visit their child's school on the Monday following discharge to liaise with the school staff.
- The paediatric community nurses we spoke with told us that they worked closely with the oncology team to ensure good access and flow.
- Trust data showed that the average length of stay was in line with the England average on all four indicators for both elective and non-elective admissions where children were under one year of age, and for elective admissions for those aged one to 17.
- Children scheduled for surgical interventions were invited to attend a pre-assessment clinic to help them and their families meet with the nursing team, and opportunities were provided for children and their parents or carers to ask questions.
- There were arrangements in place for the transfer of critically ill children to specialist centres in London via retrieval services provided by external organisations. Doctors and nurses said these arrangements worked well and policies for the transfer of patients could be accessed electronically.
- Children's services did not have access to a dedicated post-operative recovery area for children.

Meeting people's individual needs

- Translation services were available to parents and children who required them. The doctors and nurses we interviewed were fully aware of how to organise translation services for families.
- There were a number of poster and information leaflets for families around the various areas of children's services. We noted a range of specific leaflets for families throughout children's services. For example within the neonatal unit there were a range of specific leaflets for new mothers. Facilities were available to translate leaflets into other languages.
- Mothers told us that breast feeding support was very good and that there were good arrangements for expressing breast milk with good privacy arrangements. Breast pump hire was available for mothers at a fee.
- The hospital school was well-equipped with computers and books. School teachers were able to liaise directly with individual children's own teachers and offer examination support to sick children.
- The Child and adolescent Mental Health Service (CAMHS) liaised with children's services on a daily basis to ascertain if there were any children with mental health issues.
- Two parents said they were unhappy with the length of time they had to wait in the emergency department before their children were transferred to the children's ward.
- Parent information boards were located throughout children's services.
- We saw that the Wong-Baker smiley faces pain rating scales had been translated into a variety of languages including Arabic, Polish, Romanian, Somali and Turkish.
- The community nursing service based within the Royal Free Hospital offered support to children with learning disabilities and complex needs. However, children with a learning disability were not flagged, but the trust informed us they were working on resolving this. We noted posters in the clinical environment related to supporting children with learning disabilities.
- Nurses we interviewed told us that meal times for children were protected.
- Parents were encouraged to remain with their children whenever possible and were offered accommodation within the ward bays.
- Accommodation for parents within the neonatal unit was freely available

Services for children and young people

Learning from complaints and concerns

- Parents and visitors could raise concerns and complaints locally, through the Patient Advice and Liaison service (PALS) or the trust complaints department. Parents we spoke with said they felt comfortable raising concerns or complaints. Information on the PALS including a contact telephone number was available for parents in the hospital information leaflet.
- The nurses we spoke with told us that they fully understood the functioning of the PALS and knew how to direct parents to PALS when necessary.
- We noted a poster in the neonatal unit detailing how parents could make a complaint
- Staff told us that part of their complaints quality assurance process included discussions of the complaint's completed actions prior to its closure at the paediatric governance meeting.
- Staff told us that they had been encouraged to be transparent in their communications and that complaints were referred to the matrons or PALS.
- We saw that the friends and family tests results were posted on notice boards including areas for improvement as a result of feedback.

Are services for children and young people well-led?

Good

Overall, we rated the leadership of children and young people's service to be Good because;

- Service strategies were in place and were supported by action plans.
- A clear leadership structure was in place within the service at trust level and the individual management of the services at Royal Free Hospital were well led.
- Governance, risk and quality measurement processes were in place.
- There was evidence of ongoing innovation and improvement. Service provision was focused towards the needs of the child's and the surrounding community's needs.

However;

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

Vision and strategy for this service

- Some staff we spoke with told us that the chief executive had a strong presence and that they were aware of his vision and the trust core values. The view of the senior nurses we interviewed was that the chief executive was fully in charge and knew what was going on throughout the trust. Nurses we spoke with told us that people in the trust have confidence in the chief executive who has useful monthly open meetings for staff which were videoed and sent to all staff via email.
- The matrons we spoke with told us that they always felt supported by the head of nursing.
- An occupational therapist told us that they had been nominated for an OSCaR. The outstanding contributions and rewards scheme (OSCaR) is about celebrating the achievements of Royal Free staff and recognizing the achievements accomplished over the previous year to enhance patient care. Staff perceived these to be useful and they felt that the excellence awards were strong motivators. Nominations for these awards were designed to recognise the clear commitment that staff had to providing excellent care to patients and by inspiring others.
- Several consultants we spoke with told us that they had serious reservations about the impending closure of the paediatric assessment unit at Chase Farm and several had residual concerns about the success of the merger of the Barnet and Chase Farm sites with the Royal Free. This was not generally shared by the nursing staff who told us that the merger was going well in some areas.
- We identified that there was an all-encompassing vision and strategy, which was attributed to the overall provision of children's services at the trust. This was enhanced by a pan trust lead for nursing and for neonatal medical care and encapsulated neonatal provision, acute care provision, day care, and outpatients.
- Staff told us that the trust values were fully embedded in children's services and that practice education management was exemplary.
- Some staff were not aware of the trust vision and values.

Services for children and young people

Governance, risk management and quality measurement

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

Leadership of service

- Children's services for The Royal Free Hospital NHS Foundation Trust were led by a clinical director, a head of nursing and a divisional manager. In addition there was a neonatal matron who covered both sites and 2 matrons who covered the children's wards on both sites.
- A clear leadership structure was in place within the service. Staff told us that day-to-day clinical leadership was good and that they received support from their immediate line managers. The staff we spoke with felt well supported by the senior team and they told us that they read or viewed the chief executive bulletin which kept them up to date with events throughout the trust.
- Nurses told us how supportive the matrons of children's services were to them.
- A senior nurse said the chief executive staff briefings were very helpful and that "we were lucky to get our chief executive".
- Although there were no identified children's champions within the trust we saw that a citation in the trust annual report indicated that it was a trust intention to appoint children's champions.

Culture within the service

- A positive culture was demonstrated among all the teams and staff we met. Staff spoke positively about the service.However, they identified concerns in relation to the merger.
- Staff described positive working relationships including those between the multidisciplinary teams and other agencies involved in the delivery of children's health services.
- All staff we spoke with told us that should they need to raise a concern they felt confident and supported to do so.
- Some staff felt that the continuing difference between the culture of the different hospitals within the trust might impact on optimum care delivery.
- A nurse we spoke with in the outpatient department told us " I enjoy working here and I have been given a lot of opportunity for development –it is a nice team but it would be great to have more staff"
- One of the sisters of the neonatal unit told us that "this is one of the nicest units I have worked on", and a neonatologist said they felt supported by the trust.

Public engagement

- Public engagement with children, young people and their families was still at an early stage of development but the service had plans to undertake a 15 step challenge audit.
- Staff told us that children had been involved in the design of the outpatient department.

Staff engagement

- Staff engagement took place through a number of forums, for example, ward meetings, via email correspondence, development and training days and at formalised meetings aimed at various staff groups such as senior nurse meetings.

- The CEO and others from the executive management team held regular staff forums and information was cascaded via regular newsletters and videos.

