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

Acute hospital sites at the trust

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

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
</tr>
</thead>
</table>
| The Royal National Orthopaedic Hospital (Bolsover Street) | 45-51 Bolsover Street, London, W1W 5AQ | Diagnostic and screening procedures  
Services for everyone  
Treatment of disease, disorder or injury |
| The Royal National Orthopaedic Hospital (Stanmore) | Royal National Orthopaedic Hospital, Brockley Hill, Stanmore, HA7 4LP | Assessment or medical treatment for persons detained under the 1983 Act  
Diagnostic and screening procedures  
Services for everyone  
Surgical procedures  
Treatment of disease, disorder or injury |

(Source: Trust Website)

The trust has many specialty services as listed below:

- Foot and ankle reconstruction.
- The trust is a leading UK tertiary centre for the treatment of complex peripheral nerve injuries.
- Shoulder and elbow surgery, including routine and complex primary arthroplasty, revision arthroplasty, prosthetic joint infections, instability, and rotator cuff dysfunction.
- Spinal deformity surgery.
- Joint reconstruction.
- The Sarcoma Service is one of five designated centres in the country.
- Spinal cord injury and rehabilitation.
- Chronic pain management.
- Limb lengthening service including Ilizarov work.
- Ponseti method for correction of congenital talipes equinovarus (CTEV) or club foot deformity.

Activity

The trust had 13,138 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 237 (1.8%), 7,751 (59.0%) were day case, and the remaining 5,150 (39.2%) were elective.
The trust had 3,082 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 91 (3.0%), 511 (16.6%) were elective, and the remaining 2,480 (80.5%) were day case. During this period the Jubilee Rehabilitation Unit had an occupancy rate of 62%.

The trust had 135,870 first and follow up outpatient appointments from June 2017 to May 2018.

**Is this organisation well-led?**

We rated Well Led at The Royal National Orthopaedic Hospital NHS Trust (RNOH) overall as Good.

**Leadership**

As part of the inspection process, we interviewed members of the board, both the executive and non-executive directors, and a range of senior staff across the trust. We looked at performance and quality reports, audits and action plans. We looked at previous board meeting minutes and papers to the board. We also spoke with staff about how they perceived the trust culture and their understanding quality improvement initiatives.

We looked at investigations of deaths, serious incidents and complaints. We sought feedback from patients and stakeholders. We spoke with a wide range of staff and asked their views on the leadership and governance of the trust.

The work of the Royal National Orthopaedic Hospital NHS Trust was overseen by the trust board, which had a statutory responsibility for the trust.

Of the executive board members at the trust, 20% were British Minority Ethnic (BME) and 40% were female.

Of the non-executive board members 0% were BME and 0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>20.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>9.0%</td>
<td>18.2%</td>
</tr>
</tbody>
</table>

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

The trust board included executive and non-executive members with a range of experience, knowledge and skills appropriate to their roles. We found that as a group, the board had wide-ranging private and public-sector experience, and a variety of skills that enabled them to perform their roles. The board had overall responsibility for monitoring quality of performance and finance.

Board membership was stable with most executive members have been in post for several years.
The chief executive, Rob Hurd, had been in post since August 2008. The chair, Professor Anthony Goldstone, had been in post since February 2011.

The executive team comprised of: chief executive, chief nurse, medical director, chief operating officer, director of finance, and a director of people and organisational development. The executive team were widely experienced and each had a broad portfolio of responsibility. From our conversations with them, it was evident that they were each suitably skilled, and were able to discharge their duties with competence and integrity.

The non-executive directors comprised of six individuals of varying backgrounds and experience (including the chair). Individual responsibilities amongst the non-executive directors included chairing the following committees and groups: Finance Committee, Audit Committee, Quality Committee, Chair of People and Culture Committee.

They spoke positively about the collaborative relationship with each other and with the executive team and were confident in their position to provide constructive challenge to the executive directors. Through our conversations and our review of trust board papers, we found the non-executives had a sufficient level of involvement and influence as part of the overall leadership of the trust and clearly understood the challenges of which the trust faced.

The Chair of the trust was additionally the chair of the quality committee, and we considered this to be a conflict of interest given that the quality committee reported to the board, the trust should consider reviewing this and appointing another chair of the quality committee from within the other non-executive members.

Additionally, the Trust had three associate non-executive directors (non-voting) to bring further skills and expertise to the board, and to ensure succession planning. Monthly board development sessions were held to allow the board to drill down into any issues to gain a greater level of understanding of how these could be addressed. The trust’s improvement strategy sets out the trust’s intention to train all board members in improvement methodologies.

NHS Improvement has no current concerns with the boards capacity in terms of ability and skills.

The chair of the audit committee had been in post since October 2017, and was a qualified chartered accountant with several years of experience working as a chief financial officer in a private sector organisation. They also chaired the trust’s finance committee.

A self-assessment review of the audit committee was undertaken in March 2018. This concluded that the committee was broadly effective but had a number of actions to take forward which included all board committees performing biennial self-evaluations, having a list of legal and regulatory issues regularly reported to the audit committee, exploring the need in the self-evaluations for reducing the size of board committees and having greater alignment between the trust’s risk registers and Board Assurance Framework (BAF).

The trust director of finance (DoF) had been in post since October 2016, and is a qualified accountant with several years of experience working in a finance function, mainly in the civil service. The trust chief executive officer (CEO) is also a qualified accountant with a background of
working in senior finance positions across the NHS and prior to being appointed CEO he was the DoF of the trust.

A review of board and finance committee minutes indicated an appropriate focus on financing and resourcing.

The trust had a current fit and proper persons policy and checks were in place. We reviewed the files of all executive and non-executive directors and found they contained evidence of relevant checks to comply with the Fit and Proper Persons Requirement (FPPR) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 5).

The dates when appraisals were undertaken was noted on the fit and proper person’s requirement checklist for executive directors where they had been in post sufficient time for this to have taken place. In relation to the non-executives, the appraisal documentation was held on individual fit and proper persons requirement files which confirmed the appraisals were undertaken by the chair. However, the files need to be reviewed as they were disorderly and information was difficult to find.

The non-executive directors were provided with training and support to fulfil the obligations of their roles.

Staff told us that the executive team were visible and approachable. The chief executive was well liked and respected amongst staff we spoke to. Nursing staff told us that the chief nurse was supportive, providing strong leadership and guidance. Non-executive and executive directors visited wards and clinical areas regularly. However, it was not clear how many visits were made to Bolsover Street outpatient department.

The clinical structure comprised of six clinical divisions; each managed by a clinical director, a divisional head of nursing a divisional general manager. The therapies division had an additional Clinical Director of Therapies (Allied Health Professional). The divisions reported to the board through the operational leadership team. The divisions were: children, outpatients, imaging and access, joint reconstruction and cancer, specialist surgery, critical support services, medicine and therapies and private patients.

The divisional leadership teams were able to evidence a collaborative approach to working together, and convey what the current issues of concern and organisational risks were. The triumvirate structure was well established and ensured each staff group within the divisions had a voice.

The chief pharmacist worked closely with the general manager, clinical director and head of nursing within the critical support services division. There was a medicines optimisation strategy and action plan which set out clear lines of accountability for medicines optimisation and was approved by the trust board.

The Trust had created a leadership development programme and was investing in staff who had potential to become leaders in the future to support succession planning for example The DoF had a succession plan in place for themselves and other senior members of the finance function.
The Medical director was the Caldicott Guardian and able to describe his role and how he discharged it.
There was a guardian of safe working hours for junior doctors and we were satisfied that all safeguards were in place, and that junior doctors were satisfied that their wellbeing and hours of work were monitored.

Vision and strategy
The trust had a clear vision and strategy, and delivery of this was underpinned by the VAL-YOU values. The VAL-YOU campaign was part of the trust’s effort to make the hospital the best place to work in the NHS. The VAL-YOU campaign was launched in 2016. The values included putting patients first; excellence in all we do; trust, honest and respect for each other; and equality for all. Senior leaders told us staff were expected to work towards these values every day. Staff were aware of the trust values and understood their roles in ensuring these values underpinned their work daily.

The trusts goal was to be a world-leading orthopaedic hospital with the best patient care and staff experience in the NHS, to achieve this the trust had 5 strategic aims and objectives. They were:

1. Patient care

The key areas of focus for patient care was to reduce length of stay; improve operating theatre utilisation and develop medical staff job planning to support effective use of capacity.

2. Staff experience

To recruit, develop and retain highly skilled and engaged staff who embrace and deliver the Trust’s aims and values.

3. Infrastructure

Continue and develop the new Stanmore site and develop a digital strategy to support of the trust’s aims and objectives.

4. Financial stability

Maintain financial control and achieve agreed activity levels and continue to develop relationships and partnerships to help achieve the trusts vision. Increase income from non-NHS sources in line with strategic aims.

5. Research, innovation and education

Continue to develop financially viable integrated clinical research activities and the academic track record.

The trust aligned its overall strategy to the National Orthopaedic Alliance (which includes other tertiary orthopaedic hospitals), and to their involvement in the sustainability and transformation plans. (STP).

The trust had an estates redevelopment programme to modernise much of its estate.
but have not been able to provide a comprehensive fully funded estates strategy to date. The new in-patient ward block opened in December 2018 after our inspection, replacing some of the older buildings on the Stanmore site. This has been financed by a capital loan from the Department of Health and Social Care (DHSC) which will be paid off using proceeds from the phased disposal of the land on the Stanmore site by 2021. The trust has aspirations to build a second new in-patient ward block, which will be partly funded by a further land disposal.

Culture
The Royal National Orthopaedic Hospital NHS Trust states it will continue to develop an organisational culture founded on honesty, openness and continuous improvement, which recognises and reports errors and poor care and enables a swift and effective response. And additionally, a commitment to a culture free from the fear of retribution when issues or concerns are raised and a determination to place the interests and needs of patients at the heart of everything the trust does.

At our last inspection in May 2014, we told the trust it must focus on culture and behaviours of staff to address instances of bullying, areas of unsupportive leadership and negative working environments. During this inspection all the staff we spoke with said they had experienced a significant improvement in the working atmosphere and environment. For example, staff said new opportunities for communication meant they worked more closely with colleagues and developed relationships with colleagues in other teams and specialties. Divisional teams had introduced a triumvirate leadership model to address gaps in leadership. For example, staff said before the new structure, senior staff relied on individual relationships to communicate and deliver the service. The new approach meant leadership was structured and had resulted in a substantial change in practice.

At our last inspection in May 2014 we told the trust they should improve staff awareness of the employee assistance programme (EAP). The trust had addressed this and at this inspection information on the programme, including posters and wallet cards, were readily available. Staff said they knew how to access the support provided. Senior staff demonstrated promotion of the EAP was one part of a broad improvement in engagement strategies, which included more substantive action from staff survey results.

The Trust is working towards the adoption of the NHS' national Equality Delivery System (EDS2) as a framework to support their work to comply with equalities legislation and meeting the requirements of the Public Sector Equality Duty. The EDS2 aims to drive up equality performance and embed equality into every day working.

We spoke to the BME forum leads and received positive feedback about equality at RNOH, including there was lots of opportunity for training and development, as well as fairness in recruitment. Each year the Trusts holds a diversity day to celebrate people individuality and cultures.

The trust were working to improve the working environment for staff and have adopted the Workforce Race Equality Standard (WRES), which helps the trust to derive information about the experience of staff from a BME background.
The WRES is an analysis of staff records and the staff survey results. The information suggests that the trust had made improvements since the introduction of this standard in 2015 but that there are still areas for improvements. Much of this work is underway and aims to improve the working environment for all staff, not just for BME staff.

However, some staff still felt that they were not treated equally, and found it difficult to raise concerns. The 2017 NHS Staff survey reported that the percentage of staff experiencing discrimination at work in last 12 months was 14% against a national average of 9%.

Staff we spoke with during our core service inspections and in focus groups recognised the work the senior leadership team had done over recent years to improve staff morale and recognise the value of its workforce. Nursing staff we spoke to mostly spoke of strong support and clear leadership, both at divisional and executive level. At a previous inspection and through information we had received, there had been some evidence of bullying, however at this inspection and core service inspection it was found that staff acknowledged that this had improved. However, the NHS Staff survey showed the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months was 27% against the national average of 23%.

Amongst the consultant body, there had been some challenging behaviours by senior medical staff, which did not meet the values of the trust. The medical director who has been in post since January 2017, had challenged these behaviours and held individuals to account, and led by example. The chief executive and the medical director reported a significant reduction in poor attitudes and behaviour in the last year.

Managers encouraged an open culture to reporting incidents without blame. We conducted a review of incidents and complaints and saw evidence that the trust was committed to and responded appropriately to the statutory duty of candour. Where an incident met the requirement of the duty of candour we saw evidence that the trust met the regulatory requirements.

The results from the 2017 NHS Staff survey showed the RNOH performed better than other acute NHS trusts in the following 17 key areas.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. Percentage appraised in last 12 months</td>
<td>91%</td>
<td>88%</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>3.39</td>
<td>3.16</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.14</td>
<td>4.08</td>
</tr>
<tr>
<td>KF17. Percentage feeling unwell due to work related stress in last 12 months</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>KF19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.79</td>
<td>3.73</td>
</tr>
<tr>
<td>KF15. Percentage satisfied with the opportunities for flexible working patterns</td>
<td>60%</td>
<td>54%</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>4.07</td>
<td>3.94</td>
</tr>
</tbody>
</table>
KF7. Percentage able to contribute towards improvements at work  |  76%  |  73%
KF8. Staff satisfaction with level of responsibility and involvement  |  4.04  |  3.93
KF9. Effective team working  |  3.89  |  3.79
KF14. Staff satisfaction with resourcing and support  |  3.62  |  3.41
KF5. Recognition and value of staff by managers and the organisation  |  3.68  |  3.53
KF6. Percentage reporting good communication between senior management and staff  |  46%  |  35%
KF10. Support from immediate managers  |  3.89  |  3.81
KF2. Staff satisfaction with the quality of work and care they are able to deliver  |  4.22  |  4.02
KF3. Percentage agreeing that their role makes a difference to patients / service users  |  95%  |  91%
KF27. Percentage reporting most recent experience of harassment, bullying or abuse  |  50%  |  47%

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

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF20. Percentage experiencing discrimination at work in last 12 months</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>KF21. Percentage believing the organisation provides equal opportunities for career progression / promotion</td>
<td>80%</td>
<td>88%</td>
</tr>
<tr>
<td>KF25. Percentage experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>24%</td>
<td>21%</td>
</tr>
<tr>
<td>KF26. Percentage experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>27%</td>
<td>23%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

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

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.
In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th>KF25</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute specialist trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>24%</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>23%</td>
<td>17%</td>
<td>20%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>25%</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>28%</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>88%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>68%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>15%</td>
<td>14%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Of the four questions above, the following two questions showed a statistically significant difference in score between White and BME staff:

- KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
- Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.
The trust scored about the same as the England average for recommending the trust as a place to receive care from September 2017 to August 2018.

(Source: Friends and Family Test)

The trust’s sickness absence levels from June 2017 to April 2018 were below the England average.
In the 2018 General Medical Council Survey the trust performed the same as expected for all the indicators.

We spoke with both junior doctors and consultants during the core services inspection and focus groups. All were very positive about the trust and said they were well supported by their consultants and other staff and had opportunities for training and development, and research.

The trust has used the NHS Counter Fraud Authority self-review tool which enables organisations to produce a summary of the counter fraud work they have conducted over the previous financial year. A red, amber or green rating is given to each standard to indicate the level of compliance. The trust’s overall rating during 2017/18 was amber. This meant that it was not fully compliant with the standards for providers.

**Governance**

The Board met monthly and included both a private board and a public board on the same day, following guidance on trust board meetings.

There were effective governance structures and processes in place at board and committee level. Roles and responsibilities were well understood and there were clear and explicit terms of reference for all committees.

The trust’s governance structure is in line with expectations with the appropriate board committees, sub-committees, and divisional governance groups in place. Reporting into the board were the risk management committee, audit committee, clinical governance committee, remuneration committee, finance committee, and quality committee. However, where necessary other trust committees reported to the board as required.

The audit committee met four times and finance committee 12 times in the last financial year.

The finance and audit committee both have clear terms of reference (ToR) setting out their roles, responsibilities, membership, frequency and reporting requirements to the board.

As previously mentioned the chair of the trust was additionally the chair of the quality committee, and we considered this to be a conflict of interest given that the quality committee reported to the board, the trust should consider reviewing this and appointing another chair of the quality committee from within the other non-executive members.

Quality objectives were overseen by an executive director whose responsibility it was to ensure the right support and progress was reviewed. The medical director and chief nurse held responsibility for delivery of the clinical priorities, whilst direct operational priorities were the responsibility of the chief operating officer.

In each division, team meetings including governance fed up to the operational leadership team.
The executive directors held performance review meetings with the operational leadership team, who in turn held performance reviews with Divisions. These meetings were where the core business of the trust was discussed on a regular basis with quality, risk, financial and operational performance scrutinised directly through the committee structure without the need for additional executive oversight.

The internal audit annual report for 2017/18 concluded that the trust had an adequate and effective framework for risk management, governance and internal control. The programme of work looked at 10 different areas for assurance. No area was given a ‘no assurance’ rating but a ‘partial assurance’ rating was given for learning lessons from complaints, incidents and clinical audit. 60 management actions were identified as a result of internal audit recommendations. As at 25 May 2018 only two of these actions had not been implemented by the original timescale.

The trust’s finance director took a collaborative approach to identifying and implementing efficiency savings, seeking approval from the divisional staff rather than imposing schemes. The divisional leadership teams were required to sign off on any proposed plans. Executive challenge sessions were undertaken with each division to ensure patient safety was not compromised by any savings plans.

The trust website detailed five strategic aims as described previously within each and accompanying risks. A summary of these is below.

**Patient care**
- Maintain clinical excellence and high-quality care for patients
- Provide more timely access to care
- Increasing capacity and productivity will enhance patient care, access to our services and support financial stability.

**Staff experience**
- Deciding what excellent looks like (Creating the Required Culture) – all our people will decide what good, values-led/based behaviour looks like at the RNOH
- Developing strong, values-led leaders (Creating the Necessary Capability) – setting clear and high expectations and supporting them to deliver these
- Communicating the Important Stuff (Creating Supporting Infrastructure) – Make sure people know what is expected and who will help them deliver that

**Infrastructure**
- Meet in-year milestones for enabling projects for new Stanmore site
- Develop Digital Strategy in support of the Trust’s aims and objectives
- Financial stability

- Maintain financial control and achieve agreed activity levels
- Increase income from non-NHS sources in line with strategic aims
- Continue to develop relationships and partnerships to help achieve Trust vision

**Research, innovation and education**
- Further develop financially viable integrated clinical research activities and academic track record
The Board Assurance Framework (BAF) is a key mechanism which boards should be using to reinforce strategic focus and better management of risk. The BAF brings together in one place all of the relevant information on the risks to the board’s strategic objectives. The trust board had sight of the most significant risks and mitigating actions were clear.

The BAF gave confidence to management and the board that they had a broad and deep understanding of how the trust was performing and the key strategic risks.

The assurance mapping process identified and recorded the key sources of assurance. This informed board members of the effectiveness of how key strategic risks were being managed or mitigated, and of the key controls and processes that were relied on to manage risks. As a result, the BAF supported the achievement of the organisation’s strategic objectives.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.

Members of the board said the format and content of the BAF had improved and it helped them to understand the key areas of focus for the organisation.

However, a new BAF template is being implemented from November 2018 following feedback from NHS Improvement. The revised BAF better articulates the principle risks underlying the strategic risks, any change to the level of risk, the controls put in place to mitigate the risks and assurance around these controls. Responsibility for each risk is assigned to an executive risk owner and a lead committee and it includes both internal and external risks.

In its own well led assessment the trust had identified areas of improvement to be made in the identification, assessment and management of risk to the organisation. These included:

- More clear alignment between the issues raised in the BAF and risk registers maintained by the trust
- Lack of assessment of the BAF in meetings
- Requirement to keep more up-to-date risk registers and with the risks more accurately described.

The main risks facing the trust were the trust’s deficit position, workforce vacancies and estates redevelopment and were articulated by the senior team managers we spoke to and aligned with those in the BAF.

The trust’s corporate and divisional risk registers contained few finance based risks and, where these had been included, many had not been reviewed in over a year. How the risk registers link in to and inform the BAF was also unclear.

It was noted that there are many attendees at board and senior management meetings. As a result, some senior managers we spoke to considered that discussions were not as focused as they otherwise might have been and board meetings were a considerable long.
Management of risk, issues and performance

The structure of performance management meetings and level of reporting was comprehensive, providing sufficient opportunity for executive directors to hold divisions to account. The quality of performance reporting at trust and division level was high.

The main risks facing the trust were the trust’s deficit position, workforce vacancies and estates redevelopment and were articulated by the senior team managers we spoke to and aligned with those in the board assurance framework (BAF).

Risks were appropriately reported on the trust-wide risk register and were monitored via the quality governance committee and sub-groups, divisional quality and safety groups. Strategic risks, which could prevent the trust from achieving corporate objectives, were recorded on the board assurance framework which was monitored at the board. Overall, we found that core service leadership teams had a good knowledge of the risks contained within their registers and reflected the concerns that were identified during our discussions.

The trust had an effective system for the management of safety alerts and information regarding safety alerts was distributed via the trusts intranet and email.

Incidents were reported at the trust using an online incident reporting system which utilised several stages to ensure that all steps in the process were complete before the incident could be closed. The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts.

Learning is shared on a monthly basis via the quality report and each division has a section to review. Learning is also discussed and shared in the monthly QUILL (Quality Improvement and Lessons Learnt Review Panel) which is attended by the divisional leadership teams. Learning from the previous week is discussed at the start of each executive committee and a patient story is taken to the board bi-monthly. A weekly message of the week is distributed to wards which often focuses on learning from incidents or other important trust and national issues.

The executive lead for safeguarding was the director of nursing, quality & patient experience. Named professionals were in post and acted on the executive leads behalf to ensure all necessary measures were taken to safeguard children and adults.

The safeguarding sub-committee met bi-monthly and reported to the trust board via the quality committee.

Bi-monthly safeguarding reports were reported to the quality committee and safeguarding committee. Safeguarding compliance and assurance was monitored through those committees via the safeguarding dashboards, the risk register, the quality committee reports, policy, audit and learning from cases.

On wards we saw staff following appropriate procedures for the disposal of waste with segregation into appropriate containers and good management of sharps containers, in accordance with trust policy.

During the core service inspection, concerns were raised in relation to fire safety. Senior divisional staff said they held occasional mock or practice fire and evacuation drills. However, there was no
evidence of this and the trust’s fire safety adviser told us evacuation drills were rare and the trust no longer provided practical fire extinguisher training for staff. This was not in line with Department of Health guidance on fire safety and procedures in Health Technical Memorandum 05-01. The fire safety adviser had scheduled fire drills but said these had been cancelled due to pressures on the service.

After the inspection we wrote to London Fire Brigade to request an assessment by them. We also requested information from the trust detailing a response to our concerns. The trust agreed to review its fire safety management.

Finance overview
There have been recent improvements to the finance function with the introduction of finance business partners at 8b level (previously 8a) who work with each of the divisions. Upgrading these posts has helped improve the capability of finance function by attracting higher calibre candidates and has improved staff retention. The DoF was drafting a business case to increase the number of procurement posts with the intention this will enable further savings from suppliers to be identified.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£140.5m</td>
<td>£143.7m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£6.6m)</td>
<td>(£10.6)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£147.2m</td>
<td>£154.2</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£7.4m)</td>
<td>(£16.2m)</td>
</tr>
</tbody>
</table>

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

An update from the finance committee and a monthly finance report was presented at each board meeting. This report included a full monthly review of financial performance covering income and expenditure against plan; analysis of the pay, non-pay and income position; performance against efficiency/CIP target; CQUIN achievement; capital expenditure; liquidity; and cash position of the trust.

However, there was no reference to underlying position or divisional financial performance in the monthly board finance report.

A balanced scorecard with a comprehensive set of metrics covering clinical quality, workforce, information management and technology and access standards was presented to the board each month.

The finance and audit committee chair expressed some limitations with the current monthly finance report, believing the report to be too detailed for board members to review in meetings. This had been highlighted to the finance director and suggested that there was a need for a front-
page summary dashboard to be introduced containing key financial performance metrics and trend data with significant concerns/risks highlighted.

Divisional monthly finance reports included the financial performance of the division, including variance against plan for income, pay and non-pay costs and performance against efficiency/CIP targets with areas of concern highlighted. However, the reports do not contain any financial forecasts.

All managers we spoke to were aware of the trust’s underlying deficit and financial challenges, including the loss made on specialised orthopaedic activity due to tariff prices, ability to deliver growth in private-patient income and the capital funding required to redevelop the trust’s estate. Given its specialised nature, the trust relied heavily on a small number of consultants to generate a large proportion of its private patient income. Loss of these consultants could significantly impact on the trust’s income position.

**Trust corporate risk register**

The trust provided a document detailing their 13 highest profile risks. Each of these have a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/05/2017</td>
<td>103</td>
<td>High number of Incorrect clinical information or examinations requested resulting in unnecessary or incorrect radiation exposure</td>
<td>Red - 16</td>
</tr>
<tr>
<td>02/07/2017</td>
<td>122</td>
<td>The Accessible Information Standard applies to providers of NHS services and compliance became a legal requirement on 1st August 2016. At the time of writing, the RNOH was not compliant with the requirements set out in the Standard and was at risk of failure to comply with statutory regulations for delivering care equally to all service users.</td>
<td>Red - 16</td>
</tr>
<tr>
<td>29/07/2017</td>
<td>243</td>
<td>In February 2017, the Lord Chancellor announced that the way that the discount rate is calculated for payments for future losses and expenses. The reduction from 2.5% to 0.75% was brought into effect in 20 March 2017. This has the potential to significantly increase damages paid in clinical negligence claims (particularly for younger patients) and is likely to lead to increased CNST scheme contributions.</td>
<td>Red - 16</td>
</tr>
<tr>
<td>20/06/2017</td>
<td>244</td>
<td>A high number (9) SHO resignations are anticipated between now and July 2017. This will create a significant workforce gap within the organisation in the absence of a successful recruitment campaign.</td>
<td>Red - 16</td>
</tr>
<tr>
<td>03/09/2018</td>
<td>371</td>
<td>Whilst a PoCT Policy exists and training is being undertaken, there are currently no central records of staff</td>
<td>Red - 16</td>
</tr>
</tbody>
</table>
that have been trained, thereby leaving the Trust without understanding of this risk and training requirements.

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/09/2018</td>
<td>42</td>
<td>Workforce Shortage: High in bank rates numbers of nursing vacancies due to turnover and recruitment inability</td>
<td>Red - 16</td>
</tr>
<tr>
<td>30/09/2018</td>
<td>445</td>
<td>On 19th October one of our members of staff sustained a needlestick injury. OH Assist were contacted but did not have an effective or confident plan in place which resulted in them ringing a number of Trusts to secure the clinical expertise of a virologist. This risk was finally resolved with support from a virologist at the Royal Free but remains an ongoing risk currently.</td>
<td>Red - 16</td>
</tr>
<tr>
<td>30/09/2018</td>
<td>86</td>
<td>A reduction in funding from Health Education England, and increased controls on spending are limiting our education capacity, potentially reducing our attractiveness as an employer of choice and reducing the capability of our staff.</td>
<td>Red - 16</td>
</tr>
<tr>
<td>03/09/2018</td>
<td>373</td>
<td>Historically medical device training has been neglected.</td>
<td>Red - 15</td>
</tr>
<tr>
<td>19/09/2018</td>
<td>39</td>
<td>Failure to deliver trust training targets</td>
<td>Red - 15</td>
</tr>
<tr>
<td>19/09/2018</td>
<td>490</td>
<td>Uncertainty as to the ‘preferred’ providers of supplementary medical services for those services not available at the RNOH.</td>
<td>Red - 15</td>
</tr>
<tr>
<td>29/04/2017</td>
<td>52</td>
<td>Infrastructure / enabling works</td>
<td>Red - 15</td>
</tr>
<tr>
<td>29/04/2017</td>
<td>61</td>
<td>There is a risk that Therapy &amp; Prosthetics legacy patient records could be damaged or lost due to the environment in which they are stored in Louis Fleischman building.</td>
<td>Red - 15</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register / Board assurance framework)

The trust’s corporate and divisional risk registers contained few finance based risks and, where these were included, many had not been reviewed in over a year.

**Information management**

Information governance systems were in place including confidentiality of patient records. The trust had a senior information risk officer (SIRO) who was responsible for overseeing the management of information risks and incidents within the organisation. A ‘Caldicott Guardian’ was also in place who was responsible for the management of sensitive patient information. Several other staff were assigned to oversee other aspects of information management, such as freedom of information requests.

The trust undertakes various data quality audits to validate the quality of the information the audits included but were not limited to; clinical records audit; corporate records audit; NHS number audit and clinical coding audit. The business intelligence reporting/information portal (Insight) provided...
information dashboards where data sets could be reviewed to identify errors and omissions for correction.

The trust intranet was a primary tool for ensuring that staff had access to the most up to date policies and operating procedures. We viewed these on inspection and found that all policies were up to date. However, we saw some paper copies of guidelines/policies stored in some clinical areas which were out of date. This could mean staff were accessing out of date guidance. The nurse education team provided material on the trust intranet for staff to access information on training opportunities, external placements and continuing professional development.

All staff had access to their work email and senior staff informed us they provided organisational information and updates to staff on a regular basis. Relevant information was displayed on notice boards in all clinical areas visited.

Although staff said the electronic patient records system worked well for daily clinical observations, they said it was often difficult to find key information. For example, there was no overarching or standardised system in place to ensure communication from other services was logged into a record. This meant clinical staff planned treatment without always having access to the latest patient information if this was provided by professionals outside of the trust. Doctors said different interpretations of the electronic filing systems and different departmental standards across clinical services contributed to this, which wasted time and had an impact on patient safety.

Clinical staff identified further risks in electronic information management and said patients often ‘dropped off’ the system if they were discharged and then scheduled for pharmacy intervention at a later date. This meant doctors could not always trace their most recent medical notes. The trust was required to submit notifications to external bodies, including the CQC, for which they were compliant.

The trust had Wi-Fi for public use, which was easy to access.

**Engagement**

The Trust had performed well in the national staff survey demonstrating significant improvement in the last three years that have placed it amongst the strongest performers in the NHS for staff experience. Recent work looking at how to improve retention in the STP area showed that RNOH had the best score amongst ten local trusts in 20 of 30 questions. RNOH has demonstrated its commitment to improving staff experience by recognising that commitment in the trust's vision.

Through feedback from staff, staff survey's, focus groups and research, the charter of values and behaviours appeared to be embedding well. On the whole staff, felt supported by managers, gave feel positive about senior leaders, felt valued, had opportunities to develop and considered that they made a difference to patients. However, the trust understood that this was not a universal experience, and are working to address pockets of poor experience through local staff survey action plans.

A patient group was established to ensure understanding of patient experience was considered when developing services. We spoke to the group during the inspection and they told us that they were involved in projects, conferences and that the board explained clearly to the group about issues that effected the trust. things to us as a group. One of the group attended the board meeting each month and felt they were listened to by the board.
Healthwatch worked with the RNOH patient group and each provided feedback to the other. The trust board received direct updates and reports the programme of cross-trust ward and departmental visits carried out by the patient group. There was limited direct Healthwatch engagement directly with the trust beyond working with the patients group. There was not a big focus for local residents, as few used the service.

Rob Hurd CEO was senior responsible officer for the North Central London (NCL) adult elective orthopaedics services review. The RNOH also interfaced with a wide range of other STP projects.

A national charity had a leisure centre on the grounds of the Stanmore site and provided practical help to people who had been paralysed by spinal cord injury. Feedback about this facility was very positive.

Additionally, RNOH had its own charity which carried out fundraising activities and used donated funds to support RNOH patient services and staff. The Trust had a partnership "Ways of Working" agreement with the Charity that laid out the way in which the two parties worked together as independent entities but in partnership. Partnership working was strong and underpinned by trust and respect.

Communication with stakeholders and other regulators was good and it was recognised that the trust worked hard to foster clear and open relationships.

**Learning, continuous improvement and innovation**

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>Three working days</td>
<td>N/A</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>25 working days</td>
<td>27.2%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>Data not available</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

The trust reported that they received 114 complaints from August 2017 to July 2018. The surgery core service received the most complaints with 66 (57.9% of the total complaints received).
<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Surgery</td>
<td>66</td>
<td>57.9%</td>
</tr>
<tr>
<td>AC - Medical care (including older people's care)</td>
<td>22</td>
<td>19.3%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>13</td>
<td>11.4%</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>8.8%</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>1</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

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

Communication and clinical treatment were the two subjects with the most complaints. Customer care training has been introduced because of the high number of complaints citing communication.

To address some of the aspects of clinical care, clinicians have been given extra administration time to improve access to follow-up care. However, learning from complaints has been identified as insufficient by the board.

We reviewed complaint files during the inspection and found they had clear documentation and investigations were comprehensive and involved the clinicians in the area which the complaint was about. The response to the complainant was personalised, detailed and showed what actions if any the trust was taking.

From August 2017 to July 2018, the trust reported that they received a total of 76 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>49</td>
<td>64.5%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>17</td>
<td>22.4%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>8</td>
<td>10.5%</td>
</tr>
<tr>
<td>Critical care</td>
<td>2</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

The surgery core service received the most compliments with 49 (64.5% of the total complaints received). However, the trust were reviewing how compliments were captured, as it believed the data is only a small proportion of the actual compliments received in the trust. There were a number of themes which had been identified in relation to the compliments, namely, patients overall care, professionalism of staff and the nursing care received. When a compliment is received, in the chief executive office a signed thank you letter is sent to the patient from the chief
executive. A further thank you letter alongside the compliment received, is also sent to the general manager of the named department/member of staff to congratulate them.

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

A learning from deaths review panel had been established, consisting of the Clinical Director of Clinical Governance (Consultant Anaesthetist), Medical Audit Lead (Consultant Anaesthetist), Deputy Director of Nursing, Deputy Director of Quality and the Clinical Audit and Effectiveness Manager. The mortality rate at the RNOH was low, both compared with other NHS providers and compared with the expected number of deaths for the trust, risk adjusted for case mix complexity. The trust had a mortality ratio of 0.2, meaning that for every five patients that are expected to die only one patient actually dies.

As a result of the very low mortality rate, the learning from deaths panel had agreed to undertake a review of all deaths that occur in the trust. This exceeded the expectation of the national guidance, but provided the RNOH with an opportunity to understand the learning from all deaths that occurred.

In the reporting year January to December 2018, there were two deaths recorded at the hospital. Both patients had had complex needs and co-morbidities and there had been a comprehensive review of the deaths that did not identify any concerns.

The trust was involved in academic research studies. Surgeons were given dedicated research time and the trust were encouraging more nurse-led research. The trust was actively participating in clinical research studies. Staff at the trust continued to be involved in national and international studies for example in genetic bone disorders and hip interventions for children with cerebral palsy.

The allied health professions team had significantly improved research outputs from no publications to over 30 publications and a ten-fold increase in return on research investment in the space of five years. The team had implemented the National Institute for Health Research (NIHR) clinical academic pathway, which improved governance and structure. The research teams were exploring more integrated use of technology in their services, including remote clinics via digital video software.

The department had provided input into the development of new guidelines for the classification and diagnosis of Ehlers Danlos. Ehlers Danlos is a group of disorders that affect connective tissues supporting skin, bones, blood vessels and organs. Patients with rare bone diseases were invited to participate in a rare bone disease study.

The trust had contributed to pioneering work looking at the use of 3D printing in orthopaedics. This involved 3D printing models of patients’ anatomy for surgical training, and 3D printing titanium implants for patients with bone defects.

A play specialist had designed and developed a 3D printed miniature model MRI scanner with the hospital’s clinical engineering team to help children understand what happens during an MRI scan. The model made noises like that of a real scanner and played recordings of what scanning technicians were likely to say so children would know what to expect when they were in the scanner. This helped alleviate children’s fears and anxieties and had significantly reduced the
number of children requiring general anaesthetic when undergoing MRI scans. In 2017, of the 43 children aged under 12 requiring an MRI scan, 37 children underwent the scan without general anaesthetic by being supported by the play specialist team using the model MRI scanner.

Accreditations

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

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

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterile Services British Standard Institute (BSI) Accreditation</td>
<td>Critical care</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical</td>
<td>Medical care</td>
</tr>
<tr>
<td>Laboratories ISO 15189</td>
<td></td>
</tr>
</tbody>
</table>

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

RNOH was undertaking a programme of work to gain full Anaesthesia Clinical Services Accreditation (ACSA).
This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.
Acute services

Medical care (including older people’s care)

Facts and data about this service

The trust operates across two sites: Stanmore (inpatient and outpatient services) and Bolsover Street (outpatient services). The medical care service at Stanmore Hospital provides care and treatment for back pain, spinal cord injury, histopathology, rehab, Spinal Cord Injury Centre (SCIC) & urology, chronic pain & medicine, neurophysiology therapies, chronic pain management, neuromodulation, prosthetics & orthotics, rheumatology & metabolic/ rare bone disease, sport & exercise medicine.

There are 67 medical inpatient beds located across three wards; Angus McKinnon Ward, Spinal Cord Injury Centre and Jubilee Rehab.

(Source: Routine Provider Information Request)

The trust had 3,082 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 91 (3.0 %), 511 (16.6%) were elective, and the remaining 2,480 (80.5%) were day case. During this period the Jubilee Rehabilitation Ward (JRW) had an occupancy rate of 62%.

Admissions for the top three medical specialties were:

- Pain management - 1,610
- Metabolic unit - 696
- Rheumatology - 398

(Source: Hospital Episode Statistics)

At the time of our inspection Angus McKinnon was closed. We inspected the JRW, the SCIC and inpatient and rehabilitative therapies services.

The JRW operates Monday to Friday and provides patients with a multidisciplinary rehabilitation programme. This includes input from medical teams, pain management specialists and a wide range of allied health professionals.

The SCIC operates 24-hours, seven days a week and provides patients living with long-term, complex trauma and non-trauma injuries with multidisciplinary specialist inpatient care and rehabilitation.

Is the service safe?

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

**Mandatory Training**

The trust set a target of 95.0% for completion of mandatory training.

**Trust level**

A breakdown of compliance for mandatory training courses as at August 2018 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELITE Basic IT Skills</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>4</td>
<td>4</td>
<td>100.00%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>59</td>
<td>67</td>
<td>88.10%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>66</td>
<td>76</td>
<td>86.80%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>66</td>
<td>76</td>
<td>86.80%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Awareness</td>
<td>59</td>
<td>70</td>
<td>84.30%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP</td>
<td>62</td>
<td>76</td>
<td>81.60%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>59</td>
<td>75</td>
<td>78.70%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>56</td>
<td>74</td>
<td>75.70%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Level 3</td>
<td>47</td>
<td>66</td>
<td>71.20%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - Level 2</td>
<td>52</td>
<td>75</td>
<td>69.30%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>51</td>
<td>76</td>
<td>67.10%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>46</td>
<td>76</td>
<td>60.50%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Mentor Update</td>
<td>40</td>
<td>70</td>
<td>57.10%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95.0% target was met for two of the 14 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses as at August 2018 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>48</td>
<td>65</td>
<td>73.8%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP</td>
<td>44</td>
<td>65</td>
<td>67.7%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>43</td>
<td>65</td>
<td>66.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling for Inanimate</td>
<td>42</td>
<td>65</td>
<td>64.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>41</td>
<td>65</td>
<td>63.1%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - Level 2</td>
<td>39</td>
<td>62</td>
<td>62.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>24</td>
<td>41</td>
<td>58.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>35</td>
<td>65</td>
<td>53.8%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
In medicine the 95.0% target was met for none of the 10 mandatory training modules for which medical staff were eligible.

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

We looked at the mandatory training completion rates for individual medical areas during our inspection. The team in the Spinal Cord Injury Centre (SCIC) had an overall compliance rate of 73%. We spoke with the ward manager about this who identified a number of factors contributing to the figure including some staff working permanent night shift, lack of availability of resuscitation courses, long term sickness and maternity leave.

Nurses and HCAs who worked in the Jubilee Resuscitation Unit (JRW) had an 85% mandatory training completion rate. On this unit the ward manager said staff were accountable for their own training completion.

Senior service staff added to mandatory training in response to feedback from staff as well as incidents and complaints. For example, therapies managers introduced training in the use of a distressed patient algorithm to help staff manage situations in which patients became aggressive.

### Safeguarding

The trust set a target of 95.0% for completion of safeguarding training.

#### Trust level

A breakdown of compliance for safeguarding training courses as at August 2018 the trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2</td>
<td>60</td>
<td>72</td>
<td>83.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>58</td>
<td>75</td>
<td>77.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>0</td>
<td>33</td>
<td>0.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95.0% target was met for none of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from as at August 2018 the trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>39</td>
<td>54</td>
<td>72.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----</td>
<td>----</td>
<td>--------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>32</td>
<td>57</td>
<td>56.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95.0% target was met for none of the five safeguarding training modules for which medical staff were eligible.  
(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff demonstrated good understanding of the principles of safeguarding and how they applied these in practice. They took appropriate action to address safeguarding concerns, liaised with specialists and implemented learning from the outcomes of investigations. For example, therapies managers had implemented new standards of documentation for patient rehabilitation and updated the trust’s chaperone policy. This resulted in training for all clinical and non-clinical staff in the therapies teams and reflected that patients often engaged in exercises in a state of undress.

### Cleanliness, infection control and hygiene

All medical care areas, including inpatient therapies areas, were visibly clean and free from dust and dirt. Cleaning staff were present throughout our inspection and responded quickly to requests for additional services, such as deep cleaning and decontamination. Staff used brightly coloured ‘I’m Clean’ stickers to identify when an item had been cleaned and disinfected and was ready for use.

Each clinical area underwent a weekly hand hygiene audit. From April 2018 to September 2018 the JRW team achieved 89% compliance in the five out of six months in which data were available. In the same period the SCIC achieved 100% compliance although data were only available for four out of six months. There had been no instances of hospital-acquired *Escherichia coli* (E. Coli), *Clostridium difficile* (C. Diff) or methicillin-resistant *Staphylococcus aureus* (MRSA) in the previous nine years. The audit measured compliance with the World Health Organisation five moments to hand hygiene campaign. The annual 2018 audit found overall 95% compliance with some areas of consistent good practice and some for improvement. For example, allied health professionals (AHPs) achieved 90% or above compliance with each standard but nurses and HCAs scored 79% in the requirement that they perform handy hygiene after leaving a patient’s environment. The infection control team led an action plan to maintain areas of good performance and to improve areas of low compliance or inconsistency.

Staff maintained infection prevention and control displays and included information for staff and patients on good hygiene practice. Cleaning schedules were on display in key areas, including wards and bathrooms, and disposable curtains were labelled with their latest usage date. Alcohol hand gel was prominently displayed at the entrance to clinical areas and in each patient bed space. The trust contracted routine daily cleaning tasks to another organisation and a lead nurse carried out spot-checks to ensure practice remained in line with trust standards.

Staff took swabs for MRSA on admission, unless patients had been swabbed in the previous four months and had not had a hospital admission in the interim. If patients received a positive swab result for MRSA, staff cared for them in a side room. Additional side rooms were available in surgical wards to increase capacity and reduce the risk of cross-infection in medical areas.
The spinal cord injury clinic (SCIC) team carried out a two-weekly patient safety survey that included cleanliness, hygiene and laundry standards and staff used results to improve practice.

The JRW and SCIC were fully compliant with the Department of Health (DH) Health Building Note (HBN) 00/09 in relation to infection control in the built environment and with HBN 00/10 in relation to infection control and flooring.

In most areas staff adhered to the standards of the Sharps Instruments in Healthcare Regulations (2013), including in the storage, handling and disposal of sharps. However, two sharps bins in the JRW were incorrectly assembled and in use. This included a sharps bin used for cytotoxic items. We escalated this to a healthcare assistant (HCA), who addressed the issue immediately.

A lead nurse, a senior nurse, staff nurse and senior HCA provided a dedicated infection control team. The team carried out a programme of audits designed to maintain continual oversight of infection control standards. This include a range of catheter and vascular access audits.

Two clinical nurse specialists in antibiotic therapy provided specialist, targeted support. This team supported clinical colleagues to manage infection control challenges, such as a lack of side rooms for isolation and unusual infection risks presented by patients from countries with a high prevalence of specific conditions.

Each ward or clinical area had an infection control link nurse who attended meetings and training with the infection control team to keep up to date with the latest standards and practices.

The infection control team monitored standards for the insertion and management of vascular access devices. Quarterly audits from April 2017 to March 2018 indicated on-going improvements in staff knowledge, documentation and standards of practice. Individual wards implemented monthly auditing to supplement the trust-level quarterly audits, which enabled ward managers to quickly addresses areas for improvement.

**Environment and equipment**

The facilities and estates team managed the safety of the environment and provided staff with on-call support for equipment maintenance and replacements. All 34 items of equipment we checked were labelled with an up to date electrical safety sticker.

Each bed space had an emergency call bell that patients used to obtain help. Nursing teams checked the system weekly and the facilities team provided maintenance in the event of a failure.

Each clinical area, including the therapies gym, had a cardiac arrest and resuscitation trolley. We reviewed the status of each and found variable standards of checks. In the therapies gym suction equipment, defibrillators and oxygen were in date and staff had consistently documented daily safety checks. In the SCIC and JRW some items of equipment had expired and had not been replaced despite being noted on daily safety checklists. For example, a carbon dioxide detector in the JRW had expired in June 2018. Staff had marked this as not for use and noted they had escalated it to the divisional head of nursing. However, no action had been taken. We spoke with the ward managers about this who addressed these areas immediately, although we could not establish why safety check systems in place had failed to immediately address them.
Patients in the SCIC had noted noise levels out of hours sometimes disturbed them. To address this, staff included questions about noise levels in the two-weekly patient safety survey to understand how and when this occurred.

Staff in the SCIC used a daily bedside equipment safety checklist during handovers to ensure equipment remained in safe working order. During our inspection staff demonstrated a consistent approach to completion, for example with respiratory equipment.

The trust operated a no smoking policy on site. However, this was not enforced and there was evidence of extensive smoking around the JRW and SCIC buildings, which presented a fire risk.

Senior divisional staff said they held occasional mock or practice fire and evacuation drills. However, there was no evidence of this and the trust’s fire safety adviser told us evacuation drills were rare and the trust no longer provided practical fire extinguisher training for staff. This was not in line with Department of Health guidance on fire safety and procedures in Health Technical Memorandum 05-01. The fire safety adviser had scheduled fire drills in the SCIC but said these had been cancelled due to pressures on the service. Therapies staff had sourced a wheelchair to be based permanently in the gym to help evacuate patients with reduced mobility following learning from an evacuation in outpatients in July 2018.

Staff used waste streaming methods for offensive and hazardous waste that were fully compliant with DH HTM 07/01 in relation to the management and disposal of healthcare waste.