Innovation, improvement and sustainability

- The trust's vision of delivering excellent integrated care for users of children's services when and where it was needed appeared to be fully embedded within the staff culture.
- Leaders and staff were focussed on continually improving care and had a patient-centred approach to developing services.

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 present configuration in July 2014 with the acquisition of Barnet and Chase Farm Hospitals by the Royal Free Hospital. Each hospital previously having had an established palliative care team.

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

The trust's nursing director has 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, Royal Free, Barnet and Chase Farm. The palliative care team worked cohesively and were divided into two teams. This enabled a streamlined service to be provided in accordance with the geographical area to be covered. One team was based at the Royal Free Hospital and the other team was at Barnet and covered both Barnet and Chase Farm Hospitals.

The palliative care team for the Royal Free Hospital worked with the North Camden Community team. Together they operated a seven day week service between 9am and 5pm with 24 hour consultant telephone advice. The community team was not inspected for the purposes of this inspection.

The Royal Free Hospital reported 875 deaths 2013/14 and 904 deaths 2014/15. The palliative care team at the hospital received 855 referrals January to December 2015. Of these 57% (490) were cancer and 43% (365) were non-cancer.

The palliative care team based at Royal Free Hospital was made up of two palliative care consultants, 0.4 whole time equivalent (WTE) psychologist, a nurse consultant, band 8a lead nurse, clinical nurse specialists, occupational therapist, administrative support and a social worker. The team delivered palliative services to all clinical areas across the hospital and worked with all areas of the hospital involved in the care of patients who were on the end of life care plan.

We spoke with 15 clinical staff and six other staff. We visited a variety of wards across the hospital including wards: 5 east B, 7 west, 8 east, 9 north, 9 west, 10 north, 10 west, 11 east, 11 south, 11 west, 12 east B and 12 south. We also visited the Patient Advice and Liaison (PALS) office, bereavement office, Macmillan information centre, mortuary and hospital chapel and prayer room. We reviewed the medical records and drug charts of seven patients at the end of life and seven Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records.

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

End of life care

Summary of findings

Overall we rated the end of life care service at Royal Free 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 duty of the inspection was to determine whether the hospital had policies, guidelines and training in place to ensure that all staff delivered suitable care and treatment for a patient in the last year of their life. 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 at the hospital to provide education to nurses and health care assistants. Medical education was led by the medical consultants and all team members contributed to the education of the allied healthcare professionals.
- The majority of end of life care was provided by clinical staff on the wards. The palliative care service worked as an advisory service seeing patients with specialist palliative care needs, including those at the end of life.
- Staff at the hospital provided focused care for dying and deceased patients and their relatives. Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.
- Staff in the mortuary, bereavement office, PALS and chaplaincy supported the palliative care teams and ward staff to provide dignified and compassionate care to end of life care patients and their relatives.
- Medical records and care plans were completed and contained individualised end of life care plans. Most contained discussions with families and recorded cultural assessments. The Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were all completed as per national guidance. However there were inconsistencies in the documentation in the recording of Mental Capacity Act assessments.
- There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. These referrals were seen and acted upon within 24 hours.
- The end of life care service had supportive management and visible and effective board representation. This had resulted in a well led trust wide service that had a clear vision and strategy to provide a streamlined service for end of life care patients.

End of life care

Are end of life care services safe?

Good

We rated safety for the end of life care service at The Royal Free 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 place that took place. Staff gave us examples of how they reported incidents and the feedback they received.
- There were robust systems and processes to ensure that a high standard of infection prevention and control was maintained. The mortuary was visibly clean. Staff in all departments could show appropriate hand hygiene and complied with the trust's policies and guidance on the use of personal protective equipment.
- There was 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.
- We saw the documentation used in the mortuary for recording patients details and the bereavement officers explained the systems to process death, burial and cremation certificates.
- The trust had a programme of end of life care mandatory training for all staff in line with recommendations by the National Care of the Dying Audit 2014. All clinical staff received training at induction and there were established e-learning modules.

Incidents

- The trust had an incident report writing policy and used an electronic incident reporting system. Permanent nursing and medical staff, porters, mortuary and administrative staff gave us examples of how they reported incidents. Staff told us the trust encouraged them to report incidents to help the whole organisation learn.
- A total of seven incidents had been logged since October 2014 which were attributed to end of life care. Of these, four were about medication errors and syringe drivers, one about a delay in patient transport, one about moving a patient to the mortuary who had not been verified and one about a medical consultant refusing to assess an end of life care patient.
- 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 saw there were regular clinical and business meetings within the palliative care department where clinical incidents and clinical pathways 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 with staff they were able to describe the rationale and process of duty of candour.

Cleanliness, infection control and hygiene

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

Environment and equipment

- We saw and were provided with the up to date servicing and maintenance records for all the equipment used in the mortuary.
- 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.

Medicines

- The trust had a medicines management policy. The policy ensured that medicines were prescribed, stored, administered and managed safely according to current best practice.
- There was trust wide guidance for the administration of medication using the McKinley T34 syringe driver. Syringe drivers help reduce symptoms by delivering a steady flow of injected medication continuously under the skin.
- All registered nurses and medical staff received training about the safe use of medication for an end of life care patient and prescribing anticipatory medication. The prescribing of anticipatory medication is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms. A patient discharged with anticipatory medication would allow qualified staff to attend and administer medication which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital. All patients on an end of life care plan were discharged from hospital with anticipatory medication called 'Just In Case' medication which ensured that streamlined care was maintained.
- Across the wards, we reviewed seven 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 the patients received timely and appropriate care.
- The hospital audited the set up time for patients needing a syringe driver in November 2014.The audit involved 20 patients in 26 clinical areas over the period of one month. Six patients (30%) were commenced on the syringe driver within one hour of the prescription being raised and 30% were commenced within four hours.
- The hospital 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 Barnet hospital performed an audit of opioids in palliative care and the initiating of drug treatments. The results of this audit were to influence practice trust wide. The aim of the audit was to ensure the safe and effective prescribing of strong opioids for pain in palliative care of adults as set out in NICE guidance. The results of the audit showed that there were variable drug and dose schedules prescribed despite regular teaching sessions and guidance available on the intranet. Specialist advice was not sought in 50% of complex situations. However, where there was evidence of specialist advice, the drug and dose schedules were appropriate. Recommendations were to be presented and an action plan devised at the palliative care business meeting which was to occur after the inspection.