All 29 items of electrical equipment had an up to date electrical safety check documented and processes were in place for staff to take faulty equipment out of use for repair.

The infection control team carried out quarterly environmental ward audits and spot-check audits to measure compliance against four trust standards, each of which had a 100% target. Both the JRW and SCIC performed consistently well and from April 2017 to March 2018 achieved standards above the trust’s 90% minimum. Although this demonstrated consistent standards, data from the SCIC was available for only four out of 12 months, which meant it was not fully representative of practice.

Assessing and responding to patient risk

Staff used the national early warning scores (NEWS) system to monitor patients’ condition and identify deterioration. In the JRW, staff assessed each patient on admission. As patients were only admitted to the programme if they were medically stable, staff did not routinely monitor NEWS scores unless a patient reported feeling unwell or nurses or therapists saw a change in condition. Staff in the SCIC monitored each patient’s NEWS score using a digital tool, which meant they monitored this in real time. The system automatically alerted nurses to a patient whose condition was deteriorating and provided access to observation results to help staff identify the likely problem. For example, nurses could quickly assess the patient for a potential sepsis infection based on the NEWS score and related observations and start the Sepsis 6 pathway. Nurses acted within established thresholds to escalate a patient’s care to the medical emergency team and used the situation, background, assessment and recommendation (SBAR) tool to support the on-call team. Where staff escalated a patient’s care to the emergency team, this automatically meant the critical care outreach team would review them overnight to monitor their condition.
The nursing team reviewed NEWS scores during handovers and safety huddles and worked with multidisciplinary teams to implement additional care, such as palliative care.

Staff in the SCIS documented each patient’s personal evacuation plan. In the JRW staff did not record this and said patients always had enough mobility to evacuate unaided and that staff would be aware of any additional needs in relation to this.

Junior doctors used an electronic handover system and a telephone handover system to escalate patients whose condition changed or deteriorated and required more senior input.

Overnight, nurses in the JRC escalated patients who deteriorated to the on-call medical specialist registrar (SpR) who led the medical emergency team (MET). This system meant patients had access to rapid medical review although doctors told us the lack of a screening or priority review system meant they were frequently called inappropriately overnight.

Staff used a rapid review document to monitor risks relating to falls, pressure ulcers and infection control. This helped to quickly identify areas of good practice and areas for improvement and identified potential problems in care early, which enabled staff to address them. The rapid review process was a new initiative implemented in April 2018 and staff had developed action plans based on each patient’s outcomes using the checklist. This helped them to track progress and ensure the risk they had identified was mitigated as far as possible.

Staff in SCIC completed an evacuation assessment for each patient based on their level of need. This included the level of support each patient would need in an emergency.

Fainting was a risk amongst patients in the gym who undertook rehabilitation exercises and therapists were trained to recognise the differences between fainting and more serious medical conditions.

A therapist was part of the resuscitation team and represented the service on the resuscitation committee. This individual maintained ALS status and worked with colleagues to ensure consistent standards of life support training.

A cardiac arrest (crash) team supplemented the MET and a critical care outreach team provided a 24-hour, seven day on-call service to support patients whose conditions worsened.

**Nurse staffing**
Stanmore hospital reported is 84.7 planned WTE staff and 69.6 actual staff for the period April to July 2018 for medicine.

A breakdown by department is below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Injuries Ward (247) L5</td>
<td>30.5</td>
<td>20.9</td>
</tr>
<tr>
<td>Community Liaison Siu (211) L5</td>
<td>7.7</td>
<td>9.4</td>
</tr>
<tr>
<td>Rehabilitation Ward (342) L5</td>
<td>9.3</td>
<td>8.8</td>
</tr>
<tr>
<td>Department</td>
<td>Staffing</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>Cancer Services (372) L5</td>
<td>4.6</td>
<td>7.6</td>
</tr>
<tr>
<td>Angus McKinnon Ward (330) L5</td>
<td>16.4</td>
<td>7.0</td>
</tr>
<tr>
<td>JR &amp; Cancer Medical Unit (674) L5</td>
<td>5.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Tissue Viability Service (232) L5</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Interventional Chronic Pain (258) L5</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Siu Urology/Fertility (241) L5</td>
<td>2.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Metabolic Bone Disease Unit (244) L5</td>
<td>1.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Spinal Outreach (234) L5</td>
<td>1.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Rehab/EMG Consultants (278) L5</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Pathology (385) L5</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>F.A.R.S. (269) L5</td>
<td>0.4</td>
<td>0.0</td>
</tr>
</tbody>
</table>

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

From August 2017 to July 2018, the trust reported a vacancy rate of 13.9% for qualified nursing staff in medicine. This did not meet the trust target of 9.5% for vacancy.

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

The nurse vacancy rate on Angus McKinnon ward had reached 50% in early 2018 and the senior team had temporarily closed this ward as a result.

From August 2017 to July 2018, the trust reported a turnover rate of 24.4% for qualified nursing staff in medicine. This did not meet the trust target of 12.0% for turnover.

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

From August 2017 to July 2018, the trust reported a sickness rate of 4.3% for qualified nursing staff in medicine. This did not meet the trust target of 3.0% for sickness.

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

From August 2017 to July 2018, the trust reported a bank usage rate of 7.4%, an agency usage rate of 1.3% and 1.8% unfilled in medicine.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Two registered nurses and two healthcare assistants (HCAs) were planned for day shifts on the JRW and two registered nurses and one HCA worked overnight. This meant nurse to patient ratio was 1:15 although patients on this unit were primarily cared for by therapists and the pain team.

A team of three clinical nurse specialists and a nurse consultant supported the leadership of the metabolic medicine service, which reflected an increase in staffing from July 2018. This team ran clinics, led multidisciplinary meetings and coordinated biological treatment pathways.

The trust had introduced an electronic rostering system for nurses and HCAs as part of a ‘safe care’ initiative. This tool calculated required staffing levels based on patient acuity and highlighted instances of potential unsafe staffing to the head of nursing in advance the shift.
Ward managers monitored the staffing levels and shortages in their areas and reported these in patient safety information on display. For example, in September 2018 the SCIC had 85% of the planned numbers of nurses and HCAs on shift. The ward manager in SCIC increased the nurse to patient ratio for patients who were ventilated to ensure their safety. This included a ratio of 1:2 where patients were cared for on the main ward and 1:1 where they were cared for in a side room.

Medical staffing
Stanmore hospital reported is 66.6 planned WTE staff and 65.5 actual staff for the period April to July 2018 for medicine. A breakdown by department is below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>JR &amp; Cancer Medical Unit (674) L5</td>
<td>33.8</td>
<td>31.6</td>
</tr>
<tr>
<td>Spinal Rehab &amp; Urology (268) L5</td>
<td>10.1</td>
<td>8.9</td>
</tr>
<tr>
<td>Histopathology (673) L5</td>
<td>6.2</td>
<td>7.0</td>
</tr>
<tr>
<td>Rheumatology &amp; Sports Med. (423) L5</td>
<td>7.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Interventional Chronic Pain (258) L5</td>
<td>3.3</td>
<td>4.9</td>
</tr>
<tr>
<td>Metabolic Bone Disease Unit (244) L5</td>
<td>0.8</td>
<td>2.0</td>
</tr>
<tr>
<td>Rehab/EMG Consultants (278) L5</td>
<td>1.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Psychiatry (236) L5</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Prosthetics &amp; Orthotics (230) L5</td>
<td>2.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Rehabilitation Ward (342) L5</td>
<td>0.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Therapies Adult Orthopaedic (467) L5</td>
<td>1.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

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

From August 2017 to July 2018, the trust reported a vacancy rate of 1.5% for medical staff in medicine. This met the trust target of 9.5% for vacancy.

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

From August 2017 to July 2018, the trust reported a turnover rate of 0.0% for medical staff in medicine. This met the trust target of 12.0% for turnover.

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

From August 2017 to July 2018, the trust reported a sickness rate of 1.5% for medical staff in medicine. This is lower than the trust target of 3.0% for sickness.

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

From August 2017 to July 2018, the trust reported a bank and locum usage rate of 19.2% in medicine;

• Bank: 6.1%
• Locum: 13.0%
• Unfilled: 0.0%

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

In June 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 18 whole time equivalent staff working in medicine at Royal National Orthopaedic Hospital NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>62%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>38%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>0%</td>
<td>22%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital - Workforce Statistics - Medical (June 2018)

Three consultants and three junior doctors led treatment in the SCIC seven days a week and consultants led a daily ward round. Two SpRs and two senior house officers (SHOs) were based on the unit from 9am to 10pm Monday to Friday and one of each grade of doctor was in the unit from 10pm to 9am. During the day a spinal surgical consultant was on site and they were available on call overnight. At weekends two SpRs and three SHOs were on the unit from 9am to 5pm; one SpR and two SHOs were on the unit from 5pm to 10pm and one SpR and one SHO was on the unit from 10pm to 9am. A consultant was in the unit or available on call at all times.

An SHO was based in the JRW Monday to Friday from 8am to 6pm and carried out requests from specialist consultants following their review of each patient. This included preparation of to take away (TTO) medicines ready for patient’s discharge. The system reduced delays in blood tests and prescriptions and meant a named doctor had ownership of each patient’s medical needs. The SHO maintained oversight of patients attending intravenous infusion clinics on a day-case basis, which provided medical support for clinical nurse specialists.

Senior staff described challenges in recruiting enough junior doctors from the Deanery due to the specialist nature of the service. However, the hospital offered junior doctors exposure to work in areas such as specialist rheumatology care, which they told us was a key factor in retention. The medical director led a contingency plan for doctor staffing levels to fill junior doctor posts, which included more direct engagement with prospective new doctors.
**Records**

Staff used a combination of paper and electronic records to document medical reviews and observations. Allied health professionals documented observations and rehabilitation activities on a dedicated electronic records system. This enabled therapists involved in all elements of care and rehabilitation to track the progress of therapy and collect data for patient safety and outcomes.

Nurses in the JRW reviewed patient records prior to the start of each week-long rehabilitation programme and updated these weekly. The ward manager recognised this did not meet trust protocol and was working with the nursing team to implement daily observations.

The ward manager on JRW monitored the quality of nursing documentation through a weekly audit. From October 2017 to October 2018 the audit highlighted consistent practice, with 95% of nursing documentation contents compliant with trust standards.

Nurses in the JRW carried out a daily handover and documented this in each patient’s records. Where patients had similar or the same names

We reviewed a sample of five sets of patient’s notes in SCIC and found consistent standards of risk assessment. Staff had fully completed risk assessments for falls, venous thromboembolism (VTE), moving and handling and waterlow scoring for tissue viability. Staff in the JRW had completed risk assessments consistently in a sample of eight records we reviewed on that unit, with some areas that would benefit from greater attention to detail. For example, staff had only partially completed one patient’s waterlow score and had not reassessed a patient for fall’s risk after they had experienced a fall the previous day.

Each ward collected and displayed nursing documentation audit data as part of on-going safety performance and displayed this openly. For example, the SCIC team achieved 98% compliance with trust standards in nursing documentation in September 2018.

The orthopaedic oncology occupational therapy team audited the standards of patients note completion against the College of Occupational Therapists (2010) and the Charted Society of Physiotherapist (2013) standards. The audit, in 2017, found a need for significant improvement in ten specific areas in which compliance was at less than 80%. Senior staff in the service implemented an action plan, which had been completed.

The occupational therapy team in SCIC carried out a patient’s records audit in 2018 to assess compliance with trust standards and those set by the College of Occupational Therapists (2010), the British Dietetic Association (2015) and the Charted Society of Physiotherapist (2013). This found 74% compliance with significant improvement from the 2017 audit, including 100% compliance in documentation of a full patient history and evidence of discussion about the risk of declining.

Following audits in 2017 and 2018, the physiotherapy team in SCIC implemented new standards for patient documentation relating to respiratory function tests prior to discharge. The team completed an action plan to address deficiencies found through the audits and were due to measure progress in early 2019.

The speech and language therapy team implemented a documentation improvement plan in 2018.
to address areas such as need for improved recording of social history and handovers.

From April 2018 to November 2018 staff in the SCIC achieved 98% compliance with trust policy in the standards of patient’s records and the JRW achieved 94%.

**Medicines**

Established safety procedures were in place for the storage, administration, documentation and disposal of controlled drugs (CDs). Two registered nurses were required to sign for CDs to ensure wards maintained a contemporaneous record of stock. We looked at the CD records in the SCIC for the month leading to our inspection. Although documentation was consistent in most cases, there were three missing signatures. We spoke with the clinical facilitator who said they would address this with the team and identify what had contributed to the oversight.

Inconsistent standards of documentation had resulted in a patient receiving two doses of a prescribed medicine, instead of one dose, every day for five consecutive days. This resulted from poor completion of a medicines chart by a doctor and was only found when the patient raised a concern. Staff completed an incident report and an investigation although we were not assured learning was widely shared.

Staff recorded daily temperature checks on fridges used to store medicine. This ensured medicine was kept within the safe temperature range recommended by the manufacturer.

Residential rehabilitation patients were only admitted to the JRW if they were stable on their current prescription and had no recent changes. The pain management team reviewed patients on this unit regularly and initiated new prescription regimens during rehabilitation programmes. At our last inspection in May 2014 we told the trust they should review the prescribing of opioids for older patients in relation to side effects such as delirium and confusion. The lead consultant for pain management was working with the medical team to reduce problems in the community relating to opioid dependence and the pain team led an active programme of prescription reduction. Pharmacist audits showed there had been a significant reduction in patients being discharged with two or more opiate painkillers in last 12 months.

A chronic pain pharmacist provided dedicated cover to the pain team and worked with them to achieve prescription reduction whilst managing needs relating to delirium. Consultants reviewed patients postoperatively and worked with the polypharmacy team to coordinate each individual’s prescription.

Staff followed established processes for managing medicines that were known to take extended periods of time to be effective. For example, the metabolic medicine team worked with pharmacists in the administration of specialist medicines that could take up to three months to have an effect. This team initiated patients on an initial trial of medicines in a controlled clinical environment to ensure there were no untoward side effects and to ensure the patient could tolerate the medicine. This was part of a safety protocol that meant patients started treatment regimens only when staff had carried out appropriate checks. A member of the metabolic team saw patients during the first 12 weeks of treatment for blood tests and to review any side effects, which was a monitoring process to contribute to overall patient safety. Clinical nurse specialists adjusted medicine doses in addition to consultants, which meant patients had access to more rapid changes in their dosage.
We looked at a sample of 12 medicines charts for patients in the SCIC and in the JRW. Ten charts were fully legible and two charts had illegible entries, including one chart with an illegible opioid prescription. Staff had clearly documented patient’s allergies in each record. In four records nurses had completed a self-administration form that assessed patients to be able to manage their own medicines. However, patients had not signed this documentation. This meant we were not assured they had been fully involved in the process. Staff noted allergies and CDs in bold text in handover documents.

A senior nurse said medicines management and safety was an on-going concern and they monitored this through the divisional risk register. A nurse educator worked with staff after a medicines error and incorporated themes and trends into training. The education team led study days in a range of topics, including intravenous medicine competency, enteral feeding and skin traction. There was evidence of appropriate action following medicines errors involving nurse prescribers, including reflective practice and completed action plans.

The pharmacy team provided an on-call service 24-hours, seven days a week.

A pharmacist independent prescriber was part of the pre-assessment team. They counselled patients about their medicines prior to admission and the trust operated a ‘green bag’ scheme for patients to bring in their current medicines on admission. This meant staff could readily identify which medicines patients had brought themselves and check they were safe to use alongside those prescribed in the hospital.

Pharmacists completed full medicine reconciliation for all patients within 24 hours of admission during weekdays and 72 hours at weekends. A clinical pharmacist screened all electronic prescriptions before dispensing medicines.

The pharmacy team had implemented the principles of antimicrobial stewardship, which meant a pharmacist reviewed and re-prescribed antibiotics after 72 hours.

Staff carried out a range of medicines related audits to assess how they were performing, and to identify areas for improvement. These included audits of controlled drugs, medicines reconciliation, and safe and secure handling of medicines. However, there had been no missed or delayed dose audits completed in previous 12 months. This meant there was a lack of assurance of oversight of this measure of safety.

Staff told us that the pharmacy team were a valuable resource in identifying issues with medicines and encouraging improvement. In all areas we inspected there was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety.

The trust made effective use of pharmacist independent prescribers who, for example, were used in the pre-assessment of patients and in facilitating discharge.

Arrangements for the supply of medicines were good. There were effective arrangements in place for medicines supplies and advice out of hours.
Incidents

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

From September 2017 to August 2018, the trust reported no incidents classified as never events for medicine.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in medicine which was a medication incident that met the reporting criteria set by NHS England from September 2017 to August 2018.

(Source: Strategic Executive Information System (STEIS))

Between October 2017 and October 2018 staff reported 337 incidents. This included incidents reported by AHP therapists during rehabilitation. Of the total, staff classified 65% as a near miss or no harm, 34% as low harm and less than 1% as moderate harm. Slips, trips and falls was the most common reporting category and 25% of incidents related to this. In most cases there was evidence the reporting member of staff had received feedback and that action had been taken as a result. However, it was not always evident staff took prompt action following an incident. For example, a member of staff reported a patient fell on SCIC and noted x-rays were not ordered until four hours later. The doctor on duty did not follow these up and the patient’s fracture was not found until 17 hours later. Although the ward manager implemented a root cause analysis investigation the number of falls on this ward suggested a need for more consistent oversight of patients at risk.

Staff said they felt incident reporting had become more transparent and recognised in the trust and as a result they had started to report near misses to help improve safe systems of working. However, we were not assured staff always reported all incidents that occurred or categorised them appropriately. For example, staff on JRW said they did not usually document incidents in which patients were violent or aggressive towards them. They also said they did not always report incidents in which a patient experienced a fall caused by an epileptic fit. Staff described an incident in which the ward manager and a psychologist each met with a patient one-to-one to discuss their threatening behaviour. The team had not escalated this to senior divisional staff or to psychiatrist, which meant senior and multidisciplinary staff did not have oversight. This meant the team and trust did not have assurance that incident records were accurate or adequately reflected risks on the ward. Incident records indicated staff on the JRW had reported only one incident related to patient aggression or violence from October 2017 to October 2018 despite staff reporting this was a frequent occurrence. A senior therapist was organising a training session for staff on JRW to ensure they understood their responsibilities in escalation.

Staff carried out thorough investigations of incidents, including a root cause analysis based on the severity and impact. Where investigations identified opportunities for learning, staff implemented action plans to achieve improved practice. For example, one incident in SCIC involved a hospital-acquired infection in a patient. Staff identified a loose shower head as the cause. After fixing the shower head the team implemented new safety and hygiene checks to avoid future recurrence.
The SI related to a ‘failure to rescue’ incident, which resulted in a patient’s death after processes to monitor and respond to deterioration failed. The investigation identified staff did not use the electronic NEWS tool for patients with certain conditions because they did not think it applied to them. In addition, staff used a paper-based system for patients with certain conditions to help them assess risk more accurately. Investigating staff also identified a lack of process in place for deteriorating patients who did not display typical or expected warning signs. Senior staff reviewed training needs and standard operating procedures and addressed the key areas with an action plan and new multidisciplinary competency refresher training for all clinical staff. As a result of the increase in training and reflective learning facilitated by senior staff, individuals told us they felt their teams were more stable and there had been no subsequent similar incidents. Doctors told us they had established more generalist risk assessment strategies for patients, which would help to identify risks such as sepsis during reviews. Learning from the SI indicated some specialist clinicians had not identified more general medical risks, which the division addressed through training and reflective exercises.

Therapies teams had a low tolerance threshold for falls. This meant whenever a patient in the gym experienced an uncontrolled fall the therapist responsible for them submitted an incident report. The nature of the rehabilitation activities in the gym meant falls were an inherent risk and therapists maintained a comprehensive incident log to track trends and themes in specific activities and amongst patients with similar conditions.

The SCIC team used two-weekly safety reviews to identify and discuss trends in incidents, such as falls, and to propose corrective action. Staff in each area demonstrated knowledge of the trends and themes in incidents. For example, staff in SCIC said they submitted approximately five incident reports each month relating to patient falls. The JRW, SCIC and therapies teams said their most common incident related to patient aggression or threatening behaviour. The teams used a colour card system as part of a warning process to de-escalate inappropriate behaviour. This included a formal written warning followed by presentation of a yellow card as a final warning and a red card to denote staff would discharge the patient from the rehabilitation programme.

Specialist teams were involved in incident investigations and outcomes. For example, the tissue viability team reviewed each incident that involved marks on the skin or any kind of tissue viability issue. The team carried out a rapid review with the deputy divisional director of nursing or other divisional lead and identified opportunities for improved practice with the appropriate ward manager.

The nurse education team led training initiatives in human factors to help identify individual actions that contributed to incidents and how staff could use reflective practice and self-awareness to avoid them. They integrated this with the trust’s vision for care and used the acronym HALT (‘Hungry? Angry? Late? Tired?’) to remind staff of the common contributing factors to mistakes. The lead nurse for education actively promoted the HALT initiative and attended team meetings to discuss it in more depth.

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

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

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services.
(Source: NHS Digital - Safety Thermometer)

Staff collected NHS Safety Thermometer data on a weekly basis to provide a responsive approach to safety performance. The JRW demonstrated a track record of good performance and from October 2017 to October 2018 achieved a harm-free care rate of 88%. This reflected no falls and no hospital-acquired pressure ulcers. The infection control team carried out a post infection review of all patients who experienced a fall in the hospital. This helped ward teams to identify preventable causes.

A divisional team led a slips, trips and falls working group and was developing a study day to promote the implementation and development of a ‘call don’t fall’ scheme. Staff had developed this scheme after learning from incidents that identified patients were at risk of falls because they did not want to interrupt staff who appeared busy by asking for help. The scheme reflected a broader programme of work to reduce avoidable falls, which included the introduction of new falls assessment tools, a specialised study day for staff and new moving and handling care plans.

The teams on JRW and SCIC displayed the latest NHS Safety Thermometer and ward safety data for their areas. This included instances of hospital acquired C. Diff, MRSA and E. coli as well as safe staffing data and a count of clinical incidents. In the SCIC six areas of data collection had not been completed for September 2018, including for hand hygiene, NEWS and pressure ulcers. Overall harm-free care in this month, based on the data collected, was 96%.

Is the service effective?

Evidence-based care and treatment
Trust protocols, policies and treatment guidelines were available on the intranet with hard copies available in each clinical area. Staff told us they found the IT system to be reliable and said there was always a computer available for them to access information.

The Spinal Cord Injury Centre (SCIC) was one of eight similar services in England and adhered to the fixed patient catchment areas established by each centre. The units contributed to a national database of performance to enable them to benchmark with each other and enabled staff in the unit to admit patients in line with established guidelines.

The specialist nature of some services, such as metabolic bone medicine and treatment for E-D, meant there was limited existing benchmarking data available against which to assess care standards and outcomes. For example, clinicians treated patients who presented with a number of rare bone diseases and led studies to establish more information on the natural progression of the diseases to evaluate how therapeutic treatment had worked. Specialist staff engaged with
international networks to establish systems to audit, assess and benchmark care. For example, a clinical lead had established their service with a European reference network for specialist care in embryonic medicine to help ensure the service reflected the latest understanding of treatments.

The speech and language therapy (SaLT) team and tracheostomy team carried out an audit to address the lack of national guidance for managing dysphagia and communication difficulties in patients with a spinal cord injury. The audit team used existing standards for patients in intensive care and identified strategies to adapt these to the SCIC environment. This was a key example of staff at service level continually sought opportunities for improvement and strategies to establish more robust assessment frameworks.

Dedicated SCIC audit teams held meetings bi-monthly to ensure momentum in auditing and identify new opportunities for development. A therapies audit champion used protected time to coordinate audits within the service and present plans and outcomes to senior staff. Staff designed audits in the service to benchmark standards against national best practice guidance, such as to establish standards of shockwave therapy against National Institute of Health and Care Excellence (NICE) guidance.

Therapies staff used evidence-based tools to deliver care and treatment in line with national and international standards, such as the E5-QD measure of health status and the disabilities of the arm, shoulder and hand (DASH) for shoulder therapy. Therapists used the Canadian occupational performance measure (COPM) to assess patients’ ability to perform functional tasks in the context of their hobbies and recreational interests. This helped staff to establish rehabilitation plans that were aimed at enabling patients to achieve personal goals and maintain a routine important to them.

Staff in the Jubilee Rehabilitation Ward (JRW) were carrying out research into the use of the Stanmore nursing assessment of psychological status (SNAP) to benchmark and improve psychological care. This included the development of advanced communication techniques based on trigger points staff identified and documented in care plans.

A clinical reference group for pain was part of a national reference body with NHS England to help define and inform national best practice standards in pain management. This team worked with NICE to ensure guidance was up to date and reflected the latest understanding.

The clinical education team met monthly to review Nursing and Midwifery Council updates and incorporate these into training plans. This ensured training and development programmes reflected the latest national guidance.

The nurse education lead carried out impact assessments on trust policies to ensure they were accessible and met the equality and diversity needs of patients and staff. They had recently restructured documentation to place the impact assessment as the front page of each policy to ensure equality and diversity was more prominently embedded in the hospital’s work.

AHP therapies teams held an annual clinical audit and research forum. This had grown as more staff became involved in research and audit and the senior team implemented a competitive entry process for the first time in 2018. The forum included 22 posters and presentations from AHPs that reflected the diverse range of research and audit in the division.
Therapists tracked audits using an annual planner and from June 2017 to May 2019 47 individual audits relevant to inpatient medicine and rehabilitation were underway or planned. This included audits led by each specialist therapies team and reflected a wide range of projects to improve care, knowledge and standards. Audits were assessed by divisional teams based on priority and each was benchmarked against local, national or international standards to provide a clear rationale for the project. For example, a 2018 audit in SCIC aimed to identify compliance with the trust’s integrated care pathway and standards set by the national wheelchair manager’s forum and the 2015 healthcare standards for NHS-commissioned wheelchair services. The audit found 96% compliance overall, including 100% compliance with the standard that all patients be referred to their local wheelchair service within 14 weeks of admission.

Audits demonstrably improved service standards, staff knowledge and patient outcomes. For example, an audit in November 2017 in the SCIC reviewed the extent to which staff met patient’s postural management using wheelchairs. The audit found broad areas for improvement in meeting individual need. For example, only 57% of patients had a wheelchair of the correct width and only 43% had a wheelchair of the correct length. The audit let to improved clinical training for staff renewed communication with commissioners to source more specialist equipment.

**Nutrition and hydration**

The nutrition and dietetics department introduced a range of initiatives to improve nutrition and hydration standards. These included improved food record documentation and kitchen-based information, new nutritional care and action plans and updated menus to meet individual need. In 2017 the team audited implementation of 11 of the new initiatives against a compliance standard of 100%. The audit found highly variable practice. For example, only 64% of nutrition care plans indicated if patients had a food allergy, intolerance or dislike and staff had correctly calculated a malnutrition risk score for only 51% of patients. However, there were areas of improvement. For example, 80% of patients were offered an alternative menu in line with the care plan, compared with 75% in 2016. The team implemented a structured action plan to improve standards and consistency, including improved training from dieticians. All actions had been completed by November 2018 and the nutrition and dietetics team planned to re-audit in 2019.

The trust standard for nutrition was that all patients should receive a nutritional assessment within 24 hours of admission, which staff consistently achieved. Ward managers monitored compliance with this standard following a 2017 audit that identified a need for improvement. For example, staff completed a nutritional assessment within 24 hours of admission on JRW and SCIC in 80% of cases.

Staff used the malnutrition universal scoring tool (MUST) for each patient, starting at admission, to monitor them for nutritional needs. We reviewed a sample of five patients’ notes in the SCIC and found MUSTs were up to date in three of them. One patient had an out of date MUST that needed updating and staff had not completed an initial MUST for another patient.

Staff carried out audits of nutritional assessment documentation as part of weekly safety checks although they did not complete this consistently. For example, there was no audit data for SCIC in this measure for September 2018.

Staff and volunteers trained to support patients with feeding were available at key times on SCIC.
Each member of staff or volunteer helped patients they could work with safely based on their training competencies. For example, volunteers could not help patients with a risk of aspiration.

The lead dietician was working with surgeons and staff on SCIC to improve hydration amongst patients pre- and post-operatively. For example, patients in the SCIC could often not keep themselves hydrated and staff managed this through the use of a patch and attached straw. To better manage and address patient’s thirst, surgeons and the lead dietician worked together to alter the surgical list so that patients and the SCIC could better manage hydration when they returned to the ward. The team used perioperative quality improvement data as part of the research to measure effectiveness and whether changing list times improved hydration afterwards.

The JRW and SCIC each had a kitchen with facilities for snacks and drinks. The catering team was provided by an external company and provided a lead for each clinical area. We spoke with the catering lead on JRW, who was responsible for preparing and planning mealtimes. They demonstrated excellent knowledge of each patient’s needs, including their personal preferences and individual dietary requirements. Catering staff had direct phone access to the dietician team and referred to them when needed, such as to check whether a patient’s special requests were in line with their dietary plan.

A dietician used the results of an audit in April 2018 to update the trust nutrition policy and reinforce guidance for ward-based teams on food safety. For example, the nutrition steering committee had identified a safety risk from food brought in from home by patients and their relatives. This was not always labelled or dated and presented a risk that patients who were unwell would consume expired food or drinks. The dietician prepared a new communication project to provide ward teams with improved guidance on managing and storing food.

**Pain relief**

Staff assessed, managed and prescribed for pain relief in line with the Royal College of Anaesthetists (2015) Core Standards for Pain Management and 2017 guidance from the British Pain Society.

A team of five pain consultants, four senior nurses, a pharmacist, physiotherapist and dedicated administration team led the pain management service and worked with anaesthetists and rheumatologists to coordinate complex care. The service was part of the North London Pain Network and member services referred patients directly to the specialist service.

Pain management was evidence-based and the specialist team carried out a rolling programme of audits and research and shared learning widely through sector publications, such as the British Journal of Pain.

Pain management was a substantial element of the medical care provision and a team of clinical psychologists managed chronic pain as part of an MDT approach with pain consultants and nurse specialists.

Nurse consultants in the pain team were qualified prescribers and prescribed main management medicines in line with NICE neuropathic pain guidance. Nurses attended a quarterly prescribing group and the pharmacy team audited nurse prescribers annually to ensure the maintenance of standards.
The metabolic team cared for patients living with complex bone disorders, including brittle bone disease, and worked closely with the chronic pain team to coordinate care and treatment.

**Patient outcomes**

From May 2017 to April 2018, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in pain management had a similar to expected risk of readmission for elective admissions
- Patients in endocrinology had a lower than expected risk of readmission for elective admissions
- Patients in rheumatology had a slightly higher than expected risk of readmission for elective admissions

**Elective Admissions – Trust Level**

![Graph showing elective admissions at trust level]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.*

From May 2017 to April 2018, patients at The Royal National Orthopaedic Hospital (Stanmore) had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in pain management had a slightly lower risk of readmission for elective admissions
- Patients in endocrinology had a lower than expected risk of readmission for elective admissions
- Patients in rheumatology had a higher than expected risk of readmission for elective admissions

**Elective Admissions - The Royal National Orthopaedic Hospital (Stanmore)**

![Graph showing elective admissions at specific site]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.*

The trust did not take part in the following audits:

- Sentinel Stroke National Audit programme.
• National Lung Cancer Audit programme
• National Audit of Inpatient Falls.

Staff facilitated regular goal-setting meetings with each patient immediately after admission and then every two weeks. The multidisciplinary team (MDT) worked with patients to guide them with rehabilitation progress and discharge planning. The consultant in charge of the patient’s care, the case manager, occupational therapist, physiotherapist, junior doctor and healthcare assistants joined each goal setting meeting. The team worked with patients and their relatives to set realistic objectives and goals relevant to each individual’s future plans and offered objective feedback on what they hoped to achieve. This was a continual process and the team provided patients with progress updates and discussions as their treatment progressed to help goals remain realistic.

Staff actively sought out research opportunities that had the potential to lead to improved patient experience and outcomes. For example, a consultant in SCIC was involved in a study to identify alternatives to pharmacological treatment for patients with an over-active bladder.

Nurses used intentional rounding to continually monitor patient’s fundamental care needs. We reviewed five sets of patient’s notes in the SCIC and found staff completed this process consistently.

Clinicians established wider clinical care plans to support patients after they had been discharged from inpatient services. For example, metabolic medicine staff cared for patients who had rare diseases that community or GP services had little experience with. To ensure this did not disadvantage patients, staff established communication plans so that patients could speak to a specialist out of hours if they needed medical advice. This included where patients admitted a hospital emergency department for an urgent situation. In each case a specialist from this hospital liaised with the patient’s local care team to coordinate their care and ensure local interventions did not adversely affect their long-term specialist treatment.

Allied health professionals (AHPs) had an eight-year track record of research in the hospital, designed to improve patient outcomes and quality of life. Therapists had access to a structured research development pathway as part of their development and the trust supported several individuals to complete PhDs. The metabolic medicine team was leading an international project in rare bone diseases as part of a strategy to maintain the service as a centre of excellence for patient outcomes.

MDTs were involved in research to establish the readiness of patients to return to work after rehabilitation. This helped staff to identify the effectiveness of care and treatment interventions and to assess their impact. The MSK team identified a need to improve how they measured patient’s ability to return to work after rehabilitation and were part of the research to capture more information about the patient and their treatment journey.

**Competent staff**
From April 2017 to March 2018, 81.3% of staff within medical care at the trust received an appraisal compared to a trust target of 92.0%.

<table>
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<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
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New nurses and healthcare assistants (HCAs) undertook a formal induction followed by a four-week supernumerary period. This included teaching sessions from specialist teams, including the tissue viability and infection control teams. Staff spoke positively about this process although nurses in SCIC said the initial spinal medicine induction was too basic and they would have benefitted from a more intensive induction before taking up their post.

A nurse educator had developed six study days for preceptors and had been invited to join a national preceptorship panel to contribute to national improvement work. A preceptorship facilitator provided dedicated one-to-one support to newly qualified nurses as part of a recent restructure of the programme to align it with the Capital Nurse preceptorship and Nursing and Midwifery Council guidelines.

We looked at the appraisal completion rates for individual medical areas during our inspection. The SCIC team had an up to date completion rate of 92% and JRW had a 100% completion rate. The team on Angus McKinnon ward had a 100% completion rate at the time it was temporarily closed.

Therapies staff had one-to-one supervisions with a senior member of their team every two weeks. This was part of a support strategy in recognition of the emotional impact their work could have and enabled them to review rehabilitation planning and their training needs regularly.

All HCAs undertook the national care certificate as part of their training and the education team had adapted this to the specialised nature of the hospital. For example, care certificate training included the use of specialist moving and handling equipment, the care of patients with shoulder problems and training in physiotherapy gym-based competencies. A dedicated HCA educator had completed significant work to improve the value of the qualification to HCAs and their nursing colleagues. For example, they had completed advocacy work with ward managers to secure more involvement from nurses and had carried out a programme of one-to-one bedside teaching to help HCAs embed their learning. In 2018 131 HCAs started the care certificate and 113 completed it.

A dedicated education and health coaching nurse practitioner based in the SCIC led a nurse and patient education programme and worked with colleagues to deliver a wide-ranging research programme. The practitioner supported the delivery of six-weekly formal education sessions and worked with patients to improve their knowledge of their condition.

| Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T) | 45 | 45 | 100.0% |
| Support to ST&T staff | 21 | 19 | 90.5% |
| Qualified Healthcare Scientists | 16 | 14 | 87.5% |
| Qualified Allied Health Professionals (Qualified AHPs) | 97 | 82 | 84.5% |
| Support to doctors and nursing staff | 77 | 61 | 79.2% |
| Medical & Dental staff - Hospital | 96 | 74 | 77.1% |
| Qualified nursing & health visiting staff (Qualified nurses) | 68 | 52 | 76.5% |
| NHS infrastructure support | 40 | 27 | 67.5% |

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
A nurse-led clinical education team delivered a programme of training and study opportunities to staff across medical services. This included mentor study days and preceptor awareness sessions in addition to clinical specialty days. The team was in the process of adapting and developing practice assessments to ensure on-going compliance with Nursing and Midwifery Council changes. The team supported education groups, which were made up of a range of individual staff and met periodically to identify what they wanted to achieve from study days. Educators had secured funding for a mobile simulation trainer, which enabled them to carry out simulation training with staff on each ward. This helped to improve access to training as it meant staff did not need to leave their usual area of work.

The education team had written and published a clinical pocket reference book on managing deteriorating patients. This resulted from learning from an incident and provided a quick-reference, easy-to-read guide for nurses. This was evidence of the commitment of the team to responding robustly to areas of need in training and education.

Staff had access to highly specialised clinical competency training and professional development. For example, senior staff nurses undertook tracheostomy care training and training to care for patients who experienced vaso-vagal attacks. The trust supported staff to achieve academically and the nurse education team provided dedicated guidance in this. One nurse we spoke with had earned a degree in orthopaedic care, a post graduate qualification in education and a Master’s level degree whilst working in the hospital. This was representative of the approach of clinical teams to development.

HCAs undertook a range of training to help them increase their skills and achieve promotion. A nurse educator was dedicated to leading training and development opportunities for HCAs and had designed a responding appropriately to patients in deterioration (RAPID) training programme specifically for this staff group.

Senior SCIC staff had developed a development pathway specifically for HCAs. This enabled staff to develop progressively to a new senior personal assistant role, followed by an assistant practitioner role and onwards to graduate nursing roles with support from the trust. The new programme included a teaching framework, competency assessments, supervised practice and problem-solving scenarios. Junior or newly-qualified pharmacy staff had the opportunity to progress to a pharmacy technician role.

All staff were required to complete regular refresher training in multidisciplinary competency frameworks as part of improvements from a serious incident. The training included autonomic dysreflexia, respiratory care and multi-professional care strategies.

The trust facilitated access to a three-day Health Education England training programme in motivational interviewing and health coaching. All staff involved in delivering patient care undertook this training, which helped them to record patient discussions, identify their needs more closely and develop individual action plans. Trainers set up training stations on the SCIC, which enabled staff to access short training sessions during their shift to put their new knowledge into practice. Clinical staff carried out training as part of the Stanmore nursing assessment psychological status (SNAP) project. SNAP nurses provided training in advanced communication techniques with patients who were aggressive or challenging in their behaviour. The project included the use of prompt cards to help patients communicate their feelings and to help staff track behavioural
patterns to identify trigger points and how to avoid them. The psychiatric team delivered part of the SNAP training and helped staff to build psychological profiles of their patients to deliver more effective care.

Staff who worked in services that were highly specialised or where few providers offered the specialty attended training nationally to ensure they remained clinically competent and up to date with the latest treatment standards.

Staff in the SCIC had access to three scheduled teaching sessions each week; one each for clinical case presentation, rehabilitation teaching and psychosocial case discussion.

Junior doctors described “excellent” opportunities for teaching and learning and said they had regular protected time for development. Junior doctors developed their clinical and research skills jointly through involvement in projects in wards.

Amongst registered nurses in medical care services, 50% had completed a post-registration qualification in spinal cord injury care. AHPs were experts in their field and the trust actively sought out those with an interest in and the ability to progress into extended roles. For example, specialist physiotherapists had completed additional competency training in pain management and long-term rehabilitation. Therapy technicians had qualified in specialties such as yoga and acupuncture, which they delivered to rehabilitation patients as part of multidisciplinary treatment plans.

Occupational therapists had trained in sleep education and relaxation coaching, which enabled them to use the goal attainment scaling (GAS) technique to help patients improve their quality of life.

MDT teaching was provided weekend during protected time as this alternated between different specialty teams, such as physiotherapy and occupational therapy.

Each member of staff maintained their own professional portfolio with their achievements and progress. This was part of an initiative by the education team to ensure staff were motivated and accountable for their own development and to promote a sense of pride amongst each member of staff.

Senior staff encouraged their teams to attend conferences and undertake secondments to develop their skills and confidence and broaden their career paths. For example, a nurse from the JRW team had taken up a secondment into the metabolic medicine team and another had temporarily joined the spinal cord injury team.

The nurse education team had worked with divisional heads of nursing to implement a rotational programme for nurses. This was an 18-month structured programme that enabled nurses to rotate through the various specialties in their division. In the medicine and therapies division nurses spent time on each of the three main wards and undertook an elective placement in surgical recovery and intensive care. The rotation model was evidence-based and helped to substantially increase nurse confidence and clinical skills whilst providing a challenging and stimulating development opportunity. The education team had prepared resources to support nurses undertaking the programme and the ward managers responsible for them. This included a passport document for each nurse to help them track their progress and to reflect on challenges and successes.
Multidisciplinary working

MDTs delivered the majority of patient care on site, including 45 specialist AHP therapists and therapy technicians, nurses, clinicians and psychologists. Consultants and clinical nurse specialists led a chronic pain management team and were involved in care planning and delivery. Eight specialist therapy teams worked across medical services, including an oncology and sarcoma team, a shoulder and elbow team and a pain management team.

AHP therapists were part of specialty teams, such as spinal therapy and MSK therapy. They delivered care and treatment as part of a broader MDT team and worked together to coordinate complex, long-term rehabilitative care.

MDTs met twice-weekly to review each patient and led weekly psychosocial ward rounds. Ward rounds included a review of each patient’s psychological and social needs in relation to their physical condition and rehabilitation progress. This meant the MDT could track their improvement or recovery alongside mental health needs and ensure care and treatment was individualised to meet both needs.

Although MDT working was clearly embedded in all aspects of care, staffing levels amongst individual teams were variable. For example, the psychology team had been affected by long-term absences and had three consultant vacancies, which was reflected in the divisional risk register. Senior staff described significant challenges in recruiting orthotists and senior occupational therapists. Senior teams prioritised the inpatient rehabilitation programme as a critical area for staffing resource to reduce the risk of interruptions to care and had established a new recruitment drive to engage with newly qualified staff at university. Occupational therapists described on-going challenges in recruitment and the service relied on locum and agency therapists to meet demand.

Following an incident on the SCIC, staff undertook a significantly more intensive and advanced training programme on tetraplegic care. This increased staff confidence in addition to their clinical skills.

Security staff were trained in de-escalation and staff spoke positively of their positive influence in unpredictable situations. For example, staff on the JRW said they had asked security staff to maintain a presence in the unit but to be unobtrusive in case their uniform escalated a situation. They said the team were skilled in discretion and provided 24-hour supervision for patients and support for staff in the most challenging situations.

Senior staff told us they felt developments in MDT working represented the significant improvements services had made in working together to improve services and patient outcomes. This included the establishment of joint working between nurses and therapies teams, such as in moving and handling.

MDTs had worked together to address falls risks through more individualised care planning. For example, therapists had introduced sliding board transfer assessments into care plans to help ward staff follow safer practice when assisting patients to move. Staff completed an osteoporosis assessment for all patients over the age of 65 to help coordinate care between different teams for those at greater risk.

The psychiatric team and other MDT staff carried out a weekly psychosocial ward round of all
inpatients that helped to assess their ongoing psychological needs in addition to their physical needs.

The metabolic medicine team held an MDT meeting after each clinic to review the clinical needs and coordinated care of each patient.

We joined a sample of three MDT meetings during our inspection. In each case a comprehensive range of clinical specialists worked together to review patients and coordinate care, including for patients with highly complex, long-term needs. One meeting included input from three consultants, two junior doctors, an occupational therapist, a physiotherapist, a case manager, a dietician, a psychiatrist, a psychologist, a clinical nurse specialist (CNS), registered nurses and a ward manager. Such teams delivered an excellent standard of patient-centred care that was based on individual needs and long-term clinical understanding of each patient. This was a typical weekly MDT configuration for the SCIC and reflected a focus on individual treatment and outcomes from the key responsibilities of each professional. For example, staff discussed rehabilitation progress, tissue viability, bowel and bladder control and medical and nursing needs.

Six specialist teams in the trust provided in-reach services, including for urology, gastroenterology and cardiology. Intensive care consultants worked with medical consultants to coordinate care for patients who were ventilated.

Research nurses and administrators from the research and innovation centre (RIC) provided support on-demand to clinical staff and specialists across medical areas. A senior clinical research nurse was part of a team of 13 in the RIC and worked with staff to develop effective research frameworks and proposals.

The RIC team had organised a sandpit event to build MDT working strategies and skills. The event involved staff from different specialties, such as medical students, doctors and engineers, and engaged them in problem solving exercises. The exercise demonstrated the value of MDT collaboration and RIC staff participants had applied learning to their usual roles.

All new starters underwent an MDT induction over two days, which helped to acclimatise them to the working environment and ensure they understood the roles of each team.

Three tissue viability nurses led a specialised, dedicated service and helped to reduce the length of stay through managing skin integrity and complex dressings on a daily basis. This team usually led five inpatient beds on Angus McKinnon ward, which was temporarily closed. Instead the team responded to patient needs wherever they were based in the hospital. The team managed complex care for patients who were on bedrest for six weeks or more due to spinal injuries. This could result in deep bone-depth wounds and the team managed specialist scraping and suction techniques to help the recovery process. The team worked collaboratively with a plastics consultant who visited from another NHS trust on a weekly basis through a well-established service level agreement as well as an anti-microbial nurse specialist. This meant a highly specialist MDT team maintained oversight of the care of patients with complex tissue and skin needs.

Research was typically led by MDTs with on-demand support from the research and innovation centre (RIC) team. For example, research was on-going in complex regional pain syndrome, chronic pain and prosthetics and orthotics. RIC staff had clinical knowledge in each specialty and...
provided targeted support for staff involved in research. Hospital teams had established relationships with higher education institutions, which helped to support research teams with expertise and through the provision of students to support projects.

**Seven-day services**
The JRW provided services from Monday to Friday as part of a scheduled inpatient rehabilitation programme.

The SCIC operated 24-hours, seven days a week with seven-day consultant input. Not all specialties provided on-call cover arrangements. However, the service met patient’s immediate medical needs with continual medical doctor cover.

AHPs provided rehabilitation exercises and programmes through the outpatient gym, which was open Monday to Friday from 8.30am to 4.30pm with flexibility for on-call therapists to use the equipment in urgent situations. Therapists had taken part in a consultation that resulted in an updated model of working to provide weekend cover although this was not fully embedded in the SCIC for clinical reasons. Patients and relatives noted the impact of reduced services at a weekend, which was further impacted by the closure of the Angus McKinnon ward.

Therapies services in the SCIC were not routinely available at weekends and AHPs provided urgent reviews if a patient became unwell.

**Health promotion**
Staff were proactive in sourcing and providing health promotion material. For example, the team on JRW displayed information on a wide range of health conditions, including advice on day to day management and lifestyle and wellbeing.

Information from the World Health Organisation regarding current health threats for travellers, such as Ebola and viral haemorrhagic fevers (VHF), was readily available in the hospital and staff displayed this in patient and visitor areas.

The nurse education, SCIC and community integration teams were working collaboratively to introduce health coaching to staff and patients. This was a strategy to improve patient outcomes and care after they were discharged by providing health promotion advice and guidance on condition management.

Staff in the JRW worked with patients to establish weekend activity goals during their rehabilitation programme and reviewed them when they returned on a Monday morning.