Records

- The mortuary manager told us that effective systems were in place to log patients into the mortuary. They explained the process and showed us the ledger record book that contained the required information. We observed that the book was appropriately completed.
- On visiting the bereavement office we saw there were systems to process death, burial and cremation certificates. An officer showed us the process and explained what the role involved.
- All palliative care records were hand written and managed in line with trust policy.
- Patients receiving care from the palliative team had their documentation updated when reviewed. This gave information around changes in patient care needs and medicines management. Frontline staff on the wards

then implemented the changes required, such as applying a syringe driver or changing medication. We observed that the palliative care team provided a holistic assessment on their first visit to a patient and subsequent visits were documented in the patient's medical notes.
- We saw seven DNACPR forms and these were all completed in line with national guidance.
- Following the withdrawal of the Liverpool Care Pathway and the release of One Chance to Get it Right, 2014 by the National Leadership Alliance for the Care of the Dying Person, the trust generated the 'excellent nursing care in last days of life care bundle'. This ensured that patients who were identified as dying experienced transparent and open communication and compassionate care from all health care professionals.
- Staff told us that the 'excellent nursing care in last days of life care bundle' was user friendly with helpful prompts. The guidance and prompts were beneficial for junior staff.
- The 'excellent nursing care in last days of life care bundle' gave clear guidelines that nursing staff should assess the patient at least every four hours and complete a nursing assessment every 12 hour shift. The hospital audited the use of syringe drivers in November 2014 which showed the four hourly checks were completed by staff 70% of the time. Six of the end of life care patients we saw across the wards had a syringe driver and we saw that their records were completed in a timely manner.
- Across the wards we visited we reviewed seven medical records and nursing notes which contained individualised end of life care plans. Only one record did not contain evidence of discussion with family. All except one record contained evidence of the patient being assessed for their psycho-spiritual care.

Safeguarding

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

Mandatory training

- The National Care of the Dying Audit 2014 recommended that staff received mandatory training in the care of the dying. The trust had a programme of mandatory training for all staff and we saw evidence and records of this training. All staff who had direct contact with patients received training for caring for patients and their relatives at the end of life. This specifically identified the need for staff to communicate well and practice care in line with national and local best practice. This training was received at induction.
- There was 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 the Royal Free Hospital was 83% up to January 2016. This figure applied to 16 members of staff and included members of the community team. 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 also provided evidence that they were up to date with their mandatory training.
- The mortuary at Royal Free Hospital was the training centre for post mortems.

Assessing and responding to patient risk

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

End of life care staffing

- The palliative care team at the Royal Free Hospital cared for both hospital inpatients and community patients. The team was made up of two palliative care consultants and a 0.4 whole time equivalent (WTE) psychologist. The team also consisted of a nurse consultant, band 8a lead nurse, clinical nurse specialists, occupational therapist and a social worker.
- We were told that there were two WTE clinical nurse specialist vacancies in the palliative care team 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 was staffed by two WTE officers and an administrator.
- The bereavement office was staffed by two part time (one WTE) officers and assisted by the manager who covered the offices trust wide.
- The mortuary was staffed by a band 7 mortuary manager and an anatomical pathology technologist (APT).
- There was a comprehensive handover of palliative care patients at the hospital three times a week. On Friday afternoons there was also a meeting in preparation for the weekend . This enabled the weekend staff to be fully up to date in line with the weekend working policy.
- 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 wards 11 south and 8 east confirmed that retaining and recruiting staff was a main concern but they were aware of the trust's efforts to manage the situation. Ward managers we spoke with told us that sometimes staff were unable to provide adequate specific end of life care to patients due to workload and lack of availability of staff.

Major incident awareness and training

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

Are end of life care services effective?

Good

We rated the effectiveness of end of life care service at the Royal Free 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. We saw that the hospital had a regular audit programme.
- Since the foundation of the trust the hospital were in the process of correcting the organisational and clinical indicators highlighted in the National Care of the Dying Audit 2014.

End of life care

- The palliative care team provided a service seven days a week between 9am and 5pm, with out of hours telephone support for palliative medicine provided by a consultant.
- The chapel and prayer room were accessible 24 hours 365 days of the year. The chaplaincy team provided a 24 hour on call service for all faiths via the switchboard.
- 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 do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed for appropriate patients.

However;

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

Evidence-based care and treatment

- The hospital had implemented NICE Quality Standards for Improving Supportive and Palliative Care for Adults with the provision of a palliative care team. Following the acquisition of Barnet and Chase Farm 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 life limiting conditions. 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 the Royal Free Hospital used single observational triggers rather than a cumulative score. Triggers included respirations, heart rate, oxygen saturations, urine output and clinical staff individual assessment. The algorithm used when a patient triggered was to first alert the nurse in charge and refer to junior ward doctors. If the response was

delayed or the patient was not responding, the next stage of the algorithm was to contact the patient's registrar and the Patient at Risk and Resuscitation Team (PARRT).

- 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 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 were able to demonstrate how they accessed 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 seven 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 seven 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 patient 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.
- The Royal Free Hospital had 875 deaths 2013/14 and 904 deaths 2014/15.
- The palliative care team at the hospital received 855 referrals from January to December 2015. Of these 57% (490) were cancer and 43% (365) were non-cancer.
- The PARRT team received on average 300 referrals a month for Royal Free 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. The Royal Free Hospital had a positive outlier on both measures and was ranked 7th of English non-specialist acute providers for the current SHMI.
- Comprehensive mortality reports regarding end of life care were taken to the clinical performance committee, a non-executive chaired board committee.
- Results of the NCDAH 2014 showed the hospital achieved five of the seven organisational indicators and was worse than the England average for six of the ten clinical indicators. The hospital was worse than the England average for the trust board representation for care of the dying, formal feedback processes regarding capturing bereaved relatives views of care of delivery, multidisciplinary recognition that the patient is dying, spiritual needs, anticipatory medication, nutrition and hydration requirements, review of assessments in 24 hours of life and review of care after death.

End of life care

- 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 that a new education programme for staff was needed to support this.
- Since the audit the hospital had changed trust board representation, implemented a bereavement survey and there was multidisciplinary recognition of an end of life care patient. Also the patient's spiritual needs were acknowledged, and patient's requirements for anticipatory medication, 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 the Royal Free Hospital had completed advanced communication Skills training, psychology level 2 training and received monthly clinical supervision from a clinical psychologist. The team were all trained in specialist palliative care to at least degree level and some were pursuing masters' level qualifications. The team leader had a post graduate qualification in education. The nurse consultant was undertaking a PhD which was evaluating the effect of education and reflection to promote clinical practice.
- The palliative medicine consultants demonstrated continued professional development in line with the requirements of revalidation.
- All junior medical staff working at the trust received at least two teaching sessions a year from palliative care consultants. These covered symptom management, decision making and care of the dying. Additional sessions were provided on ethics and communication skills pertinent to this area.
- Education in palliative and end of life care for staff working in the trust included symptom control, care of the dying patient, communication skills, 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 for all staff was 71%. The appraisal rate for the palliative care team based at the Royal Free Hospital was 85%.
- We saw evidence that nursing staff, mortuary staff, porters, patient affairs and bereavement officers participated in annual appraisals and had personal development plans.
- The hospital held a nursing and midwifery clinical practice event in May 2015. This was an open day for staff to promote clinical practice and the palliative care team participated. This provided an opportunity for nursing staff to 'drop in' to ask questions to palliative clinical nurse specialists. This enabled them to link practice to policies, procedures and competencies.
- We were told that several of the nursing team were independent prescribers.

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 working for the trust had joint contracts with one of the local hospices.