**Mental Capacity Act and Deprivation of Liberty training completion**
The trust reported that as at August 2018 Mental Capacity Act (MCA) training was completed by 82.4% of qualified nursing staff in medical care compared to the trust target of 95.0%. The trust also reported that Deprivation of Liberty Safeguards training was completed by 82.4% of qualified nursing staff in medical care, compared to the trust target of 95.0%. A breakdown of training completion for qualified nursing staff can be found below.
Staff screened patients over the age of 65 for mental capacity and dementia and we saw this process was consistent in the 10 sets of medical records we reviewed. Staff used the Montreal cognitive assessment (MOCA) tool to assess each patient’s mental capacity on admission and whenever they showed or reported signs of a change.

Most staff demonstrated appropriate knowledge of the Mental Capacity Act (MCA) (2005) and the Deprivation of Liberty Safeguards (DoLS), although it was rare for patients to be admitted with a DoLS authorisation in place. In some areas staff understanding needed improvement. For example, a senior nurse in the JRW did not have knowledge of mental capacity assessments, mental health support in the hospital or of the capacity support available to patients living with learning disability.

Staff adhered to informed consent processes in all aspects of care and treatment delivery, including where treatment was part of a research project or exploratory treatment. For example, treatments for metabolic bone diseases were complex and specialist staff obtained consent from patients only after detailed educational discussions on the likely outcomes and potential side-effects of treatment.

Staff had access to support in providing care for patients with reduced mental capacity, included best interest assessors and intendent mental capacity advocates (IMCAs).

AHP notes audits in 2017 and 2018 indicated a need for improved documentation of consent. For example, the speech and language therapy notes audit found therapists had documented the type of consent they obtained for treatment in only 38% of cases. The upper limb team found only 29% of patients with mental health or psychological needs had given their consent to be referred to a specialist rehabilitation programme.
Is the service caring?

Compassionate care

The Friends and Family Test response rate for medicine at Royal National Orthopaedic Hospital NHS Trust was 47.0% for the period August 2017 to July 2018.

Friends and family test response rate at Royal National Orthopaedic Hospital NHS Trust, by ward.

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Key

| 100% | 50% | 0% |

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard. Wards with fewer than 100 responses have been omitted from the table above.

(Source: NHS England Friends and Family Test)

Therapies teams were not included in the FFT and staff said they only received feedback from the survey if ward staff passed this on to them.

The Spinal Cord Injury Centre (SCIC) team asked patients about their care as part of a two-weekly survey. The most recent results available were from September 2018 and patients had noted visiting hours and the lack of activities at weekends as areas they would like to see improved. Staff worked to offer flexible visiting times and reviewed these on request. However unscheduled visits could interrupt rehabilitative care, which the team was keen to avoid.

Two relatives of a patient cared for on SCIC spoke highly of the care team. They said they felt the multidisciplinary team motivated and challenged their family member daily to progress with their rehabilitation therapy. They said this was a very positive element of the care and they had noticed a significant improvement in the abilities of the patient.

A team of volunteers worked on wards and provided pastoral care and companionship for patients. The team also prepared items to help make patients more comfortable, such as hair care and nail care kits.

Emotional support

Staff were skilled in providing emotional support for patients with complex social and behavioural needs, including those recently discharged from prison and patients who had been rehabilitated from gang activity. Training included de-escalation strategies and extended support for patients in managing their condition.
As part of the Stanmore nursing assessment psychological status (SNAP) project, staff had completed extended training to help them understand and interpret patient’s emotional needs and moods. For example, staff used pictorial prompt cards to help patients indicate when they were feeling low or anxious and what was causing this.

Physiotherapists and occupational therapists provided emotional support routinely as part of exercise and rehabilitation programmes. Staff worked closely with patients to build their confidence and empower them to challenge local healthcare providers after they had left specialist inpatient care. For example, patients with rare bone diseases were at risk of harm if treatment in an emergency department was inappropriate, which could happen if physicians were not familiar with their specific condition. Specialists helped patients build emotional resilience and communication techniques to engage with doctors and nurses in other environments to help ensure they were understood. This was a substantive support strategy as patients reported high levels of anxiety and worry about communicating with clinicians outside of this hospital after discharge.

Staff in all clinical services recognised that patients with a spinal cord injury often experienced depression, anxiety and depression. They tailored care and treatment to ensure patient’s emotional and psychological needs were taken into account in all aspects of the service. Staff in all professional roles were trained and experienced in delivering care to patients experiencing emotional distress.

Staff actively sought out ways to increase emotional and pastoral care to patients. For example, a pain clinical nurse specialist and the JRW ward manager were leading a multidisciplinary research project into empathy shown by nurses and therapists and how this affected patient recovery. This was based on a previous study led by therapists that showed improved emotional health and states for patients when staff showed more consistent empathetic care and communication.

**Understanding and involvement of patients and those close to them**

The rehabilitation outreach team met prospective patients within five days of referral to discuss their worries and their expectations of rehabilitation outcomes. The team also established the zero-tolerance policy of aggression or violence as well as the whole team’s commitment to care and treatment. The team provided details of the therapeutic and rehabilitation service provided and established goals with each patient ahead of their admission as part of an interactive, collaborative process to ensure the hospital team understood each patient’s needs.

All clinical staff had completed advanced communication training to help them identify patient needs through better communication and interaction skills. The training included listening events, to help engage staff in better listening techniques, and workshops on increasing patient involvement in their care through motivational interviewing. This reflected a substantive improvement in strategies to involve patients in their care and to understand their needs, particularly when they could not communicate clearly or were influenced by long-term debilitating health conditions.

A multidisciplinary team of staff had facilitated a relative’s day in 2017 that also involved the peers of patients living with a spinal injury. The team used the event to involve patients, their relatives and carers in care planning and service development strategies.
Staff discussed treatment, rehabilitation and progress openly and honestly with patients and empowered each individual to explain what they wanted to achieve and work together towards this. Staff talked to each patient about their expected quality of life after treatment and rehabilitation and incorporated this into goal-setting exercises to ensure they understood what patients wanted to achieve.

Relatives and patients in the SCIC noted the impact of short staffing. One patient said they often had to wait to be rolled due to a shortage of nurses and relatives said when staff were clearly stressed they did not want to bother them to ask for help. They also said the reduced service on a weekend resulted in less interaction and opportunities for exercise and rehabilitation.

Staff had prepared an informational DVD for patients as a resource to involve them in rehabilitation and to help them understand the process and treatment pathways they would go through. Staff issued each patient with a timetable for the week ahead. This helped patients to plan their time and encouraged them to take responsibility for their weekly structure. We spoke with a patient who was receiving life-long care from the trust. They described their care as “excellent” and said they found their treatment plan, “Comprehensive and easy to follow. It tells how to manage pain, exercise and flare-ups and what to do if things get worse.”

Where patients lacked mental capacity or cognition to carry out rehabilitation programmes at home, therapies staff worked with their carers and relatives and trained them to lead exercises safely. Staff attended assertive communication training, which helped them to communicate with patients who needed help to understand their prognosis and to develop coping strategies.

Two patient educators were on shift daytimes from Monday to Friday and worked with patients to help them understand their condition and their care and treatment plans.

A patient had discharged themselves from the JRW after staff intervened in their self-administration of medicines prescribed by another service. This had the potential for harm and could have reduced the benefits of their treatment. The senior clinical team were working with the patient to establish mutual expectations to enable them to return to the unit.

Is the service responsive?

Service planning and delivery to meet the needs of the local people
From June 2017 to May 2018 the average length of stay for medical elective patients at the Royal National Orthopaedic Hospital was 14.1 days, which was higher than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 67.3 days, which was higher than the England average of 6.4 days.

From June 2017 to May 2018 the average length of stay for medical elective patients at The Royal National Orthopaedic Hospital (Stanmore) was 14.1 days, which was higher than England average of 6.0 days. For medical non-elective patients, the average length of stay was 67.3 days, which was higher than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in rehabilitation was lower than the England
- Average length of stay for elective patients in pain management was higher than the England average.
- Average length of stay for elective patients in rheumatology was lower than the England average.

Elective Average Length of Stay - The Royal National Orthopaedic Hospital (Stanmore)

Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in rehabilitation was higher than the England average.
- Average length of stay for non-elective patients in spinal injuries was higher than the England average.
- Average length of stay for non-elective patients in rheumatology was higher than the England average.

Non-Elective Average Length of Stay - The Royal National Orthopaedic Hospital (Stanmore)

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

The length of stay data reflected the specialist, long-term and rehabilitative nature of care provided. For example, a typical spinal cord injury rehabilitation programme lasted 12 weeks, with a significant programme of follow up.

The Jubilee Rehabilitation Ward (JRW) provided a range of care services for patients on a day case basis, including for pain management, fossa joint infusions and anaesthetic infusions.
Most patients who attended the JRW for an inpatient rehabilitation programme were accommodated in one of two wards, each with up to 15 patients. Patients frequently presented with social care and psychological needs relating to the long-term impact of chronic pain. As a result, staff worked to manage group dynamics and facilitate a friendly, collegial atmosphere that desensitised patients and ensured the atmosphere was friendly and welcoming.

Specialist teams worked across medical inpatient services and developed their services to meet the changing needs of patients and to reflect changes in practice. For example, a specialist metabolic nurse offered four clinics a week to patients living with rare metabolic bone disorders and to those with complex rheumatology needs.

The upper limb team provided inpatient rehabilitation services, including a one-week peripheral nerve injury programme and a one- or two-week shoulder and elbow unit programme. The team had reviewed national guidance as part of an audit to ensure the service could meet patient’s needs. This resulted in the implementation of nine key standards for the service and improved access to psychological assessment.

Staff used shared care protocols for patients who received treatment on extended metabolic treatments. This meant patients could, in principle, attend their local GP surgery for ongoing blood and liver monitoring during their treatment. Although this meant staff could plan services to improve convenience for patients, they told us GPs often refused or were unable to carry out periodic blood monitoring.

Dedicated reintegration practitioners worked with community liaison colleagues to plan complex discharges and support people with the transition from a long-term admission to leaving the hospital. The team prepared this on a gradual basis to ensure they met individual needs and to prepare the patient’s home and family. For example, they escorted patients into the community as their planned discharge date approached to help identify what additional plans were needed and to help acclimatise the patient to returning home.

Occupational therapists and physiotherapists provided a programme of one-to-one activities for inpatients in SCIC and these were also a core element of the care plan for patients in the JRW.

Multidisciplinary teams had developed the services provided in the JRW to meet demand. This included a pain management service, a short-term spinal surgery rehabilitation programme, patients living with Ehlers-Danlos syndrome and day-case patients receiving infusions for osteoporosis.

A consultant in pain management and anaesthesia and a consultant physiotherapist had recently revamped the long-standing active back programme. This was a specialist programme that focused on reducing patient’s whose daily lives were restricted by fear, or ‘fear avoidance behaviour’. Specialist staff worked with them to identify their five main fears, such as touching their toes, and prepared a treatment plan based on coping strategies.

**Meeting people’s individual needs**

The rehabilitation outreach team met with each patient in advance of joining the inpatient rehabilitation programme and assessed their physical and psychological needs. This was a strategy to establish each patient’s needs in advance and to plan for their treatment.
Chronic pain pharmacists provided phone clinics for patients after discharge to help coordinate their on-going pain management needs and reduce the prescription of opioids at home. A thrombotomist service provided blood tests twice daily and the pharmacy team provided on-demand reviews and services as patient’s care and treatment plans developed. Staff had introduced sexual support education groups for patients in response to feedback. A nurse specialist facilitated small same-sex groups of patients to discuss their concerns and challenges in sexual function and performance as well as intimacy and relationships. Staff were in the process of developing printed information for patients to refer to and in the meantime provided signposting to appropriate online and specialist resources.

A hydro-therapy pool and a specially-designed gym were located on site and therapists used both to introduce patients to their exercise and rehabilitation plans. The team worked with patients to identify similar facilities near to their home and used this information as part of discharge planning. Therapists used specialist equipment to help patients become more conditioned to steps and independent movement to help them use public transport once they left the hospital. Case managers worked with patients to plan their discharge in advance and to ensure they could access on-going care and therapy in their local area. The outreach team worked with clinical and therapies staff to plan care for patients in advance of discharge to ensure their needs in terms of pressure ulcer prevention, falls prevention and bowel care could be met.

Staff trained patients to check their own skin integrity and to carry out a self-rectal exam as part of discharge planning to ensure patients could carry out basic self-assessments once they had left the hospital.

Multidisciplinary teams discussed discharge planning for patients cared for in the SCIC, including the establishment of home rehabilitation plans for patients. This was a collaborative process with patients and their relatives and included a detailed package of care and care plan and a review of adaptations needed to the patient’s place of discharge, such as their home. Staff worked with patients and their relatives to identify adaptations such as to access and showers.

Day rooms were available in JRW and SCIC and included resources to help patients socialise or to spend time by themselves. For example, day rooms included tea and coffee making facilities, televisions, computers with internet access, books and games.

Staff booked interpreters in advance for patients who needed language support during care and rehabilitation. Although printed information was not readily available in languages other than English, staff anticipated times that patients would need an interpreter, such as when discussing rehabilitation plans for after they were discharged.

Patients in the pain management programme received reviews from consultants, one-to-one sessions with a psychologist and a rehabilitation programme led by occupational therapists and physiotherapists.

The doctor or clinical nurse specialist responsible for discharge prepared a detailed management plan with the wider multidisciplinary team and sent a copy to the patient’s GP. Therapies teams and psychologists worked with medical teams to ensure discharge summaries included details of ongoing rehabilitation plans. This included their contact details and an invitation to contact them for further discussion if this would help.
Therapies staff recognised the importance of addressing patient’s social needs in addition to their physical needs and facilitated the gym and common areas to enable patients to meet and interact with each other.

Facilities were available on site for patients and relatives, such as washing machines for those staying extended periods of time.

Two clinical nurse specialists in antibiotic therapy worked with patients through a ‘virtual ward’ system. This enabled the nurses to train patients before discharge to manage their own intravenous medicines and antibiotics. The team visited patients at home after discharge to ensure the training met individual needs and provide on-going support. The virtual ward system enabled nurses to manage and monitor up to 25 patients once they had left the hospital and deliver care remotely.

The tissue viability team provided training to district nurses to help them prepare to manage patients with complex wounds and dressings on discharge. This meant patients received more consistent care and prevented discharge delays caused by a lack of expertise in patients’ local area.

The nurse education team had led a Health Education England project to improve care and treatment for patients with a spinal cord injury. The programme improving the standard of nursing assessments and meant more staff could hold difficult conversations with patients and their families. The team involved the wider healthcare community in this, such as GPs and district nurses, which helped to ensure continuation of care for patients after discharge.

**Access and flow**
From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was better than as the England average for seven months and worse for the remaining five months. Trust performance dropped to 0% in March 2018.

(Source: NHS England)

No specialities were above the England average for admitted RTT (percentage within 18 weeks). One specialty was below the England average for admitted RTT (percentage within 18 weeks).
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<tr>
<th>Specialty grouping</th>
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<tr>
<td>Rheumatology</td>
<td>82.8%</td>
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*Source: NHS England*

From July 2017 to June 2018, 94.9% of individuals did not move wards during their admission, and 5.1% moved once or more.

*Source: Routine Provider Information Request (RPIR) – Ward moves tab*

From August 2017 to July 2018, there were six patient moving wards at night within medicine.

*Source: Routine Provider Information Request (RPIR) – Moves at night tab*

Senior ward and divisional staff held a daily bed capacity meeting to review patients waiting for admission, available beds and pressures on the service. Staff used this system to identify potential discharges and plan admissions with clinical pathway leads. This was a multidisciplinary process and involved ward managers, divisional heads of nursing, the infection control team, a social work manager, the JRW step-down manager, the bed manager and the duty service manager.

Patients were referred to the SCIC from trauma centres and the centre received approximately 300 referrals per year and accepted up to 100 with an average wait time of 52 days. Where the service could not accept a referred patient as an inpatient, staff worked with them to arrange more appropriate alternatives such as outpatient care, outreach support and community-based care. Once accepted to an inpatient care pathway, patients remained under the care of a specialist registrar for life, with regular consultant-led reviews and therapist-led rehabilitation after they were discharged from the hospital.

The division had transferred activity from Angus McKinnon ward, which was temporarily closed, to six medical beds in the SCIC. This enabled the service to continue with medical nurses and meant patients received the same standard of care.

Consultants operated patient lists based on the availability of specialist nurses and support services and to meet patient needs and demands. For example, the metabolic team saw patients from across the UK and scheduled lists in advance to accommodate patients travelling considerable distances as well as for those patients who lived locally.

The trust had a contract with a nearby hotel to provide accommodation for patients being cared for on a long-term pain management programme. A psychologist and medical consultant ensured the hotel was a safe environment for each patient and that they were medically stable before approving the location. Patients typically spent three weeks in the hotel as part of an intensive rehabilitation programme to improve their quality of life through exercise goals. Therapists had converted a conference room into a gym, which provided additional capacity for daily targeted exercises. This enabled the pain management team to increase capacity by providing on-site clinical accommodation in the JRW for patients who needed more frequent observations and providing periodic reviews of patients accommodated in the hotel.

Staff used six beds in the SCIC for patients who had completed a rehabilitation programme and
returned for additional ‘top-up’ therapy. The beds were open Monday to Friday and patients had access to care from the whole rehabilitation team during their return stay.

Specialist clinical teams worked in mobile, consultant-led teams and were not based in specific wards or departments. Allied health professional therapists followed this model, which meant patients received care from specialist teams wherever they were accommodated in medical care services.

**Learning from complaints and concerns**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. There were data quality issues with the data that has meant we are unable to report on the number of complaints received by core service.

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

After our inspection we asked the trust to provide details of complaints received from November 2017 to November 2018 that related to the SCIC and JRW. The trust said four complaints or concerns had been raised relating to the JRW. Three instances related to communication with staff and one related to a rejected referral, which the patient appealed. Instances the trust attributed to SCIC did not directly involve clinical care or the ward team and three out of five related to communication issues with the switchboard or divisional teams. One concern was raised by a patient’s GP in relation to a prescription. All the concerns or complaints had been resolved although it was not evident the trust tracked these for themes at divisional or service level.

We reviewed the trust’s response to four complaints received from July 2017 to March 2018. In each case the trust provided an apology and a thorough explanation of the issues raised, along with the outcomes of investigations carried out by divisional staff. Communication between staff and patients was a consistent theme in the complaints and learning included a requirement for a more positive attitude when dealing with frustrated patients by phone, clearer instructions from on-call doctors and more detailed explanations from therapists when delivering rehabilitation.

The SCIC team discussed complaints and concerns with patients who attended the monthly forum discussions group. In October 2018 patients had discussed elements of the environment they felt were outdated, the quality of food and the availability of showers as key areas of concern. For example, the unit accommodated 30 patients and had six showers shared between them.

Doctors held a monthly problem-solving meeting based on a specific patient issue or complaint that involved an issue other than a clinical problem. The team reviewed the incident and identified learning for them to help improve the service. For example, doctors reviewed issues about delays in treatment or receiving test results and complaints more generally about systems and processes.

A patient advice and liaison service (PALS) team was based on site and offered patients and relatives the opportunity to raise concerns without making a formal complaint.

For the period August 2017 to July 2017 there were 17 compliments within medicine.

The trust has stated that they are currently reviewing how compliments are captured and that they believe the number of compliments that has been reported is only a small proportion of the actual
number of compliments received.

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

The JRW team displayed a wall of thank you cards and letters from patients, which reflected the holistic support the multidisciplinary team provided.

**Is the service well-led?**

**Leadership**

The Jubilee Rehabilitation Ward (JRW), Angus McKinnon ward and the Spinal Cord Injury Centre (SCIC) were part of the medicine and therapies division. The clinical director for medicine, director of therapies, divisional head of nursing and general manager led the division overall and a team of 14 service and clinical managers and research leads were responsible for individual services and specialties.

The director of therapies, clinical director for medicine, divisional head of nursing and divisional general manager formed a leadership team for medical care. Clinical leads, therapies leads and nurse leads were in post for each medical specialty within the division. Some roles covered multiple services, such as a clinical lead for metabolic bone medicine, medical rehabilitation and psychology. The director of therapies was responsible overall for the rehabilitation therapies teams. A deputy director of allied health professional (AHP) research and development held a joint post as consultant physiotherapist in the shoulder and elbow service and led research strategy and development.

A research and innovation centre (RIC) director led the dedicated research service, which provided clinical staff across the hospital with support in organising research projects and obtaining ethical clearance. Specialists in the RIC team led sub-teams, such as the studies recruitment lead. Heads of service or department maintained oversight of research activities in each speciality.

Two clinical specialist managers for therapies provided five-day cover each week to rehabilitation services.

Ward managers led care on the JRW and the SCIC and were supported by senior sisters and charge nurses. Although staff spoke positively of local leadership, there were gaps in knowledge and capacity in some areas. For example, one ward manager was unaware of any item on the risk register for their service and could not identify any themes in complaints, incidents or compliments.

**Vision and strategy**

The trust had an overarching vision and strategy and all of the staff we spoke with demonstrated a good understanding of this. Staff said they felt part of the trust’s future plans and felt they had been consulted in development. One member of staff said, “Everyone has a common focus on trust values, this is the first hospital I’ve worked in where this seems to be genuine.” Another individual said, “We take [our values] seriously here. I think we promote it with passion and we look for excellence and equality in everything we do.”

Research-based care was part of the trust’s vision and strategy and was working to involve more staff and patients in this. The RIC team was working to increase the visibility of research across the
hospital and wore ‘ask me about research’ badges as part of a drive to normalise discussions during routine tasks and interaction. The division had recently created its own leadership team as part of a restructure to maintain its future vision and strategy and to support each clinical service in the development of their research plans.

The neurology and musculoskeletal (MSK) teams had produced a joint strategy paper that set out strategic objectives across medical care services.

Divisional teams met annually to identify their priorities for the next three to five years as part of a continual business planning cycle that always included a review of staffing and equipment.

Therapies services maintained a strategy specific to their services, including a focus on research, development and education. This had resulted in the successful implementation of a progressive research profile and culture supportive of this amongst staff. AHPs had a vision of establishing a nationwide orthopaedic alliance conference to showcase their research and generate greater national collaboration. Multidisciplinary colleagues had established relationships with therapists to help build cross-specialty research projects, including in metabolic medicine and discharge planning.

The RIC had a vision to be a self-funding research department by March 2019. This would reduce the reliance on external funding and enable the team to work with colleagues to develop research projects closely aligned with patient care and needs. The RIC had a strategy to increase nurse-led research and to involve nurses more readily in existing research.

Therapies services planned to move to a new building in December 2018. This would increase capacity and enabled staff to deliver care in a purpose-built environment with the benefits of more space and newer technology, including adapted facilities for patients living with dementia. Senior staff embedded trust values in supervisions, appraisals and training and in interviews with prospective new members of staff. Some teams had established their own philosophy or values specific to their area of work.

In the 12 months leading to our inspection the JRW had an average bed occupancy rate of 62%. The ward manager was working with senior divisional staff and commissioners through strategic management processes to increase occupancy to a target of 80%.

Culture

At our last inspection in May 2014, we told the trust it must focus on culture and behaviours of staff to address instances of bullying, areas of unsupportive leadership and negative working environments. During this inspection all the staff we spoke with said they had experienced a significant improvement in the working atmosphere and environment. For example, staff said new opportunities for communication meant they worked more closely with colleagues and developed relationships with colleagues in other teams and specialties. Divisional teams had introduced a quadrumvirate leadership model to address gaps in leadership. For example, staff said before the new structure, senior staff relied on individual relationships to communicate and deliver the service. The new approach meant leadership was structured and had resulted in a substantial change in practice.

A member of the team from each profession chaired each multidisciplinary meeting as part of a
rotational system that meant staff had the opportunity to develop skills in this area. This offered staff the opportunity to develop specific facilitation and mediation skills and empowered each individual to be able to challenge colleagues in a safe and structured environment.

Ward managers and service leads held monthly team meetings to review staffing, incidents, complaints, medicine management and training needs.

Staff were knowledgeable about initiatives in the trust and said communication from senior teams was consistent and that that local managers and team leaders included this in team meetings.

All the staff we spoke with were positive about the culture of learning and development in the trust and said they felt their clinical and professional skills significantly improved as a result.

All the staff we spoke with understood the principles of the duty of candour, including their responsibilities following an incident or complaint.

Although most staff spoke positively about the working culture, some nurses we spoke with in the SCIC said they experienced significant impact from persistent short-staffing. They felt the high level of specialisation needed and an inflexible approach to shifts contributed to staff turnover, which they felt the trust senior team had not addressed. Senior staff said they recognised orthopaedics was not usually an attractive specialty for new nurses and they were working with universities to increase visibility and understanding and to establish frameworks to ensure new recruits were well looked after.

Divisional AHPs had worked to change the working culture for research to enable staff to develop more momentum with projects without compromising patient care. This led to the introduction of monthly protected time for research activity.

**Governance**

Divisional teams held a monthly meeting that included heads of nursing, general managers, service managers and administration leads.

Divisional governance leads maintained oversight of clinical governance and quality through a series of committees and working groups within a defined structure. This was a new role and the lead attended monthly clinical quality and governance committees and monthly learning and development meetings. The division had introduced the new role as part of a drive to improve the dissemination of learning from a general trust level to departmental and ward level.

Divisional heads of nursing attended monthly governance and quality and operational meetings. Services managers and therapies managers attended divisional meetings in additional to service-specific groups, which helped to embed learning and development processes between teams.

Each department or ward or had a monthly quality meeting, which included a review of incidents and complaints.

Senior staff had identified an opportunity for more useful, structured action plans from serious incidents and governance committees were exploring this as a key element of development.
Associate research and development directors led research governance processes with clinical leads and other researchers.

Clinical staff described challenges in accepting patients from areas of the UK whose local government or commissioners refused to approve care on financial grounds. Senior staff included such discussions in governance meetings and planning and worked with services outside of England to try and facilitate treatment. The hospital had a special relationship with the Maltese health service and treated patients from Malta within that remit, using existing governance structures to ensure care pathways ran smoothly.

Staff involved in clinical research adhered to the best practice standards of the National Institute for Health Research (NIHR) Good Clinical Practice (GCP) standards, which helped maintain ethical standards. The trust required staff to have completed GCP training before they were able to be involved with research. Where staff were involved in clinical trials organised by other organisations, the RIC team and ethics committee provided ethical oversight to ensure staff acted legally and within the governance requirements of the trust. For example, where radiology trials involved the use of treatment, the RIC team liaised with the radiation protection advisor to ensure this was safe and proportionate.

Clinical services held monthly meetings and alternated these between business and governance quality meetings.

Clinicians held monthly morbidity and mortality (M&M) meetings at specialty or departmental level and escalated these to monthly trust-wide M&Ms. Clinical staff in the SCIC held a morbidity and mortality meetings every two months.

An RIC governance lead ensured research activities were compliant with trust standards and ethics requirements.

Each department or specialty was responsible for their own governance. For example, the peripheral nerve injury team had appointed a dedicated clinical governance lead. At a more senior level, heads of nursing and therapies represented their specialties at divisional governance meetings.

The director of therapies attended the trust board. The research lead for therapies had also attended board on behalf of the research and innovation centre leadership team and had liaised with the trust’s charitable group to secure funding for a senior full-time research therapist.

We reviewed the minutes of 34 governance meetings that took place from November 2017 to September 2018 including SCIC audit meetings, divisional operation meetings, quality and complex case meetings, clinical strategy meetings and the inter-regional prosthetic audit group meetings. The minutes reflected well-developed and embedded governance processes that included a broad range of staff in each specialty and service. Meetings included on-going monitoring of divisional and trust strategic aims, such as patient care and quality and staff experience. Operational meetings included routine reviews of mandatory training, impact of practice on clinical effectiveness and incidents and complaints. Divisional teams used governance meetings to identify opportunities for policy development and to review pathways and processes, such as a proposed new cross-centre transfer policy for prosthetic treatment.
Management of risk, issues and performance

Divisional staff used risk registers to identify, track and mitigate risks to their services. Senior staff identified nurse staffing as the most significant risk. The estate and facilities for prosthetics and orthotics was a significant risk and senior staff said this would be addressed fully when the new building opened. Therapies teams had identified the emergency alarm system in the hydrotherapy pool as a risk as it only sounded in the gym. However, the therapies team schedules meant the hydrotherapy pool would only ever be in use when the gym was staffed, which meant staff were always in place to respond to an alarm.

A significant risk related to aggression and violence from patients, which resulted from the long-term effects of persistent and chronic pain.

The divisional leadership team temporarily closed Angus McKinnon ward after nurse vacancies reached 50% of the establishment as a risk management strategy. Despite challenges in recruiting to all elements of the specialist multidisciplinary roles for the inpatient rehabilitation programme, there had been no interruptions to admissions in the previous two years.

Divisional teams held monthly performance review meetings with each team, which maintained an oversight of workforce and quality and safety issues.

Senior pharmacy and divisional staff were working to address a significant risk to the future supply of medicines due to pressures on the supply chain and a potential interruption to supply.

There was limited oversight of fire safety and emergency planning in medical inpatient areas and the trust’s fire safety adviser did not have the authority to implement substantive safety improvements. There was a need for improvement in local safety practices, such as more consistent use of a system in the JRW to indicate when patients were on or off the unit. Although nurses told us they routinely used this system, this was not the case during our inspection. We asked the fire safety adviser about this who said it was an example of a broad range of improvements needed to make fire safety a greater priority on the site.

Staff did not have access to fire training that was specific to the types of mobility problems most often experienced by their patients. This meant staff developed evacuation plans based on their individual understanding.

There were no designated fire wardens in the SCIC or JRW and the fire safety adviser told us there had been no interest from staff in a recent recruitment drive to establish these roles. Although the adviser had provided fire safety checklists for ward managers the trust did not require these to be completed. During a site visit the fire service noted they could not reach the external fire exit of the SCIC or the fire hydrant due to uncontrolled parking that significantly hindered access. Although senior staff had discussed this in health and safety committee meetings, there was no evidence they had acted to address this risk.

A clinical lead described the limited clinical nurse specialist input into rheumatology as a key risk to that service. They said there was a reticence in the trust to acknowledge the importance of senior nurse input in the specialty, which meant other staff were at risk because they were required to handle highly toxic medicines without advanced training.
The RIC team held a bi-monthly audit meeting and each specialty and department alternated presentations and leadership. No formal clinical activities were scheduled for the meeting to encourage more staff to attend and the RIC team worked to secure a representative from each department.

Therapies and specialist teams held monthly clinical strategy meetings, which led to improvements in safety and care practices. For example, a patient had suffered a cardiac arrest and died in the prosthetics department. Senior staff identified a need for faster access to resuscitation trollies and better staff knowledge in their responsibilities following a patient death.

The trust was part of Health Education England’s Capital Nurse programme, which aimed to stabilise and improve nurse staffing in London. The hospital was the first site to receive a Quality Mark for their work in improving and maintaining nurse staffing. This reflected a range of strategies to improve recruitment and retention, including a new return to nursing programme strategy, university alliances and specialist education for international nurses.

A medical gas committee provided risk management and oversight across medical services and the nurse education lead led training and study days in medical gas safety. They had trained nurses as designated officers as defined by the Department of Health guidance in Health Technical Memorandum 02/01.

**Information management**

Although staff said the electronic patient records system worked well for daily clinical observations, they said it was often difficult to find key information. For example, there was no overarching or standardised system in place to ensure communication from other services was logged into a record. This meant clinical staff planned treatment without always having access to the latest patient information if this was provided by professionals outside of the trust. Doctors said different interpretations of the electronic filing systems and different departmental standards across clinical services contributed to this, which wasted time and had an impact on patient safety.

Clinical staff identified further risks in electronic information management and said patients often ‘dropped off’ the system if they were discharged and then scheduled for pharmacy intervention at a later date. This meant doctors could not always trace their most recent medical notes.

The nurse education team provided material on the trust intranet for staff to access information on training opportunities, external placements and continuing professional development. The team maintained a separate intranet sub-site specifically for staff at bands two to four, which focused on support, engagement and development.

**Engagement**

Senior nurses and consultants had developed strategies to support their teams and maintain strong team-working dynamics, which could be affected by challenging relationships with patients who displayed aggression. This included increasing the depth of the pre-screening process for patients to ensure they understood the nature of the service and ensure staff planned for individualised support.
At our last inspection in May 2014 we told the trust they should improve staff awareness of the employee assistance programme (EAP). The trust had addressed this and at this inspection information on the programme, including posters and wallet cards, were readily available. Staff said they knew how to access the support provided. Senior staff demonstrated promotion of the EAP was one part of a broad improvement in engagement strategies, which included more substantive action from staff survey results.

Staff had used a recent survey to indicate they often felt pressured to work when they were unwell. To address this senior staff increased support opportunities for sickness and ensured all staff had the opportunity to obtain support anonymously from a professional not connected with the trust. Therapies staff had reported verbal abuse from patients as one of the most stressful elements of their job and managers found afterwards staff had become accustomed to it instead of reporting each incident.

Senior AHPs had led a listening event to find out why some therapists were reluctant to engage with research. This led to four key improvements including more investment in research skills, development more proactive identification of funding, such as health innovation grants. Senior AHPs shared learning with nursing and medical colleagues to help them encourage their teams to be more research active. Therapists held a key role in this and worked with nursing colleagues to ensure they understood the difference between audits, evaluation and research.

The SCIC team organised a monthly patient forum, one each for females and males, to encourage a rolling programme of feedback and reflexive practice. The group shared learning and achievements and staff the group as a positive opportunity for patients to discuss challenges with each other and with staff. This was one aspect of a demonstrable drive in the hospital to empower patients in making decisions about their own care and rehabilitation. Therapies teams led monthly forums to sustain a consistent approach to engagement and invited speakers from other trust teams and services to present their work and improve cross-team working.

Medical services produced a monthly newsletter for staff, which included feedback from patients and their relatives as well as wider trust news and projects. The nurse education team published a newsletter twice annually and planned to integrate this with the divisional newsletter to improve readership and dissemination.

An education and health coaching nurse practitioner carried out a staff survey in 2017 to gather feedback on learning and developing opportunities and on challenges to their daily work. They found staff felt positively about the times of training sessions and the mix of face-to-face and online learning. They identified a need for more support for staff in delivering information to relatives and in providing information to patients on sexual function and activity. Staff also felt they would benefit from more training in understanding changes in cognition. The practitioner implemented broad changes and improvements to training opportunities with colleagues and presented the results at two international conferences and in a peer-reviewed journal paper.

The metabolic clinical nurse specialist had organised a patient and relative workshop to help foster supportive communication between current and past patients who received biologic medicine treatment. However, the trust had suspended this due to a need to move staff into the workshop space and the clinical nurse specialist planned to resume this initiative as soon as they could.
The trust provided multiple options for staff support, including psychological and emotional support and complementary and massage therapy. A psychiatrist had established a dedicated talking group for staff to give them the opportunity to talk about challenging situations and the impact of providing long-term complex care. Ward managers and specialist service staff arranged debriefs for staff involved in challenging or upsetting situations and staff had access to a wellbeing service provided by an external employee assistance programme. For example, a nurse educator had introduced ‘hot debriefs’. These were rapidly arranged debriefs straight after a challenging situation and was mandatory for all staff involved. This helped to resolve issues and problems immediately. All the staff we spoke with said they knew about the options open to them and felt provision for emotional support had improved since our last inspection.

Clinicians involved in research described limited opportunities for sharing their learning and outcomes with colleagues in other specialties and described this as a key area for improvement in the future. They said although some initiatives were in progress to address this, it was challenging to schedule time for all researchers to attend meetings together.

A professor of nursing had taken up a new post in the hospital and was working to embed research into the daily work of each team. This was a strategy to engage more staff in research for their professional development and to develop more advanced understanding of the conditions they treated. This model had worked successfully with the therapies teams and senior teams plans to map it to match the nursing role. The RIC tea had established a secondment programme for nurses interested in research to develop their skills and build experience. To date one staff nurse had successfully joined the programme and worked with RIC one day per week.

A project evaluation panel in the RIC encouraged staff from any clinical service to submit research proposals and audit and evaluation plans based on their professional interests and the needs of their service.

The trust held a large-scale listening exercise annually that all staff spoke positively about. They recognised this as an opportunity to present their research ideas to the trust board, as well as present how they had developed their service in the previous year. The RIC team wanted to improve patient engagement in research and was working with NIHR to identify patients’ experience of research to help identify opportunities for improvement. For example, the team wanted to know if patients previously involved in research felt they had received enough information and if they felt the information had been appropriate. The RIC engaged with other NHS trusts to fulfil research plans, such as with a trust that employed research doctors and who collaborated on a hip infection study.

Therapies teams operated a ‘staff member of the month’ scheme that involved patients nominating individuals who had exceeded their expectations in care. Once staff achieved five nominations they received a silver badge of recognition. Staff said they felt senior colleagues furthered this by visiting departments regularly and presenting employee of the month awards and leadership awards. The trust had awarded a clinical team of the year award 2017 to the team in the JRW. Staff we spoke with said they felt engagement from the director of workforce and the senior team positive and demonstrated genuine support and interest in their work.

The infection control lead nurse had been closely involved in the new building design and planning
to ensure it would meet Department of Health compliance standards. They ensured procurement of soft furnishings was appropriate for patient’s safety and worked with designers to ensure negative and positive pressure rooms would be fit for purpose.

A member of the education team was a qualified mediator and worked with staff experiencing problems to resolve conflicts of interest and performance issues.

The nurse education team led a pre-registration student nurse forum. This was a strategy to engage with student nurses and maintain their interest for future employment once they qualified.

**Learning, continuous improvement and innovation**

Senior divisional staff were leading a safer staffing stream as part of a trust improvement project to ensure future sustainability, particularly of senior house officers (SHOs). The team had secured business case funding to recruit a resident medical officer (RMO) to cover on-call SHO shifts, which would ensure continuity of service.

To address significant challenges in the recruitment of specialist spinal nurses, senior staff had established new development and promotion pathways. This enabled them to develop a more specialist team internally from existing junior staff and to recruit to less specialist, junior posts externally. For example, new posts included senior band three HCAs, senior band four rehabilitation assistants and band five pharmacy technicians.

Therapies managers had developed secondments and fixed term opportunities to improve retention amongst their teams, which was at risk due to the stability of the senior team and lack of promotional opportunities.

Staff in the SCIC had developed a new staffing structure to address persistent short staffing amongst staff nurse grades and to bring the service in line with the national service specification for specialist rehabilitation. This was a substantive project that involved the conversion of five staff nurse posts into seven HCA posts, one pharmacy technician and a reintegration practitioner to oversee discharge processes. Staff involved in development had established a comprehensive training and development framework for the new roles and had tailored this to the future growth needs of the service as part of a wide-ranging sustainability and development plan. We spoke with three HCAs about the opportunities available to them and each said this was a key factor for their remaining in the trust. Staff said they felt well-supported in the process and noted the training was challenging but that had resources and time with senior staff to help them.

Senior therapies staff had developed extensive opportunities for development to help retain their teams. This included research and audit opportunities. The division had supported a physiotherapist who had successfully completed a Master’s degree to continue their studies with a doctorate. The education and health coaching nurse practitioner was part of a multi-centre study to develop a smartphone application (‘app’) that would provide staff with on-going educational guidance in the care management of patients with a spinal injury. The app included reminders for clinical observations and provided live access to the latest clinical guidance relating to the conditions staff were treating.

Staff were research active. For example, the education and health coaching nurse practitioner published regular blogs with a professional nursing publication. Staff across the hospital had a
substantial publication portfolio in peer-reviewed journals and track record of research presentation at international conferences. The trust hosted the annual National Nursing Orthopaedic Conference and encouraged staff to present their work.

The RIC governance team monitored international research projects and developments as a strategy to opportunistically participate in new studies and to maintain research plans in line with the latest knowledge and data available.

Staff in all specialties continually sought out opportunities to develop the research profile of their service and worked to establish external relationships to support this. For example, therapies staff secured monthly visits from a higher education academic to work with them on research projects, which had recently resulted in new hip care rehabilitation precautions for patients who had undergone surgery.

The nurse education team was planning ahead for changes in the team, including a planned retirement and the need to work between the existing site and the new building. This included the development of existing staff to cover more senior roles.

The AHP team had significantly improved research outputs from no publications to over 30 publications and a ten-fold increase in return on research investment in the space of five years. The team had implemented the National Institute for Health Research (NIHR) clinical academic pathway, which improved governance and structure. The research teams were exploring more integrated use of technology in their services, including remote clinics via digital video software.

**Surgery**

**Facts and data about this service**

The trust operates across two sites; Stanmore (inpatient and outpatient services) and Bolsover Street (outpatient services). The trust has nine surgical wards with 91 beds dedicated to surgical patients. All beds for this service are on the Stanmore site.

The trust has many specialty services as listed below:

- The foot and ankle reconstruction unit specialises in the management of a wide range of foot and ankle problems including sports injuries, arthritis and deformity. A multi-disciplinary team (MDT) approach to care provision is taken.
- The trust is a leading UK tertiary centre for the treatment of complex peripheral nerve injuries. Services include highly complex brachial plexus nerve repair and nerve transplantations in both infants and adults. The unit also deals with nerve tumours in the upper and lower limbs.
- The upper limb unit covers all aspects of shoulder and elbow surgery, including routine and complex primary arthroplasty, revision arthroplasty, prosthetic joint infections, instability, and rotator cuff dysfunction.
- The surgery unit at the trust is a referral hub for primary and revision elbow replacements, and
also has a large primary and revision shoulder replacement practice. The arthroplasty practice includes the management of prosthetic joint infections and has well-established pathways for the treatment of infected shoulder and elbow replacements.

- The spinal surgical unit at the trust includes one of the largest spinal deformity services in Europe. Referrals to this service come from throughout the UK and internationally. Specialist spinal surgeons treat a wide variety of patients from simple to very complex problems.

- Joint reconstruction unit provides a range of services, including cartilage transplantation, hip reconstruction (primary hip replacement, revision hip surgery, hip reconstruction, joint revision, osteotomy, knee reconstruction).

- The Sarcoma Service is one of five designated centres in the country which specialises in the care and treatment of patients with bone and soft tissue cancers. Treatment includes bespoke endo-prostheses, bone transportation and bone grafting and the trust is a leading authority in limb salvage.

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

The trust had 13,138 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 237 (1.8%), 7,751 (59.0%) were day case, and the remaining 5,150 (39.2%) were elective.

(Source: Hospital Episode Statistics)

We visited all surgical areas including all inpatient wards, main theatres (which included three separate recovery areas totalling 14 beds, of which five were dedicated to paediatrics), and pre-operative assessment clinics.

We spoke with 25 patients including relatives. We observed care and treatment and looked at a sample of 20 patient records. We also spoke with 54 staff including allied healthcare professionals (AHPs), nurses, health care assistants (HCAs), doctors in training, consultant anaesthetists and surgeons, ward and theatres managers, senior and lead nurses, members of the senior management team and divisional managers. We reviewed and used information provided by the organisation in making our decisions about the service.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Key aspects of mandatory training such as infection control were undertaken as part of the induction process for new starters. Ongoing mandatory training was undertaken as e-learning modules and further classroom based sessions.

The trust set a target of 95% for completion of mandatory training.
Trust level
A breakdown of compliance for mandatory training courses from as at August 2018 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>As of August 2018</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target (%)</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Blood Awareness</td>
<td>130</td>
<td>143</td>
<td>90.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Level 3</td>
<td>108</td>
<td>141</td>
<td>76.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>108</td>
<td>143</td>
<td>75.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control – Level 2</td>
<td>92</td>
<td>143</td>
<td>64.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mentor Update</td>
<td>73</td>
<td>143</td>
<td>51.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Immediate Life Support</td>
<td>11</td>
<td>23</td>
<td>47.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for none of the six mandatory training modules for which qualified nursing staff were eligible.

Following the inspection we requested updated mandatory training figures and found the trust target was met for only adult basic life support – 1Y (100%). The department was below mandatory training targets for conflict resolution, equality, diversity and human rights, fire safety, health and safety, infection control, information governance and moving and handling.

A breakdown of compliance for mandatory training courses from as at August 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>As of August 2018</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target (%)</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Blood Awareness</td>
<td>45</td>
<td>66</td>
<td>68.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>43</td>
<td>69</td>
<td>62.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>31</td>
<td>54</td>
<td>57.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control – Level 2</td>
<td>39</td>
<td>70</td>
<td>55.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Level 3</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Immediate Life Support</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for none of the six mandatory training modules for which medical staff were eligible.

We requested further information regarding mandatory training figures for medical staff in surgery. Compliance in the majority of modules was poor. The department did not meet the trust target for adult life support, conflict resolution, equality, diversity and human rights, fire safety, health and safety, infection control and information governance.

Safeguarding
Staff had access to the trusts safeguarding policy and knew how to access the safeguarding team.
for advice and guidance when required. Staff told us the team were supportive in giving advice and guidance where required.

Safeguarding information, including contact numbers and the trust lead were kept on wards and staff were aware of how to access this.

Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and children and were able to define triggers that would prompt them to obtain a safeguarding assessment for patients.

The trust set a target of 95% for completion of safeguarding training.

Trust level
A breakdown of compliance for safeguarding training courses as at August 2018 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>As of August 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>3</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>122</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>118</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>0</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for one of the four safeguarding training modules for which qualified nursing staff were eligible.

We requested training numbers following our inspection. The information provided by the trust showed for nursing staff showed the department only met the 95% trust target for safeguarding children level 1. Performance across all other safeguarding training was poor. Safeguarding adults level two was 88.5% and level three was 34%. For safeguarding children level two compliance was 89% and level three was 91%.

A breakdown of compliance for safeguarding training courses as at August 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>As of August 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>49</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>46</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for one of the three safeguarding training modules for which
medical staff were eligible.

Following the inspection we requested updated safeguarding compliance numbers. Data showed that medical staffing did not meet the trust target of 95% for any safeguarding trainings. Safeguarding adults level one (87.5%) and level two (59%) were below the target. For safeguarding children the department did not meet it for level one (87.5%), level two (64.6%) or level three (81%).

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

Cleanliness, infection control and hygiene

The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of the spillage of body fluids.

All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

Throughout our visit we found all areas of the surgery department to be maintained to a high standard of cleanliness. Areas were clean, tidy and free from dust.

We reviewed patient areas across the wards as well as dirty utility areas and treatment rooms. All areas were visibly clean. Patients and relatives were satisfied with the level of cleanliness on the wards and theatre.

We saw the use of green ‘I am clean’ stickers in the utility rooms which were used to identify which equipment had been cleaned by staff and were ready to be reused. We saw stickers were marked with the date the item was cleaned and observed staff replacing stickers.

There was easy access to personal protective equipment (PPE) such as aprons and gloves in all areas we inspected and saw all staff used PPE as required. There was also sufficient access to handwashing and drying facilities. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice.

During the inspection we saw staff did not always adhere to good infection prevention and control practice. We saw some staff were not ‘bare below the elbow’. We also saw numerous occasions where staff were not adhering to infection control precautions, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients.