End of life care

- The hospital palliative care team had formed close and mutually helpful working relationships with the clinical teams in the local hospices. The lead nurses for the hospital team and the hospices met regularly. This meant they could support each other and discuss cross organisational operational issues.
- Members of the palliative care team were members of local end of life care steering groups for each borough that covered the local hospices. The steering group enabled cross organisational discussion of the end of life care strategy for each area.
- Weekly multidisciplinary meetings were held at the hospital on Tuesday mornings with doctors, nurses and members of the extended team. The meeting covered all aspects of patient's medical and palliative care needs. The outcomes of the meeting were recorded and shared with the extended team. We saw that the team administrator coordinated the meetings ensuring an accurate list was kept of patients discussed and a record of attendance.
- 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 close working relationship between the palliative care team and the practice development nurses on the wards ensured that end of life care was embedded in trust structures, for example induction.
- 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 services and highlight concerns and areas of good practice.
- The private patients ward, ward 12, was well integrated with the NHS services. The palliative care team worked collaboratively with the ward for all end of life care patients.
- We saw the palliative care team handover where all patients on the caseload were reviewed. Each patient was allocated a clinical nurse specialist (CNS) and this was defined with the use of colour coding. If a CNS was unavailable the caseload was divided between remaining nurses. The handover was a well-managed business like session with clear priorities and work plans agreed.

Seven-day services

- The palliative care team for Royal Free Hospital and North Camden Community team operated a seven day week service between 9am and 5pm with 24 hour consultant phone advice.
- The mortuary was staffed 8.30am to 4.30pm Monday to Friday. Within these hours collections were possible from 8.30am until 3.30pm and 30 minute viewing appointments were available to families between 10am and 3pm. Out of hours arrangements meant exceptional requests could be met for both collections and viewings outside of normal hours.
- The chapel, Muslim prayer room and Jewish Shabbat room were accessible 24 hours a day every day of the year. The chaplaincy team provided 24 hour on call service and were contactable via the switchboard.
- The Patient Advice and Liaison (PALS) office was open Monday to Friday 10am to 4pm.
- The bereavement office was open Monday to Friday 9am to 4pm.
- The Macmillan office was open Monday 1pm -4pm, Tuesday to Thursday 10am to 4pm and Friday 10am to 1pm.

Access to information

- NICE QS13 guidance states: "Provider organisations should ensure that patients and carers have easy access to a range of high quality information materials about cancer and cancer services".
- The hospital had a Macmillan cancer information and support centre where patients, their family and friends could ask questions and talk through their concerns with a cancer specialist.
- The 'excellent nursing care in last days of life care bundle' contained a leaflet for patients and their relatives to explain the end of life care plan, facilities and contact details. They were provided with the leaflet when their relative was started on the bundle.
- The hospital provided a trust wide leaflet 'Planning your discharge booklet: information for patients, relatives and carers'. The booklet was designed to help the

hospital plan a patient's discharge. It explained the different services a patient may need and arrangements that can be made to support them when they leave. It also contained a list of useful telephone numbers.
- A person collecting a death certificate from the bereavement office was provided with a trust wide information wallet. This contained contact details for bereavement support, hospital contact details and a feedback card.
- The chaplaincy team provided a leaflet which explained its services, contact details and special events. Details were advertised on the chaplaincy centre notice boards and available on the hospital's web page.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical staff we spoke with understood the DNACPR decision making process and described decisions with patients and families. They told us they provided clear explanations to ensure that the decision making was understood. There was a trust wide guideline for DNACPR.
- While visiting ward areas we checked medical records and we viewed seven DNACPR forms. We saw that all decisions were recorded on a standard form and signed by an appropriately senior clinician. All the forms were kept in the front of the patients' notes. Five of the records had evidence that there had been discussion with relatives. However, two of the forms had not been counter signed by a senior health professional.
- An audit performed by the Patient at Risk and Resuscitation Team (PARRT) in December 2015 looked at trust wide decisions for the use of DNACPR. The audit found that the DNACPR decisions were made based on clinical considerations. The audit observed that DNACPR discussions were well documented, especially by the respiratory teams.
- We were told that DNACPR remains a high priority in teaching. Focus remains on the documentation of the communication of the decisions with the patient and their relatives.
- The trust had a consent policy which was based on the model developed by the Department of Health. The policy included the process for consent, documentation, responsibilities for the consent process, consent training and use of information leaflets to describe the risks and benefits. The policy also included consent for advanced decisions, guidance for lasting power of attorneys and mental capacity.
- There was a trust wide Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS) Policy 2014.
- Two of the DNACPR forms we observed had recorded that the patient did not have mental capacity. However we did not observe documentation of the Mental Capacity Act assessment in the medical notes.
- We saw the appropriate DoLS assessment and documentation for a patient on ward 11 south. 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 the end of life care service at the Royal Free 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 between all areas of the hospital to provide exceptional care for end of life care patients.
- We spoke with patients and relatives who were complimentary about the care they had received. Staff showed us thank you cards and letters they had collected.
- On the wards we visited 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

End of life care

- Staff on all wards we visited said that end of life care was a vital part of their role and they enjoyed the relationships they formed with patients and their relatives.
- A patient on ward 8 east who was being discharged home congratulated the team for "going over and above the norm in their care".
- Staff on ward 9 west told us of an occasion when an end of life care patient who was known to them was admitted to the emergency department. The patient was transferred to the ward and was able to die in a dignified and calm manner with staff they were familiar with.
- An end of life care patient on ward 9 west told us that the staff "are fantastic" and staff respond immediately when they action the call bell.
- Patients told us staff always introduce themselves and seek consent before treatment. A relative of an end of life care patient on ward 11 east told us that all staff had been "outstanding".
- 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 20 cards and letters thanking the team for their support and care. Comments included "wonderful care you gave during their illness" and "it was a difficult time for us all and we were grateful that they were able to have a dignified passing".
- Trust wide the hospital received four responses for the mortuary and bereavement service survey for the period October 2015 to December 2015. All responses were positive except one response stated that they felt they were not dealt with in a timely and sympathetic manner and was not given enough time.
- Positive comments on the survey included "the bereavement officer was very sympathetic and also very helpful with regard to registering the death. Thank you for your kindness".
- Staff told us about an incident where exceptional care was provided for an end of life care patient. The patient was dying and asked to see their dog again. The ward was able to accommodate this wish in a dignified and sensitive manner.
- A further example we were told about involved a young patient who was dying. There was joint work between the intensive care unit (ICU) and the palliative care team. The patient's ventilation was switched off safely which enabled the patient to communicate with their family members in the last 30 minutes of their life.
- The PALS office at the hospital displayed 11 thank you notes. Comments included "just to say how grateful I am for my prompt and thorough treatment received", "quick response", "thank you for your care, time and support" and "thank you very much for going out of your way". We saw that the team had received the unsung hero award for the Royal Free London NHS Foundation Trust Oscars 2014.

Understanding and involvement of patients and those close to them

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

Emotional support

- Staff provided emotional support for end of life care patients. We observed occasions when this occurred on the wards.
- Bereavement support was not specifically provided by the hospital. Relatives were signposted to the relevant agencies that could support them. A relative on ward 10 north 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.

End of life care

- The chaplaincy team were involved in supporting families in times of loss and grief. The hospital held an annual memorial service in the chapel every November. In 2015 97 families attended.

Are end of life care services responsive?