In theatres, we found some keyboards were not easy clean and there was dust on the computer shelves. There was also an access panel behind the scrub area which did not meet infection control cleaning standards as it was not a smooth surface.

Where patients had a known or suspected infection, they were nursed in single rooms. There were signs displaying presence of infection, which meant staff, and visitors were aware of the precautions to take prior to entering the patient area. We observed staff adhering to these protocols and doors remained closed. However, not all wards had side rooms which could pose a risk if patients needed barrier nursing.
We requested hand hygiene data for surgical services and were provided with quarterly figures. The majority of wards and areas had 100% compliance for hand hygiene between April and September 2018. In October 2018, compliance in recovery was 55% and compliance on the Duke of Gloucester ward was 87%.

Operating theatre staff followed an aseptic technique to prevent contamination, with the use of sterile instruments following this technique. We also observed the correct flow of clean to dirty instruments through the surgical process.

The Sterile Services Unit (TSSU), was a centralised service, which demonstrated the dirty to clean pathway. There were specific areas designated to the cleaning and decontamination of equipment, so as not to cross contaminate clean instruments. TSSU had recently gained accreditation.

Environment and equipment
The operating theatre comprised of ten laminar flow theatres, with anaesthetic rooms that required separate clean preparation and dirty areas.

Wards were accessed by staff using swipe card and visitors pressed a buzzer to alert reception staff. Wards ranged in size and layout and were mostly set out in a manner that ensured people were safe.

There were two recovery areas in theatres with a total of 10 beds for patients. Staff were aware that the building was outdated and not fit for purpose. A number of the wards were moving to a new build in November 2018. However, the wards were well maintained and staff were able to deliver good care.

The department provided information regarding performance in the Patient Led Assessment of the Care Environment Audit (PLACE). All wards looked at were rated as very confident except Margaret Harte ward and the Coleman unit which were rated as confident. The audit identified that the use of the day room for storage on the Coleman unit brought the score down.

Medical equipment in operating theatres and surgical wards had stickers indicating when servicing had taken place and when the next service was due. All of the equipment we checked were in date.

There was equipment available for bariatric patients.

We saw there was a high number of joint replacement systems in place and many representatives (reps-sales support staff) in theatres. There was a system in place for booking reps into theatres. Senior leaders told us that there was no formal consent process with regards to reps in theatres. Staff discussed with patients that there might be student or visitors present during surgery prior to it taking place.

We reviewed equipment checks on the wards and in theatres. Surgical equipment including resuscitation and anaesthetic equipment was available, was fit for purpose and checked in line with professional guidance. Surgeons reported adequate supply of equipment when needed.
On the majority of wards, daily checks were carried out on the resuscitation trolleys, and new safety seal tag numbers were being recorded. Equipment within the trolleys were sterile wrapped where appropriate and within expiry dates.

On Jackson Burrows ward we found the resuscitation trolley checks were not completed correctly. There were large gaps missing off the checklist where it had not been completed. We also found equipment was in front of the resuscitation trolley which could prevent staff from accessing it in the event of an emergency. We raised this concern with staff and when we returned to the ward the equipment had been moved.

On Jackson Burrows we also found two wall mounted suction machines that staff had difficulties accessing. This was due to a lack of space making it difficult to release them. We asked some staff members to show us how to release the suction and they were unable to demonstrate how to do this. This could pose a risk if staff needed to access the machines in the event of an emergency. We also found some unsecured freestanding oxygen cylinders on Jackson Burrows ward. This was raised to staff and when we returned they were secured in stands.

In theatres we found theatre doors were not fitted with smoke seals and corridors were being used for the storage of flammable material. The storage area was cluttered and filled with boxes. In the event of a fire this could pose a significant risk for safe evacuation of patients and staff. However, the storage area was not part of the fire evacuation route. Staff also told us that the electric doors for theatre one and two were prone to failure and manual operation was an issue as the doors were heavy.

On Margaret Harte ward we found staff were using one of the bathrooms to store commodes. This decreased the number of bathrooms available for patients on the ward. In theatres, we found a number of lead aprons in poor condition which could put staff at risk. We also saw they were not stored correctly. Some were on the floor, screwed up and over equipment. We raised this concern with staff and the aprons were removed. Following the inspection, the trust updated us regarding the issue with lead aprons. Management were already aware of the state of the aprons and a purchase had been made in October 2018 and was awaiting delivery.

Assessing and responding to patient risk
A number of risk assessments were completed on patient admission, including moving and handling, falls, venous thromboembolism (VTE) and skin condition using the Waterlow assessment tool. Staff monitored patients with a high Waterlow score with pressure relieving equipment and regular movement.

The surgical service used the national early warning system (NEWS) for monitoring the condition of patients and identifying if their condition deteriorated. Staff had completed observations and recorded NEWS scores in all records we reviewed. We reviewed numerous patient records and found NEWS scores were completed most of the time. However, this was not always completed four hourly as staff said it was based on risk.

We requested audit data for NEWS scoring. Audit data for the following wards was provided: The Coleman Unit; Jackson Burrows, Ward 4, Duke of Gloucester and Margaret Harte. In May 2018 and June 2018 performance across all wards was 100%. In July 2018 performance varied between 64%
and 100% and improved in August 2018 to between 93% and 100%. In September 2018, compliance varied between 76% and 100% and in October 2018 compliance varied between 93% and 100%.

Pre-operative assessments included a comprehensive review of patients’ previous and current health problems and needs. Physical assessments had been carried out in line with guidance on pre-operative assessment for both day case and inpatients.

Nursing staff reported the critical care outreach team were responsive when their advice or interventions were required. There was also a medical emergency team (MET) for deteriorating patients who were not unconscious.

Staff followed a sepsis pathway for the management of patients whose condition met the criteria. There was information displayed on some surgical wards about sepsis. Staff showed us ‘sepsis boxes’ containing equipment for staff to use to recognise, diagnose and manage sepsis.

Theatre staff used the ‘five steps to safer surgery’ World Health Organisation (WHO) checklist; this is a nationally recognised system of checks before, during and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. We observed the WHO checklist was completed appropriately during a surgical procedure. Audit data between October 2017 and September 2018, showed compliance for the WHO checklist being fully completed varied between 92% and 98%.

Staff understood the procedure and protocols in cases of life-threatening haemorrhage. There was access to blood in blood fridges.

**Nurse staffing**

The trust reported their staffing numbers below for the period April 2017 and March 2018 and also for the period April 2018 to July 2018, for qualified nursing staff in surgery.

<table>
<thead>
<tr>
<th>Department</th>
<th>April 2017 - March 2018</th>
<th>April 2018 - July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned staff - WTE</td>
<td>Actual staff – WTE</td>
</tr>
<tr>
<td>392 Acute Pain Services (248) L5</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>392 Anaesthetic Support Staff-OPD (292) L5</td>
<td>1.0</td>
<td>0.0</td>
</tr>
<tr>
<td>392 Duke of Gloucester (321) L5</td>
<td>24.0</td>
<td>16.9</td>
</tr>
<tr>
<td>392 Foot &amp; Ankle (428) L5</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>392 Margaret Harte Ward (335) L5</td>
<td>15.8</td>
<td>13.5</td>
</tr>
<tr>
<td>392 Peripheral Nerve Unit (420) L5</td>
<td>0.0</td>
<td>0.8</td>
</tr>
<tr>
<td>392 Plaster Theatre (205) L5</td>
<td>7.8</td>
<td>5.5</td>
</tr>
</tbody>
</table>
From April 2018 to July 2018, the trust had 56.4 (WTE) fewer qualified nursing staff in post than they had planned for.

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

From August 2017 to July 2018, the trust reported a vacancy rate of 24.3% for qualified nursing staff in surgery. This was greater than the trust target of 9.5% for vacancy.

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

From August 2017 to July 2018, the trust reported a turnover rate of 14.2% for qualified nursing staff in surgery. This did not meet the trust target of 12.0% for turnover.

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

From August 2017 to July 2018, the trust reported a sickness rate of 3.3% for qualified nursing staff in surgery. This did not meet the trust target of 3.0% for sickness.

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

From August 2017 to July 2018, the trust reported 85,115 hours filled by bank staff (18.1%) and 26,674 hours filled by agency staff (5.7%) in surgery at the trust. There were 9,078 hours (1.9%) not filled by bank or agency staff.

A breakdown of bank and agency usage by staff type is shown below:

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistants</th>
<th>Qualified nurses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank hours</td>
<td>23,553 (22.4%)</td>
<td>61,562 (16.9%)</td>
<td>85,115 (18.1%)</td>
</tr>
<tr>
<td>Agency hours</td>
<td>0 (0.0%)</td>
<td>26,674 (7.3%)</td>
<td>26,674 (5.7%)</td>
</tr>
<tr>
<td>Not filled hours</td>
<td>2,619 (2.5%)</td>
<td>6,458 (1.8%)</td>
<td>9,078 (1.9%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

During the inspection, we saw five beds on Ward 4 had been closed due to staffing levels. This decision had been taken in order to make sure the ward was still safe for patients.

Nursing vacancies was highlighted on the service’s risk registers and senior leaders were taking steps to improve recruitment and retention. The department had recently recruited a number of
‘scrub’ nurses to work in theatres.

A lead nurse led the surgical services within the hospital and a theatre manager led the theatres. We observed on our visits to the wards expected and actual staffing levels were displayed for day and night shifts. Staffing levels were mostly noted to match the requirements on the day of our visits on most wards. However, on one ward two nurses working were not trained to give intravenous fluid (IV). We saw this was appropriately escalated to managers.

In order to ensure safe staffing levels, there was a reliance on contracted staff undertaking extra hours as ‘bank staff’ in their own time. The service also used agency staff to fill shifts and senior staff informed us they used regular agency staff who were familiar with the wards.

Nursing staff conducted handovers twice daily in the morning and in the evening. We observed handovers and found them to be structured, detailed and with a focus on personalised care. It included details about each patient condition, specific tests or investigations needed and their progress. Nursing staff received an overview of all patients at the start of their shifts and then a thorough bedside handover once they were allocated a patient.

Medical staffing

The trust reported their staffing numbers below for the period April 2017 and March 2018 and also for the period April 2018 to July 2018, for medical and dental staff in surgery.

<table>
<thead>
<tr>
<th>Department</th>
<th>April 2017 - March 2018</th>
<th>April 2018 - July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned staff - WTE</td>
<td>Actual staff – WTE</td>
</tr>
<tr>
<td>392 Anaesthetics (255) L5</td>
<td>44.0</td>
<td>38.2</td>
</tr>
<tr>
<td>392 Foot &amp; Ankle (428) L5</td>
<td>6.5</td>
<td>6.5</td>
</tr>
<tr>
<td>392 Medical Liaison Team (358) L5</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>392 Peripheral Nerve Unit (420) L5</td>
<td>9.0</td>
<td>7.0</td>
</tr>
<tr>
<td>392 Shoulder Unit (239) L5</td>
<td>11.7</td>
<td>7.6</td>
</tr>
<tr>
<td>392 Spinal Surgery (222) L5</td>
<td>29.2</td>
<td>24.8</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>100.6</strong></td>
<td><strong>84.5</strong></td>
</tr>
</tbody>
</table>

From April 2018 to July 2018, the trust had 17.4 (WTE) fewer medical and dental staff in post than they had planned for.

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

From August 2017 to July 2018, the trust reported a vacancy rate of 11.3% for medical and dental staff in surgery. This was greater than the trust target of 9.5% for vacancy.

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

From August 2017 to July 2018, the trust reported a turnover rate of 2.3% for medical and dental...
staff in surgery. This was lower than the trust target of 12.0% for turnover.

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

From August 2017 to July 2018, the trust reported a sickness rate of 0.5% for medical and dental staff in surgery. This was lower than the trust target of 3.0% for sickness.

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

From August 2017 to July 2018, the trust reported 1,840 hours filled by bank staff (4.1%) and 4,384 hours filled by medical locums (9.9%) in surgery at the trust. There were no hours that were unfilled. The trust was unable to provide data that could be split by staff grade.

<table>
<thead>
<tr>
<th>Staff level</th>
<th>Bank hours</th>
<th>Locum hours</th>
<th>Not filled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,840 (4.1%)</td>
<td>4,384 (9.9%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

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

A clinical lead consultant led surgical staff.

There were consultants on duty during daytime hours and on call overnight. We observed medical ward rounds were appropriate, with a full review of each patient’s history, medicines and treatment.

Ward rounds took place daily, and there was evidence of multidisciplinary meetings to plan patients ongoing care and treatment.

We were told locum staff were used to cover posts as needed.

As at June 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average, and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at Royal National Orthopaedic Hospital NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>57%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>2%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>41%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>0%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Records
We reviewed 20 medical records and found there were good standards of record keeping. Records were kept in non-secure cabinets on surgical wards but behind nursing stations which protected patient confidentiality. Patient records were legible and signed and dated by the staff reviewing the patient.

The records reflected the patient diagnosis and management plan, patient observations and NEWS score and input from multidisciplinary team. In addition, relevant risk assessments including falls assessments, VTE risk assessment, bed rails risk assessment and assessment of pressure areas were completed. Records captured patients’ mental health needs where required.

Patient discharge summary and GP discharge letters were completed with details of the referral, diagnosis, investigations and medication.

Medicines
The provider carried out a range of medicines related audits to assess how they were performing, and to identify areas for improvement. These included audits of controlled drugs, medicines reconciliation, and safe and secure handling of medicines.

Staff told us that the pharmacy team were a valuable resource in identifying issues with medicines and encouraging improvement. In all of the areas we inspected there was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety.

The trust made effective use of their team of pharmacist independent prescribers who, for example, were used in the pre-assessment of patients prior to surgery and in facilitating the discharge process.
Arrangements for the supply of medicines were good. There were effective arrangements in place for medicines supplies and advice out of hours.

Medicines stocked in the wards were managed safely.

Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated and staff we spoke with knew how to report incidents involving medicines.

Controlled drugs were managed appropriately, with stock balances in all locations checked daily.

We saw that medicines for oral or topical use were stored separately. We also saw that tamper evident seals were in use for emergency medicines to ensure they were readily available when needed and fit for use. Regular checks of emergency medicines and equipment were carried out by staff.

Records showed that staff had completed daily fridge checks to ensure medication was stored at the appropriate temperature.

We found the majority of prescriptions charts were completed to a good quality including recording patients' allergies. However, on Philip Newman ward we found one prescription chart that was poorly completed. There was no admission date recorded and the writing was not legible. On Ian Monroe ward we found one chart where the prescribers signature was not printed underneath.

Incidents

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

From September 2017 to August 2018, the trust reported no incidents classified as never events for surgery. There had been a serious incident of wrong site surgery but due to the nature of this incident it was not classed as a never event.

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from September 2017 to August 2018.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with three (30% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with three (30% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (10% of total incidents).
- Pending review (a category must be selected before incident is closed) with one (10% of total incidents).
- Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria with one (10% of total incidents).
- All other categories with one (10% of total incidents).
Ward staff and theatre staff told us they were encouraged to report incidents and the incident reporting culture was still good within the hospital. Staff were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations.

Staff told us they received feedback following incidents via email and during ward rounds in the mornings. However, information about learning from incidents was not fed back in other ways. For example, staff did not receive newsletters and there was no learning shared on noticeboards in the department.

Mortality and morbidity (M&M) meetings occurred on a monthly basis and we saw cases were appropriately discussed.

The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour and, senior staff were very clear about their responsibilities in relation to DoC.

**Safety thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported 34 new pressure ulcers, six falls with harm and 21 new catheter urinary tract infections from August 2017 to August 2018 for surgery. We did not see any action plan around pressure ulcers during the inspection.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Royal National Orthopaedic Hospital NHS Trust:

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

We found some wards displayed safety thermometer information but this was not consistent across all surgical wards.

Is the service effective?

Evidence-based care and treatment
The surgical department followed the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) review of the perioperative care of surgical patient recommendations. Staff followed National Institute for Health and Care Excellence (NICE) for preoperative tests and surgical site infection and investigated all patients scheduled for elective surgery in the pre-assessment area. Staff supported patients to be as fit as possible for surgery and provided advice on eating the right food, moving their joints, stopping smoking and reducing alcohol intake.

Staff followed NICE guidelines, for example, sepsis screening and venous thromboembolism prevention.

Trust policies and procedures were available on the trust’s intranet and staff reported and showed us how they could access them easily. However, these were available on the trust intranet and agency staff could not access them.
Patients who were assessed to be at risk of venous thromboembolism (VTE) had been prescribed and administered with VTE prophylaxis in accordance with NICE guidance. Nursing and medical staff assessed the needs of patients on admission and throughout their hospitalisation. Treatment and care was planned and delivered in line with evidence-based guidance, standards and best practice.

We observed appropriate sepsis management from reviewing patient notes and staff administered antibiotics in line with guidelines.

The trust took part in the mandatory national surveillance programme for surgical site infection (SSI) for total hip replacements, total knee replacements and spinal surgeries. In addition to the mandatory surgical categories, other surgeries were also audited and managed by the ‘SSI Prevention Group’ which reported to the Infection Control Committee and Clinical Quality Committee for governance.

**Nutrition and hydration**

Patients could choose their meals in advance from daily menus. Patients told us the food was ok. We saw patients had access to hot and cold drinks throughout the day. There were a range of meals available to meet cultural needs and special diets such as diabetic.

Staff used the Malnutrition Universal Screening Tool (MUST) to identify patients at risk of poor nutrition and fluid intake. Records showed MUST scores and fluid balance charts were completed and monitored. Staff referred patients to a dietitian if required.

We saw staff and visitors on surgical wards respected protected mealtimes. During these times staff stopped all non-urgent duties on the wards and assisted patients who needed help with their meals.

Patients still had their nutritional state assessed on admission to the hospital. Patients with identified risks were referred to the dietitian for further assessment and dietary advice. Those patients identified as requiring support with eating and drinking were identified by a knife and fork symbol on the ‘patient ward board’ and the hostess was notified to serve meals on a red tray.

We saw nutritional advice was displayed on the Duchess of Gloucester ward to promote healing post-operatively.

**Pain relief**

Staff considered what post-operative pain relief would be required within the pre-operative assessment. We saw pain scores were recorded in patient notes. Staff collected their patients from recovery, ensured their pain was in control and a pain control care plan was in place and pain scores monitored.

The department used a range of pain scoring tools including scales (where patients rated their pain on a scale of 1-10), the use of faces and pictorial pain guides and the use of the Abbey pain scale for a non-verbal pain assessment score.

Most patients told us staff had controlled their pain well and responded quickly to requests for pain relief. Patient controlled analgesia was available and reviewed by the pharmacist. There was a pain team available within the hospital Monday to Friday.
Patient outcomes
Trust level:

From May 2017 to April 2018, patients at the trust had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions – Trust Level:

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

- Trauma and orthopaedics patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Spinal Surgery Service patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

- Trauma and orthopaedics patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- Spinal Surgery Service patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

The Royal National Orthopaedic Hospital (Stanmore):
From May 2017 to April 2018, patients at The Royal National Orthopaedic Hospital (Stanmore) had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions - The Royal National Orthopaedic Hospital (Stanmore):**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ratio of Observed to Expected Emergency Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>100</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>120</td>
</tr>
<tr>
<td>Spinal Surgery Service</td>
<td>80</td>
</tr>
<tr>
<td>Urology</td>
<td>60</td>
</tr>
</tbody>
</table>

**Note:** Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

- Trauma and orthopaedics patients at The Royal National Orthopaedic Hospital (Stanmore) had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Spinal Surgery Service patients at The Royal National Orthopaedic Hospital (Stanmore) had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at The Royal National Orthopaedic Hospital (Stanmore) had a lower than expected risk of readmission for elective admissions when compared to the England average.

**Non-Elective Admissions - The Royal National Orthopaedic Hospital (Stanmore):**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ratio of Observed to Expected Emergency Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
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<td>Trauma and orthopaedics</td>
<td>120</td>
</tr>
<tr>
<td>Spinal Surgery Service</td>
<td>80</td>
</tr>
</tbody>
</table>

**Note:** Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

- Trauma and orthopaedics patients at The Royal National Orthopaedic Hospital (Stanmore) had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- Spinal Surgery Service patients at The Royal National Orthopaedic Hospital (Stanmore) had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Royal National Orthopaedic Hospital (Bolsover Street):**
In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 the performance for hip replacements was about the same as the England average.

For knee replacements performance was worse than the England average. When focusing on the EQ-5D score and Oxford score for knee replacements, the trust performed much worse than other trusts nationally.

Senior leaders highlighted the nature of work undertaken at the hospital is highly specialist. Therefore, standard datasets such as PROMS fail to recognize the positive impact of work and data is often not reflective of patient outcomes.

The department produced an outcome annual review paper in order to demonstrate patient outcomes within the hospital. Information from this paper can be seen below.

Standard mortality indicators such as Summary Hospital Mortality Indicator (SHMI) do not reflect the case mix complexity of patients treated at the hospital. As a result, the hospital used the Copeland Risk Adjusted Barometer (CRAB) to measure mortality. Expected mortality is 1.0 and any value less that 1.0 is lower than expected. Mortality at the hospital ranged from 0.0 to 0.3 which was consistently lower than expected within the trust.

For re-admission, data provided by the trust showed that between September 2015 and August
2018 readmissions were consistently below the UK average readmission rate. The UK average was between 16.0 and 18.5 and surgical services were consistently below 9.0.

Hospital acquired infections for surgical patients were within expected levels between September 2015 and August 2018. Episodes of acute kidney injury for the same dates were lower than the national average.

The trust had taken part in the Getting It Right the First Time (GIRFT) review of critical care. The data looks at the number of patients admitted to critical care with organ failure. This was a proxy measure of the effectiveness of pre-operative optimization, peri-operative medicine and post-operative care. The trust was a positive outlier in relation to this metric which demonstrated early identification of the deteriorating patient was in place on wards.

National joint registry data standardised revision ratio (SRR) showed revision rates for hip replacement were better than other providers nationally. This was a significant outcome due to the more challenging surgical procedures undertaken at the hospital. Procedures for knee replacement was within the expected range nationally.

The trust had introduced an ‘On the Mend’ booklet for patients to advise them on what to do following operations and improve outcomes. On Ward 4, 62% of patients reported receiving this booklet and were satisfied with the advice it gave around nutrition, daily activities, medicine and exercise.

**Competent staff**
From April 2018 to July 2018, 86% of staff within surgery at the trust received an appraisal compared to a trust target of 92%. When looking at the last financial year, from April 2017 to March 2018, 91.7% of staff in surgery at the trust received an appraisal. This was just below the trust target of 92%.

A breakdown of appraisal rates by staff group for the period April 2018 to July 2018 can be found below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals Required</th>
<th>Completed appraisals</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>113</td>
<td>100</td>
<td>88%</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>35</td>
<td>33</td>
<td>94%</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>25</td>
<td>25</td>
<td>100%</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>136</td>
<td>112</td>
<td>82%</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>65</td>
<td>55</td>
<td>85%</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>12</td>
<td>7</td>
<td>58%</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>386</td>
<td>332</td>
<td>86%</td>
<td>92%</td>
<td>No</td>
</tr>
</tbody>
</table>
There were a range of courses that staff could attend advertised in the staff room. This included catheterisation, IV medicines, nutrition and medicines management study days.

There were systems in place to ensure staff were competent to carry out their role. New nurses went through an induction period to ensure they were familiar with their role. They were allocated a mentor and were required to complete a new competency pack. Staff we spoke to expressed confidence in their ability to carry out tasks they are allocated and confirmed they had received sufficient training to carry out their role.

New agency staff were inducted into the department and shown around to familiarise themselves with it.

Medical staff felt supported by their clinical and educational supervisors. The department had clinical educators in place who supported staff to access training. Medical staff had access to a range of training including simulation training and a journal club.