Good

We rated responsiveness for end of life care services at the Royal Free 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.
- The mortuary viewing area was visibly clean and appropriate for relatives.
- Staff respected the cultural, religious and spiritual needs of patients. The palliative care team identified the cultural, religious and spiritual needs of patients and this was recorded as part of the holistic assessment, and supported by the chaplaincy team.
- The palliative care team was involved with all discharges for end of life care patients. The response time for discharge depended on the patients preferred place of care and what area the patient lived in.

However;

- The hospital did not collect data regarding patients dying in their preferred place of death. The hospital acknowledged that they did not have a clear rapid discharge at end of life protocol or strategy as expected by national guidelines. They were reviewing their collection tools to correct this.

Service planning and delivery to meet the needs of local people

- During the inspection we observed that the palliative care team was embedded in all clinical areas of the hospital. Staff on the wards told us that the team was professional, responsive and supportive with specialised advice and knowledge. Where a patient was referred to the team they were prompt in responding, assessing the patient and planning care and other required referrals, for example, therapists. Staff on the wards confirmed that the referral criteria was clear and patients were seen within 24 hours if not sooner.
- 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 ward 10 north told us they were 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 subject to availability and suitability.
- The hospital had provided concessions for visitors of patients who were end of life. Parking permits were provided to assist with the cost of parking.
- The mortuary had a viewing suite where families could visit their relatives. They were escorted by the mortuary attendant who would stay with the relatives in the waiting area during the viewing for as long as they required.
- The bereavement office advised relatives on the process around the death of a patient. The officer issued death, burial and cremation certificates and arranged viewing of the deceased with the mortuary.
- The bereavement officers told us that they 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 immediately after death from the bereavement office. Contact numbers were provided to relatives within a trust wide information wallet. The staff in the bereavement office told us they were aware of whom to signpost relatives to if they required additional support.
- The Patient Advice and Liaison (PALS) office was a spacious office located off the main corridor and contained a separate seating area to accommodate confidential and private conversations.
- The hospital acknowledged that patients who were dying and those at the end of life may require rapid discharge home. The hospital told us that their aim for a dying patient was to discharge them within one working day. The aim for a patient at the end of life was to discharge them within 72 hours.

End of life care

- 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. 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 had a viewing suite which was divided into a waiting and viewing room. The suite was visibly clean and provided facilities for relatives such as seating, tissues and information booklets about bereavement. The suite was neutral without religious symbols which allowed the suite to accommodate all religions.
- The mortuary was able to facilitate the transportation and storage of bariatric patients. Additionally they had separate baskets for the transportation of babies.
- The hospital ensured that the faith needs of the community were met. The chaplaincy team offered spiritual, religious or pastoral support to people of all faiths and beliefs, religious and non-religious. The chaplaincy team was assisted by a group of volunteer visitors. They were able to contact community faith leaders who represented the major world religions and the Humanist Association.
- Relatives of end of life care patients told us that they had been offered chaplaincy support and a member of the team had visited them promptly.
- The hospital chapel was multi faith. A Christian service was provided weekly on Wednesdays and Sundays and Muslim services were held on Fridays. Jewish festival celebrations were also held in the chapel.
- The hospital had a Muslim prayer room with separate washing facilities and Jewish Shabbat room which met the needs of the local community.
- We observed in six of the seven care plans and medical notes that staff respected the cultural, religious and spiritual needs of patients. This was part of the initial holistic assessment and was supported by the chaplaincy team.
- The hospital had access to translation services via telephone or could be booked through a centralised booking system.
- Patients living with learning disabilities or dementia were supported by the hospital. A blue butterfly flagging system on the notes identified the patients who required extra assistance. Patients living with learning disabilities were also issued with passports which recorded their individual needs.

Access and flow

- The hospital told us that trust wide they do not have a process for identifying patients on an end of life care plan on admission. Discussions with primary care services, particularly GP's, have resulted in the plan to use an electronic system that can be used across all systems. The trust told us they planned 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.

End of life care

- 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 it with their own. These envelopes were kept in the palliative care team office.
- 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. The protocol was not in place at the time of inspection. 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 107 patients assessed within this period 12 (10%) patients were fast tracked and these patients were deemed to have a prognosis of less than six weeks. The audit showed that the local boroughs had response time of approving continuing care applications of up to one day and the provision of care up to four days. This response time was quicker than applications from other boroughs. Applications for one clinical commissioning group (CCG) averaged 3.3 days for time from application to funding being granted and average 4.5 days to discharge. Another CCG granted funding on average 1.5 days and discharge average 3.2 days. A third CCG granted funding average 1.8 days and discharge average 3.3 days.

Learning from complaints and concerns

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

Are end of life care services well-led?

End of life care

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 Royal Free Hospital cared for both hospital inpatients and community patients. The team was led by two consultants, a nurse consultant and a lead nurse.

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

Vision and strategy for this service

- The aim of the trust wide palliative care service was to continue to provide a high standard of specialist palliative care to patients. We were told that in 2016 there will be a review of staffing across the service in the context of work load and planned future developments. The London Palliative Care mapping data from PallE8 and London Cancer Alliance will allow them to benchmark their service against similar services across the capital.
- The trust aimed to build a team which provided excellent clinical care as well as being a learning team that provided and encouraged training to non-palliative care colleagues. It contributed robustly to research and policy development and was innovative in palliative and end of life care.
- The trust wide palliative care service told us that they were proud of the higher than national average proportion of referrals of patients with a non-cancer diagnosis. They will continue to build on work previously done with the renal, liver and frailty teams to develop joint working clinics, wards and multidisciplinary teams. In 2016 they aim to start discussions with leads for end stage cardiac and respiratory disease and look at ways of developing shared care for appropriate patients. They told us they would develop this service for these patients over 2017/18.
- The trust wide palliative care service told us that over the next three years they aimed to expand the education programme, particularly the training of senior clinical and education staff who will roll out training to other staff. They aimed 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 would, in conjunction with the end of life care steering group, have mapped education in palliative and end of life care throughout the trust. By October 2016 they would 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.

End of life care

- 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 trust wide.
- 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 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 two risks relevant to Royal Free Hospital. 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 related to the on call clinical nurse specialist and consultant at weekends and out of hours that did not have access to patient's notes which were stored in the hospital offices. The risk identified that patients may receive poor or inappropriate treatment. The team were moving on to a digital notes system in preparation for acquiring an appropriate computer system.

Leadership of service

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

Culture within the service

- We were told by staff and the senior team that the trust culture encouraged candour, openness and honesty.

End of life care

- Staff told us they were positive about the amalgamation of the hospitals and felt confident about the future. They were aware of the changes and acknowledged that it was a slow process.

Public engagement

- The hospital performed a bi-annual audit that surveyed the patient experience of palliative care for patients at Royal Free and Barnet hospitals. The last audit was over a three month period in 2015. The survey consisted of 12 questions with an additional four questions for carers. The Royal Free Hospital gave out 41 surveys and 12 were returned. Barnet hospital gave out 30 surveys and four were returned. The overall response rate was 22.5% for the service.
- The palliative care team acknowledged that although overall the survey achieved some positive feedback it was too small a sample from which to draw conclusions. They told us that consideration needed to be given to future audits on the best way to capture patients' experiences of their service.
- A bereavement survey was started at the end of 2015 which would enable the trust to capture feedback from bereaved relatives. Results of this survey would be fed back to wards and services.
- At the time of inspection the trust did not have a working end of life care patient satisfaction survey. We were told that this was due to start in February 2016 and completed in March 2016. The results of this would be presented to the service business meeting in June 2016 and an action plan devised.

Staff engagement

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

Innovation, improvement and sustainability

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

Outpatients and diagnostic imaging

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

Information about the service

The Royal Free Hospital offered outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up were required. The hospital had 33 different medical and surgical specialty clinics, as well as paediatric and obstetric clinics. There were 564, 580 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. In the last year, 239,902 people used these services.

During the inspection, we spoke with 81 members of staff, which included managers, nurses, administrative staff and allied health professionals. We also spoke with 26 patients and their relatives.

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

Summary of findings

Overall we rated outpatients and diagnostic imaging at the Royal Free Hospital as good because;

- The outpatient and diagnostic imaging departments followed best practise guidelines and there were regular audits taking place to maintain quality.
- There were comprehensive systems and processes in place to prevent patients from harm in the outpatient departments.
- The diagnostic imaging department had comprehensive policies and processes in place in line with best practise guidance for reducing exposure to radiation .
- 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;

- Medical records were available electronically but some delays occurred when scanning paper records onto the system. There was no method of recording the number of hospital prescriptions issued.
- The trust had consistently not met the referral to treatment time standard or England average for the past ten months. The time to triage referrals as to their priority varied between specialities and could take as long as 34 days.

Outpatients and diagnostic imaging

- There had been a deterioration in performance of the 62 day cancer performance compared to the national standard.

Are outpatient and diagnostic imaging services safe?

Good

We rated safety of the service as Good because;

- There were good feedback systems reporting incidents to staff and governance committees.
- Medicines management was good and we saw that medicines were stored correctly.
- There were comprehensive systems and process in place to keep patients from harm.
- Patients waiting longer than 18 weeks were reviewed regularly.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments.
- Staff in the outpatient and diagnostic imaging departments had a good awareness of safeguarding process.
- Medical records were available electronically. However, we saw there were some delays in scanning paper records onto the system, which could affect patient care.
- The outpatient and diagnostic imaging areas we visited were clean and tidy. Staff overall demonstrated good infection control practices. On the whole staff were bare below the elbow.

Incidents

- Staff reported incidents using an electronic reporting system. Staff told us they automatically received feedback about incidents logged on this system. They gave us examples of incidents they had reported. Clinic overruns were also reported as incidents, which allowed service managers to monitor performance.
- Staff discussed incidents at a morning meeting and received information about the numbers of incidents via a monthly email. We saw examples of those emails.
- Outpatient staff discussed incidents at communication meetings each morning. Senior staff reviewed information about reported incidents at the governance meetings. Managers passed on any lessons learned at governance meetings back to their teams.
- In the last calendar year, the radiology department reported 10 incidents to the Care Quality Commission in

line with ionising radiation (medical exposure) regulations (IR (ME) R 2000). Staff dealt with the incidents in an appropriate manner and gave patients an explanation of what had happened.

Cleanliness, infection control and hygiene

- 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, and 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 and diagnostic imaging waiting areas. There was a handwashing 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%. It was noted in audit reports doctors had to be asked to remove their watches. On the whole staff were barer below the elbow. However, during our inspection we saw four doctors were not bare below the elbow during clinic. They were in clinic two on Tuesday afternoon, in clinic four (plastics) on Wednesday afternoon and in room nine, in clinic four (plastics) on Friday morning. We were unable to see staff handwashing between patients, as clinic room doors were shut when patients attended
- Personal protective equipment was available in all areas we visited.
- The endoscopes used in the ear, nose and throat (ENT) clinics were cleaned between each use with a triple cleaning system. At each 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 cleaning scores displayed in the waiting areas of each clinic. All areas scored above the target score of 87%.
- Seating in all outpatient and diagnostic imaging waiting areas was made of wipe clean fabric.

Environment and equipment

- The outpatient department had separate clinic areas, with dedicated waiting areas for each clinic. Seating was made of wipe clean fabric with some higher chairs available. Waiting areas suitable for children had toys available.
- At the reception desks, there were signs to keep queuing patients at a confidential distance. We saw when waiting areas were busy, this was not possible and patients booking in could be overheard which could result in a breach of confidentiality.
- In the diagnostic imaging department reception desks had screens between each which offered greater privacy to patients.
- The phlebotomy department was clean, bright and recently refurbished. Other clinic areas were in need of redecoration, which was acknowledged by the management team. The orthopaedic clinic had a television and Wi-Fi available for waiting patients.
- We saw stickers on equipment which indicated it had been serviced recently.
- The resuscitation trolleys in outpatients and diagnostic imaging were checked daily by members of staff. We saw completed checklists.
- Staff carried out regular quality assurance(QA) on equipment. We saw the records of checks stored on the shared computer drive, which indicated checks were occurring regularly. This was as part of a daily equipment QA programme.

- The mammography room was cluttered and the sink was positioned behind the machine which made it difficult to access the hand washing basin.

Medicines

- Doctors hand wrote hospital prescriptions that could only be dispensed in the hospital pharmacy. Each prescription had a serial number on it and a scan of the prescription was stored in the patients electronic medical record. A registered nurse gave a pad to each doctor at the start of clinic who kept the pad in an unlocked clinic room. The pads were stored in a locked room at the end of clinic. No record was kept of how many prescriptions were issued each day. This is not in line with NHS Protect security of prescription forms guidance (2013).
- We saw medicines kept in outpatients were stored in a locked cupboard and a registered health professional held the keys. This was in line with standards for medicines management.
- Medicines requiring refrigeration were stored in locked fridges. We saw the temperature of medicine fridges was monitored regularly and the fridge temperature remained within range.
- In the nuclear medicine department, the fridge temperature was last checked on the 14th January, which indicated it was not being regularly monitored.

Records

- The hospital used an electronic medical records system. Patient investigations, attendance history, inpatient information and correspondence were available on this system. Paper records would be kept of any surgical interventions and scanned onto the electronic record. We saw notes from an operation four weeks before the inspection had still not been scanned onto the system. This indicated it would be not available to view on the electronic record. A patient told us the information about their operation had not been available to doctors at their post-operative clinic visit.
- In the Ian Charleson centre paper records were kept in a room next to the waiting area. There was no lock on the door which indicated records were not being stored securely. Staff had requested a lock but were still waiting for the estates department to install one.

Safeguarding

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

Mandatory training

- The outpatient nursing team were 97% compliant with mandatory training which was above the 95% target.
- In diagnostic imaging staff were 82% compliant with mandatory training which was below 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.
- 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. This meant the most unwell patients would be reviewed and seen quickly.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in all areas we visited and signed by all members of staff. Diagnostic imaging staff had a clear understanding of protocols and policies. Protocols and policies were stored in folders in each room.
- We observed good radiation compliance as per policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. We saw radiographers referring to the ionising radiation (medical exposure) IR(ME)R regulations for a patient's examinations. A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required. This was in line with ionising regulations 1999 and regulations IR (ME) R 2000).

Outpatients and diagnostic imaging

- 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).
- Lead aprons were available in all areas of radiology for children and adults.
- In the nuclear medicine department, there were separate areas for patients who had and had not received radioactive injection, which prevented unnecessary exposure to radiation.
- The diagnostic imaging department used the five steps to safer surgery checklist for any interventional procedures. The department had adapted its own checklist based on the five steps to safer surgery, World Health Organisation (WHO) checklist. We saw two audits of these checklists and they were 100% compliant on both.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging departments in line with best practice.In addition to this staff could carry out a pregnancy test if required. This was recorded in a folder which we saw.

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 band six or five nurse who was the nurse in charge for the site as a 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.
- Nursing cover was calculated dependent 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.
- At the time of inspection the trust had 50% of required sonographers in post, which was in line with national shortages. These vacancies were covered by agency staff. There was a comprehensive induction process in place. We saw copies of the induction booklet. The department was in the process of recruiting more staff. In addition to this trust had employed more trainee sonographers than the number required to deal with vacancies in the future.
- There were some vacancies in the numbers of radiographers. The department employed radiographer practitioners who were training to be radiographers. This assisted with recruitment and retention.

Major incident awareness and training

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

Are outpatient and diagnostic imaging services effective?

- There was evidence of good team working in clinics, within the diagnostic imaging department and across the specialities.
- The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care.
- We saw that staff had a good awareness of National Institute for Health and Care Excellence (NICE) guidelines and this was demonstrated in their practise.

Evidence-based care and treatment

- Staff followed NICE clinical guidelines in the speciality clinics we visited. We saw audits which demonstrated staff monitored their compliance with these guidelines.
- We saw a variety of local audits were undertaken on a regular basis in outpatients and diagnostic imaging departments. They included environmental, handwashing and infection control audits. The results of these were shared amongst staff and displayed in waiting areas. We saw examples of both.

Outpatients and diagnostic imaging

- 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.
- Staff in the sexual health clinic undertook a study which was published in the British Medical Journal (BMJ). This showed screening patients for domestic violence in high-risk hospital clinic populations identified large numbers of people who had experienced past or current domestic violence. Identification of patients in this way could lead to a good uptake of referrals for domestic violence support, which would improve patient outcomes.
- We saw that patient related outcome measures were used to identify the effect of therapy on the psychological wellbeing of certain groups of patients.

Competent staff

- One hundred percent of nursing staff had received an appraisal in the last year which was greater than the target of 95%. 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).
- All reception staff had received customer care and conflict resolution training and the manager told us there were opportunities for staff to access additional training if required.
- Some staff in diagnostic imaging could give medicine to patients for certain diagnostic tests. We saw certificates which confirmed staff were competent to do so.
- In diagnostic imaging the appraisal rate was 63% which was lower than the 95% target.

Multidisciplinary working

- Staff ran 18 different 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 on the same day.
- The HIV care staff worked with local trusts and shared regular meetings. There was an integrated pharmacy and dedicated phlebotomy within this service.
- Staff told us they felt well supported by other staff groups and there was good communication within the teams.

Seven-day services

- An emergency eye clinic was available for five hours every day seven days a week.
- The hospital provided 24 hour a day, seven day a week access to emergency diagnostic tests.

Access to information

- Staff could access patient records electronically. However, on occasion, there was a delay in paper records getting scanned onto the system, which meant staff did not always have full access to information.
- Staff told us they had experienced a variety of difficulties with multiple computer systems which were not all compatible.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 100%of nursing staff had attended Mental Capacity Act training.
- Schwartz centre rounds provide a monthly, one-hour session for staff from all disciplines to discuss difficult emotional and social issues arising from patient care. Staff told us they attended them and gave us examples where they had discussions about capacity assessments and how to manage patients who were assessed as lacking capacity.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because;

Outpatients and diagnostic imaging

- Staff in the outpatient and diagnostic imaging departments treated patients with kindness, dignity and respect. Staff behaved in a professional and caring manner.
- We saw staff had processes in place to respect patient's dignity and respond to their individual needs.
- Patients were involved in decisions around their care.
- A cancer charity provided additional emotional support to patients living with cancer.
- In the diagnostic imaging department the reception areas gave patients privacy when booking in for their appointment.

However;

- Patient confidentiality was not always maintained in the outpatient department as sometimes conversations could be overheard.

Compassionate care

- In the most recent Friends and family test (October 2015), 86% of patients would recommend the outpatients department , which was lower than the national average of 92%. The diagnostic imaging department conducted its own survey in January 2016 which indicated 87% of patients would recommend the department.
- Patients we spoke with felt they had been treated with dignity and respect. They told us staff were always friendly and professional. We observed staff dealing with patients in a kind and courteous manner. Staff told us their patients were a priority over organisational boundaries.
- Signs offering patients a chaperone were clearly visible in all clinic and examination rooms we visited. Nursing staff stamped patients notes which indicated when they had been in attendance as a chaperone. This was scanned onto the electronic notes. This was in line with the trusts chaperone policy we saw.
- Clinical room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy.
- We heard staff having a conversation with a patient in clinic 14 and overheard what was wrong with the patient. Crowded waiting areas made patient confidentiality difficulty to maintain. This indicated patient confidentiality was not consistently managed in outpatients.
- In diagnostic imaging each receptionist had a separate area divided by a partition so confidentiality was maintained.
- A volunteer was in attendance at the entrance to help patients if they needed it with the self-check in system.
- Separate male and female waiting areas allowed patients dignity to be maintained in the diagnostic imaging department.
- The diagnostic imaging department also ran single sex clinics, which prevented male and female patients attending at the same time.

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 departments.

Emotional support

- A cancer charity helped to provide emotional support to patients in the breast clinic along with the specialist staff. Volunteers for the charity had experience of living with breast cancer. They provided complimentary therapies for patients which included; massage, yoga, dance and art therapy to assist with mental well being.

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.

- The trust offered appointments during the evenings and weekends to give patients a choice of time and day convenient to them.

However;

- The time to triage referrals as to their priority varied between specialities and could take as long as 34 days, increasing the time from referral to treatment.

Service planning and delivery to meet the needs of local people

- The phlebotomy department opened from 7:30am to 5:30pm from Monday to Friday and from 9am to 1 pm Saturday mornings. This gave patients a choice of times to get their blood tests done.
- In the last year the trust offered 64 outpatient clinics during the evening and weekends. The diagnostic imaging department had implemented weekend lists. This gave patients a choice of appointment times more convenient for them.
- In some clinic areas staff gave waiting patients pagers, so they could leave the reception area.
- If a patient arrived for a clinic which had been cancelled, they would be refunded their parking fee or travel expenses.
- Reception staff told us they often had to deal with phone calls whilst dealing with patients at the desk. The phone calls were of patients trying to alter appointments. We saw patient appointment letters had the hospital main phone number above the phone number of the call centre. It may have been unclear to some patients which phone number to call in order to change their appointment.
- Staff ran 18 different one stop clinics for a variety of clinical specialities at the hospital.

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 patients constitutional right to start treatment in 18 weeks.
- The trust had been below the below the England standard of 92% for incomplete pathways for referral to treatment time (RTT) within 18 weeks since April 2015.
- At the end of March 2016, 90% of patients were waiting within 18 weeks and 12 out of 19 specialities were better than the England standard. The trust had a system in place to clear the backlog with an RTT group which met regularly and were on target to meet the standard by the end of the financial year.
- 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.
- 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 only 34 clinics had been cancelled within six weeks at the hospital in the 5 months prior to the inspection. Twenty six percent of those clinics were cancelled because of annual leave. This indicated the trusts policy was not always followed, when cancelling clinics due to annual leave.
- Paper referrals were received into the outpatient appointment centre. Staff scanned them onto the computer system and the same day sent them by courier to the hospital for triage by the speciality doctor. 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 14 days. The longest time taken was 34 days. This indicated the target time was not being met.
- The hospital had few clinics dedicated to patients on a two week pathway. A majority of clinics were a mix of two week wait patients, new and follow up.

Outpatients and diagnostic imaging

- Staff at the booking centre told us there was capacity at the hospital to over book clinics to ensure patients received their appointment at the right time. Information was cascaded to front of house staff but often meant they had to stay late.
- Clinic 5 appeared chaotic with a large number of people waiting. There were multiple specialities in attendance in clinic 6 and a long patient queue at the desk.
- An audit of waiting times in December 2015 showed 22% of patients were seen on time or early, 70% within 30 minutes , 6% within an hour. 14% of patients waited more than 1 hour. Information was based on 244 patients.
- We saw white boards indicating the length of wait in clinics, several had 60 minute waits. We did not hear any reasons given to patients to explain the delays. Patients told us they routinely expected their appointments to be late.
- There were systems in place to monitor the turnaround times in pharmacy. The average time was 15 minutes and we saw patients waiting no longer than this. Patients we spoke with were happy about the waiting times. Staff told us patients waited no longer than 30 minutes and we saw data to support this.
- In diagnostic imaging urgent patients and those on a two week pathway waited no longer than two weeks for an MRI, CT or ultrasound scan. Some specific ultrasound scans were available within one week. Routine patients waited up to four weeks for an MRI scan, five weeks for a CT scan and six weeks for an ultrasound scan. Any patients waiting longer was due to patient choice.

Meeting people's individual needs

- There was a flagging system for patients with learning disabilities, living with dementia or safeguarding concerns on the electronic patient appointment system. They were identified with a yellow star. A note was made on this record with regard to their individual need. This made it easier for staff to identify patients which required extra assistance. An administrator showed us how this could be done. In addition to this clients with learning disabilities were issued with hospital passports, of which we saw a copy.
- In the phlebotomy department patients with learning disabilities, those living with dementia and those with difficulties fighting infection were seen as a priority.
- At the time of inspection, the hospital did not audit the care of patients with learning disabilities.
- Staff in the Ian Charleson centre spoke a variety of languages and would assist patients for who English was not their first language.
- We saw reception areas had wheelchair accessible desks.
- A number of patients and volunteers told us there were not enough wheelchairs available. One patient told us they arrived 30 minutes early for an appointment so there was enough time to try to locate a wheelchair. We saw two incidents at the main entrance where patients arrived in taxis and there were no wheelchairs available. Ten unused wheelchairs were outside the main entrance to the hospital at one point during our inspection.

Learning from complaints and concerns

- In the last year 46% of all complaints were 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.

Are outpatient and diagnostic imaging services well-led?

Good

The outpatients department for The Royal Free Hospital NHS Foundation Trust was led by a clinical director for out-patients, a senior operations officer and one matron across all 3 sites. 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.

We rated the leadership of the service as Good because;

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

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.
- The diagnostic imaging department had service improvement working groups to improve patient experience, ultrasound and working with the emergency department.

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.

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.

Outpatients and diagnostic imaging

- 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 and Public engagement

- 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.
- We saw letters of positive feedback sent to the outpatient department.

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.
- The heart attack service in diagnostic imaging provided rapid access for patients with a suspected heart attack. The diagnostic imaging department had received an award for the provision of this service.
- A fast track service had just been started prior to our inspection for patients with a suspected abdominal aortic aneurysm. This would reduce the time from admission to the emergency department to surgery by providing rapid access to a scan.

Outstanding practice and areas for improvement

Outstanding practice

A 'Foetal Pillow' had been designed to aid delivery of the baby at caesarean section. The foetal pillow was used to elevate the baby's head making operative delivery easier.

Particular praise must be given to the volunteers who provided additional caring activities such as massages for patients and supported patients with dementia.

We observed dynamic nursing leaders who supported clinical environments are were essential in the development and achievement of best practice models.

The neonatal unit had level 2 UNICEF accredited baby friendly status where breast feeding was actively encouraged and mothers are given every opportunity to breast feed their babies.

The vigilance and recording of mandatory training and other aspects of post qualifying education by the paediatric practice education team was exemplary.

Areas for improvement

Action the hospital MUST take to improve

- Ensure the labour ward co-ordinator is supernumerary.
- Improve termination of pregnancy pathway.
- Identify a dedicated bereavement facility for women and families to use in or near the Labour Ward.
- Take action to ensure compliance with The National Patient Safety Agency (NPSA) alert PSA001 31st January 2011.
- The trust should ensure the 62 day cancer wait times are met in accordance with national standards.
- The trust data base of clinical guidelines and procedures hosted via "freenet" must be updated as soon as possible.
- The recovery area of the operating theatre must be altered to protect children from witnessing upsetting sights and hearing frightening sounds.
- Nursing staffing levels on the children's ward must be improved.

Action the hospital SHOULD take to improve

- Clearly define the 'low risk' pathway for women identified as suitable for birth centre care.
- Use lessons learned from Barnet Hospital in reducing Caesarean section rates.
- Undertake a maternity acuity staffing assessment to identify staffing requirements for the merged service.
- Ensure ED staff are fully trained and able to identify and support patients living with dementia.
- Ensure the ED risk register captures and manages all risks.
- Improve antenatal risk assessments.
- Ensure the theatre swab, needle and instrument policy is ratified and new practices are embedded in all relevant departments across all sites.
- Ensure a safer surgery policy is produced and ratified.
- Ensure appropriate staggering of arrival times with the day surgery unit to minimise the time patients are prohibited from eating and drinking.
- Ensure that there is an electronic system in place to flag patients who may require additional support.
- Ensure that medical and nursing records are fully completed without gaps or omissions.
- Ensure that RTT is met in accordance with national standards.
- Ensure all staff interacting with children have the appropriate level of safeguarding training.
- Ensure security of prescriptions forms is in line with NHS Protect guidance.
- ED department to ensure that compliance with staff appraisals meets the trust target of 95%.

Outstanding practice and areas for improvement

- The ED department should use a formal early warning score system for early identification of deteriorating patients.
- ED Leadership team to ensure annual participation in all relevant Royal College of Emergency Medicine audits in future.
- The secure room in ED used for patient with mental health problem should meet best practice standards.