**Multidisciplinary working**
Staff reported good working relationships with other teams. Our review of patient records showed there was input from other specialist teams including physiotherapists, pharmacists and dietitians.

The surgical wards had daily ward multidisciplinary ‘board rounds’ involving nursing, therapy (occupational therapy and physiotherapy) and doctors to discuss individual patients’ treatment and discharge plans. We saw good input from all staff during these discussions.

In theatres, there were multidisciplinary sessions following surgery to discuss and scrutinise cases. This gave teams the opportunity to learn and improve.

There were weekly microbiology ward rounds in surgery to monitor antibiotic prescribing and discuss the agenda for reducing use of antibiotics.

Two cardiologists visited the surgical wards on Tuesdays and Fridays to assess and support patients.

Where patients required on-going care such as the interventions of a community nurse, referrals were made prior to discharge.

**Seven-day services**
We saw evidence there were still ward rounds during the day by a variety of consultants, registrars and junior doctors. There was a consultant presence during operating hours six days a week, and they provided an on-call presence out of hours and on Sundays.

Critical care outreach services were available to support staff managing deteriorating patients 24 hours day, seven days a week.

Radiology was available Monday to Friday, with on-call support for out of hours requests. The hospital delivered a full inpatient service for surgical services over seven days with timely access to diagnostics such as computerised tomography (CT) and ultrasound scans.
Physiotherapy and occupational therapy were available six days a week, with on-call support for out of hours if required. This was also similar for pharmacy.

**Health promotion**
Staff provided patients with relevant information to prepare them for their surgery. This included instructions regarding fasting, medication and wellness.

Staff assisted with patient rehabilitation by helping patients get out of bed and attain independence following their surgery. Staff referred patients to physiotherapy for rehabilitation as required. Ward staff confirmed that there was a physiotherapist attached to each ward to facilitate patient rehabilitation.

Information provided to patients included encouraging cessation of smoking, maintaining a healthy weight and regular exercise. Information leaflets highlighted long term benefits to patients if they adopted a healthy lifestyle.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Medical staff**
The trust reported that as at August 2018 Mental Capacity Act (MCA) training was completed by 56.9% of medical and dental staff in surgical care compared to the trust target of 95.0%. The trust also reported that Deprivation of Liberty Safeguards training was completed by 56.9% of medical and dental staff in surgery, compared to the trust target of 95.0%. A breakdown of training completion for medical and dental staff can be found below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Eligible</th>
<th>Trained</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent WRAP</td>
<td>79</td>
<td>60</td>
<td>75.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Deprivation of Liberty</td>
<td>72</td>
<td>41</td>
<td>56.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>72</td>
<td>41</td>
<td>56.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Nursing staff**
The trust reported that as at August 2018 Mental Capacity Act (MCA) training was completed by 81.8% of qualified nursing staff in surgical care compared to the trust target of 95.0%. The trust also reported that Deprivation of Liberty Safeguards training was completed by 81.8% of medical and dental staff in surgery, compared to the trust target of 95.0%. A breakdown of training completion for qualified nursing staff can be found below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Eligible</th>
<th>Trained</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent WRAP</td>
<td>143</td>
<td>119</td>
<td>83.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>143</td>
<td>117</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Deprivation of Liberty</td>
<td>143</td>
<td>117</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff had access to mental health/deprivation of liberty safeguards guidelines on the trust intranet.
Staff were able to talk about the deprivation of liberty safeguards (DoLS) and how this would impact a patient on the unit. Staff were aware of their responsibilities under the Mental Capacity Act.

The clinicians we spoke with were all aware of the concept of shared decision-making with patients. The sample of patient records we reviewed demonstrated consent for treatment and surgery was completed. Patients told us staff explained treatment and care and sought their consent before proceeding.

Is the service caring?

Compassionate care

The Friends and Family Test response rate for surgery at Royal National Orthopaedic Hospital NHS Trust was 48.0% for the period August 2017 to July 2018.

Friends and family test response rate at Royal National Orthopaedic Hospital NHS Trust, by ward:

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Coleman Unit</td>
<td>753</td>
<td>39%</td>
<td>97%</td>
</tr>
<tr>
<td>Duke of Gloucester</td>
<td>696</td>
<td>65%</td>
<td>97%</td>
</tr>
<tr>
<td>Jackson Burrows Ward</td>
<td>692</td>
<td>36%</td>
<td>90%</td>
</tr>
<tr>
<td>Ward 4</td>
<td>599</td>
<td>62%</td>
<td>99%</td>
</tr>
<tr>
<td>Margaret Harte Ward</td>
<td>359</td>
<td>64%</td>
<td>89%</td>
</tr>
</tbody>
</table>

| Key                      | 100%       | 50%       | 0%       |

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard. Wards with fewer than 100 responses have been omitted from the table above.

(Source: NHS England Friends and Family Test)

All the patients we spoke with were positive about the care and treatment they received in the department from the staff. Patients said things like: “They have been fantastic”, “The care here is outstanding”, “They are respectful, they listen and I would recommend this hospital”.

We observed staff chatting with patients and asking them questions about their interests. Patients told us staff made them feel comfortable.

We observed staff maintaining patients’ privacy and dignity at all times by keeping them covered and drawing curtains during examinations and procedures.

All staff treated patients in a compassionate and courteous manner.

We observed staff interacting appropriately with patients. Staff took extra time to explain
care and treatment options and answered any questions the patients had.

We observed many thank you cards and letters expressing gratitude and compliments from previous patients about the care they received.

**Emotional support**

There was a multi-faith chaplaincy service available in the hospital which provided services for patients and their families.

Staff supported patients on the unit and relatives informed us they were able to speak to staff about their concerns. A review of patient care records demonstrated patients had their physical and psychological needs regularly assessed. Staff understood the impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Regular checks on patient wellbeing were taken in the form of comfort rounds. Families and carers were encouraged to visit and support their relative.

There were a range of clinical nurse specialists available to support patients including nurses with specialist qualifications and skills in cancer to support patients undergoing cancer treatment.

**Understanding and involvement of patients and those close to them**

We observed doctors and nurses offering patients and relatives the opportunity to ask questions and to clarify anything they were unsure of.

Patients and relatives told us staff would always explain things in a language they could understand.

Patients told us they were always kept informed of the treatment plans and staff explained any test they were due to have.

We observed staff communicating with patients’ families regarding discharge and ensuring patients were safe when they would be discharged home. However, we saw one example where a doctor had remotely changed the patient’s medication without discussion.

In the operating theatres, we observed a patient being prepared for a surgical procedure. Their surgery was described to them, along with what the process would be and the consultant checked whether the patient understood. This was carried out in a very clear way and was easy for the patient to understand.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The hospital provided a national specialist orthopaedic service and accepted referrals from across England in accordance with the NHS England commissioning contract.

Patients were pre-assessed for their procedure in the outpatient department. Patients were admitted through the admission lounge. The lounge consisted of a small patient waiting area and a clinical room for patient assessments.
Staff completed thorough assessments of patients’ individual needs at the pre-assessment clinic to ensure care was planned in light of patients’ age, disability, gender, race, religion and sexual orientation to avoid any form of discrimination.

Bed management meetings took place once a day to identify potential capacity issues across the service.

Staff did a thorough assessment of patient’s individual needs at a pre-assessment appointment. For example, for people whose first language was not English, staff would arrange interpreters for their admission.

There was an escalation process to the discharge co-ordinator for complex discharges. Patient records showed there was involvement of carers and relatives in the multidisciplinary planning for discharge. Patients were usually kept informed of any changes to discharge arrangements. However, during the inspection we saw one example of changes being made without the patient being notified.

### Meeting people’s individual needs

Patients were provided information leaflets when they attended pre-operative assessments outlining key information and what to expect. We observed several information leaflets on a variety of topics were available in all clinical areas and wards visited.

All patients over the age of 75 were flagged on the electronic patient record system as requiring a dementia screening. In surgical wards any patient with dementia had a flower shaped magnet placed next to their name on the patient board. This helped ensure staff were aware of their needs.

Any complex cases were discussed at the complex case meeting. Senior staff told us they were in the process of ensuring patients with cognitive impairment were highlighted at the daily bed meeting and communicated to ward teams.

There was an electronic flagging system in place for patients with learning disabilities. Patients with learning disabilities were identified during the pre-admission assessment, GP letters or from a complex case alert. Patient passports were also uploaded on to the electronic records to alert all staff. This helped advise staff on how to meet the individual needs of the patients.

There was a named nurse for safeguarding adults who attended the weekly complex case meetings to discuss patients with learning disabilities. Action plans from this meeting were shared with theatre and ward staff to enhance a safe admission and discharge.

Any patients with sight or hearing impairments were identified during the pre-operative assessment and the care requirements were discussed at the complex case meeting.

The dietary needs of patients with diabetes were assessed during care planning on admission. A sign indicating the patient was diabetic was placed by patient beds to allow ward hostesses to identify patient needs. The patient menu identified food options suitable for diabetic patients. The department had access to interpreting and translation services for those who did not speak English. This included face-to-face, British Sign Language (BSL), telephone interpreting and translation services.

On Ward 4, there was a day room for patients with access to a small patio garden. There was access to bathrooms for patients with reduced mobility who required wheelchair access. Toilets were fitted with low-level pulldown chords.
There were online videos available for patients to watch prior to admission. This included a ‘Guide to Admission’ and a video around pain management. Psychological support was available for patients with mental health support needs as staff could refer patients to the mental health liaison team easily.

Access and flow

Trust Level
From June 2017 to May 2018, the average length of stay for elective patients at the trust was 5.7 days, which was higher than the England average of 3.9 days. The average length of stay for non-elective patients at the trust was 16.7 days, which was higher than the England average of 4.9 days.

Elective Average Length of Stay – Trust Level:

- The average length of stay for trauma and orthopaedics elective patients at the trust was 5.5 days, which was higher than the England average of 3.8 days.
- The average length of stay for spinal surgery service elective patients at the trust was 7.7 days, which was higher than the England average of 4.0 days.
- The average length of stay for urology elective patients at the trust was 3.4 days, which was higher than the England average of 2.5 days.

Non-Elective Average Length of Stay – Trust Level:

- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 17.8 days, which was higher than the England average of 8.7 days.
- The average length of stay for spinal surgery service non-elective patients at the trust was 13.8 days, which was higher than the England average of 9.0 days.
- The average length of stay for urology non-elective patients at the trust was 2.0 days, which was lower than the England average of 2.9 days.
The Royal National Orthopaedic Hospital (Stanmore):

From June 2017 to May 2018, the average length of stay for elective patients at The Royal National Orthopaedic Hospital (Stanmore) was 5.7 days, which was higher than the England average of 3.9 days. The average length of stay for non-elective patients at The Royal National Orthopaedic Hospital (Stanmore) was 16.7 days, which was higher than the England average of 4.9 days.

Elective Average Length of Stay - The Royal National Orthopaedic Hospital (Stanmore):

Note: Top three specialties for specific site based on count of activity.

- The average length of stay for trauma and orthopaedics elective patients at The Royal National Orthopaedic Hospital (Stanmore) was 5.5 days, which was higher than the England average of 3.8 days.
- The average length of stay for spinal surgery service elective patients at The Royal National Orthopaedic Hospital (Stanmore) was 7.7 days, which was higher than the England average of 4.0 days.
- The average length of stay for urology elective patients at The Royal National Orthopaedic Hospital (Stanmore) was 3.4 days, which was higher than the England average of 2.5 days.

Non-Elective Average Length of Stay - The Royal National Orthopaedic Hospital (Stanmore):

Note: Top three specialties for specific site based on count of activity.

- The average length of stay for trauma and orthopaedics non-elective patients at The Royal National Orthopaedic Hospital (Stanmore) was 17.8 days, which was higher than the England average of 8.7 days.
- The average length of stay for spinal surgery service non-elective patients at The Royal National Orthopaedic Hospital (Stanmore) was 13.8 days, which was higher than the England average of 9.0 days.
- The average length of stay for urology non-elective patients at The Royal National Orthopaedic Hospital (Stanmore) was 2.0 days, which was higher than the England average of 2.3 days.
Orthopaedic Hospital (Stanmore) was 2.0 days, which was lower than the England average of 2.9 days.

Royal National Orthopaedic Hospital (Bolsover Street) - elective patients:

From June 2017 to May 2018, the average length of stay for elective patients at Royal National Orthopaedic Hospital (Bolsover Street) was 5.0 days, which was higher than the England average of 3.9 days.

Elective Average Length of Stay - Royal National Orthopaedic Hospital (Bolsover Street):

[Graph showing average length of stay for all and trauma and orthopaedics]

Note: Top three specialties for specific site based on count of activity.

- The average length of stay for trauma and orthopaedics elective patients at Royal National Orthopaedic Hospital (Bolsover Street) was 5.0 days, which was higher than the England average of 3.8 days.

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was better than the England average in all months other than March 2018.

In the most recent month, July 2018, 75.9% of patients were treated within 18 weeks compared to the England average of 67.0%.

(Source: NHS England)

Three specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>96.1%</td>
<td>76.7%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>87.8%</td>
<td>70.0%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>71.2%</td>
<td>60.1%</td>
</tr>
</tbody>
</table>
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Royal National Orthopaedic Hospital NHS Trust:

Over the last two years, the percentage of cancelled operations at the trust that were not treated within 28 days fluctuated from 0% (Q1 2017/18) to 36% (Q3 2017/18). The England average remained between 6% and 12%. Since Q3 2017/18 the percentage of cancelled operations not treated within 28 days at the trust improved, with 6% of cancelled operations not treated within 28 days in the most recent period (Q1 2018/19).

Cancelled Operations as a percentage of elective admissions - Royal National Orthopaedic Hospital NHS Trust:

Over the last two years, the percentage of cancelled operations at the trust was lower than the England average in all periods other than Q2 2017/2018. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

The bed manager still oversaw utilisation of the beds. There were daily bed management meetings to ensure availability of beds and staff across the trust. This helped ensure there was good flow within the department.

We requested information regarding bed capacity for surgical wards. Data provided by the trust.
showed between April 2018 and October 2018 bed occupancy varied between 56% and 72%.

**Learning from complaints and concerns**
For the period August 2017 to July 2018 there were 66 complaints within surgery. Of these, eight were still open. The most frequent subjects of the complaints were patient care (28), communication (16) and admissions and discharges (11).

For the period August 2017 to July 2018 there were 49 compliments within surgery.

The trust stated that they were currently reviewing how compliments were captured and that they believed the number of compliments that had been reported was only a small proportion of the actual number of compliments received.

Staff informed us that they escalated complaints to their managers. They also directed patients and relatives on how to make complaints and referred them to the Patient Advice Liaison Service (PALS) where necessary. We found information posted on notice boards on all wards visited informing people about how to make a complaint. Managers told us learning from complaints was shared via team meetings.

**Is the service well-led?**

**Leadership**
Surgical services within the hospital fell under three divisions. Theatres came under the Critical Support Services Division (CSSD). Joint reconstruction and cancer services came under the Joint Reconstruction and Cancer Division. All other surgical wards came under the Specialist Surgery Division.

Each division had a general manager, service manager and head of nursing leading the department. There was also a clinical director and clinical lead.

We received mixed feedback about the leadership of the service. Surgeons and anaesthetists felt supported by the wider team and told us they received good support from consultants. Nursing staff also reported they felt supported by their senior sisters and matrons. However, some theatre staff felt that they were not listened to.

**Vision and strategy**
The trust had a clear vision and strategy and delivery of this was underpinned by the VAL-YOU values. The VAL-YOU campaign was part of the trust’s effort to make the hospital the best place to work in the NHS. The VAL-YOU campaign was launched in 2016. The values included putting patients first; excellence in all we do; trust, honest and respect for each other; and equality for all. Senior leaders told us staff were expected to work towards these values every day. Staff were aware of the trust values and understood their roles in ensuring these values underpinned their work on a daily basis.

Senior leaders told us they had put in a business case for a short stay inpatient unit. This had been escalated up to the trust and represented at the board. The team hoped space would be allocated
to them following the move to the hospital’s new build facility as it would aid theatre efficiency and patient experience.

Senior leaders told us staff engagement was high on their agenda. Following poor staff survey results around bullying, harassment and discrimination, senior leaders told us improving staff engagement was a key focus for surgical services. There were some key objectives to improve staff experience which included supporting staff to live the department’s values, developing an inclusive culture with effective leaders, sharing key information with staff and making them feel valued.

Theatres had already taken steps to improve staff engagement by implementing small focus groups to discuss key issues with senior leaders.

Culture
Staff described a ‘no blame’ culture and told us they were encouraged to report clinical incidents. There was a proactive culture in learning from incidents and sharing information and staff were able to identify changes as a result of incidents.

The majority of staff reported a positive culture and were enthusiastic about the care and services they provided for patients.

Staff seemed proud to work for the service and the majority said there was a positive culture and good work ethic amongst staff. Generally, staff felt valued by the trust and each other.

However, some theatre staff raised concerns that they did not feel listened to by the trust. Staff said any issues they identified were not always listened to and they felt the trust did not take their concerns seriously. For example, some staff highlighted there were concerns that scheduled theatre times did not appropriately reflect the actual time needed for surgery including anaesthetic time. The staff said they were not being listened to about this concern. This issue was recognised by senior leaders who were focused on improving engagement with theatre staff. For example, theatre staff were invited to mini focus groups with the divisional general manager as part of the communication improvement programme.

Governance
Within each division surgical services fell under there were monthly departmental meetings. Each month there was a quality board meeting where complaints, staffing, mortality and morbidity and serious incidents were discussed. All staff were invited to attend this meeting.

This fed into the divisional board meeting which happened on a monthly basis. This was attended by all departmental heads. This meeting had a standing agenda with a key theme each month. For example, September’s theme was serious incidents.

The divisional team also met every two weeks for a divisional leadership team meeting and any issues could be discussed here.

There were also business meetings each month in which the consultant body attended to discuss quality metrics.
Management of risk, issues and performance
The department carried out WHO checklist audits on monthly basis. Monthly compliance figures over the last 12 months ranged from 92% to 99%. The clinical audit team carried out a detailed analysis of the WHO checklist audit. The results were broken down to divisional team levels and themes around any missing elements were reported in the monthly quality report. Any areas of improvement were addressed at the divisional level. The trust also carried out WHO checklist qualitative observational audits to ensure the checklist was being used appropriately for different sections at the right time and in the right way. The monthly compliance figures for individual theatres for the observational audit ranged from 92% to 100%.

The trust took part in the mandatory national surveillance programme for surgical site infection (SSI) for total hip replacements, total knee replacements and spinal surgeries. In addition to the mandatory surgical categories, other surgeries were also audited and managed by the ‘SSI Prevention Group’ which reported to the Infection Control Committee and Clinical Quality Committee for governance.

Infections were captured on admission, re-admission and in the community through post-discharge questionnaires (PDQ) which were sent out 30 days post-operatively. Surveillance for patients with 'implants' covered up to one year following surgery whilst patients with ‘no- implant’ were monitored for SSI up to the 30th day after the operation in line with national surveillance and local policy. The RNOH average PDQ response rate for the last four quarters of audit (July 2017 - June 2018) was been above 80% (the national target rate was 70% as set by Public Health England). Over 12 months in adult hip surgery, only nine infections were detected out of 456 procedures, five infections in 472 knee procedures and eight infections in 803 spinal surgery procedures.

The trust had a dedicated infection control nurse for SSI surveillance. Actions for reducing SSIs were in line with NICE guidelines and trust policy and were managed by the SSI prevention group. For example, maintenance of normothermia pre, intra and post operatively was audited and reviewed at all SSI RCA meetings.

As surgical services fell under three divisions we reviewed three divisional risk registers. There were 13 risks within theatres, 11 risks for joint reconstruction and cancer surgical wards and nine risks for specialist surgical wards.

When we spoke to divisional leads, all three highlighted staffing levels as one of their main worries. Senior leaders had worked with human resources to improve the recruitment process including having rolling nursing adverts and looking at the role of advanced nurse practitioners. Another key risk that was identified was the infrastructure and environment. This was maintained to a safe level and some of the wards were due to move to a new build within a few weeks following our inspection. However, theatres were not moving to the new build and at the time of the inspection there was no formal plan as to updates for theatres.

Whilst we found the services had a good overview of risks, we found a fire safety risk that was not on the theatres divisional risk register. Within theatres, we found theatre doors did not have smoke seals and corridors were used for storage of flammable material. Surgery did not have compartmentation in theatres and a fire would be uncontained. This posed a risk to both patients and staff. We also found poor infection prevention and control practice and there was no action plan
to address this. Finally, mandatory training figures were poor and we did not see an action plan to address this.

**Information management**
Staff we spoke with told us they were able to access the information they needed to provide safe and effective care. Information boards displayed names and location of patients. Paper records were not stored in secure cupboards but were usually behind nursing areas which were monitored.

The intranet was available to all staff and contained links to current guidelines, policies and procedures. This meant staff could access advice and guidance easily. All staff we spoke with knew how to access the intranet and the information contained within. However, we saw some paper copies of guidelines stored on wards which were out of date. This could mean staff were accessing out of date guidance. Agency staff could not access the intranet and therefore did not have access to guidelines and policies.

All staff had access to their work email and senior staff informed us they provided organisational information and updates to staff on a regular basis. Relevant information was displayed on notice boards in all clinical areas visited.

**Engagement**
Senior leaders identified staff engagement as an area that needed to improve. At the time of the inspection there were no newsletters for staff. Senior leaders told us they planned to develop newsletters which would help improve communication within the divisions.

Theatres had introduced inter-staff awards to celebrate good practice within the department. There were also trust staff awards for all staff in which employee of the month and employee of the quarter could be voted for. We saw nomination forms throughout the surgical services encouraging patients to nominate staff for good care.

Staff attended a handover and morning huddle where senior staff discussed several issues including learning from incidents.

We saw posters advertising for patients to get involved with a patient group to help conduct inspections of ward areas, review patient information leaflets and attend specialist group meetings.

**Learning, continuous improvement and innovation**
The hospital had completed research into genetic characterization of all bone tumours. These findings had been translated into clinical tests allowing a diagnosis that could lead to a better standard of care being offered.

The department had developed their shoulder and elbow unit and a new consultant had been appointed. This meant the establishment of the upper limb unit at the hospital as a hub for the delivery of total elbow replacements. The department was working on establishing a dataset for the collection of patient outcomes for this.

The department had provided input into the development of new guidelines for the classification and diagnosis of Ehlers Danlos. Ehlers Danlos is a group of disorders that affect connective tissues.
supporting skin, bones, blood vessels and organs. Patients with rare bone diseases were invited to participate in a rare bone disease study.

The trust had contributed to pioneering work looking at the use of 3D printing in orthopaedics. This involved 3D printing models of patients’ anatomy for surgical training, and 3D printing titanium implants for patients with bone defects.

The department published a large study looking at the most common implanted hip replacement to identify factors associated with the increased corrosion in the all metal variant of this implant. The work helped inform surgeons as to which patients were at the greatest risk of developing problems due to adverse metal reactions.

**Services for children and young people**

**Facts and data about this service**

Royal National Orthopaedic Hospital cares for children and young people from all over the United Kingdom (UK). The specialist orthopaedic trust offers children and young people with services and interventions for a range of conditions, including:

- Cerebral palsy - including a multidisciplinary team approach
- Limb lengthening service including Ilizarov work
- Management of the young adult hip
- Ponseti method for correction of congenital talipes equinovarus (CTEV) or club foot deformity
- Positional foot deformities
- Upper limb surgery
- Antenatal counselling following diagnosis of congenital limb deformities — particularly club foot and scoliosis
- Sarcoma
- Peripheral nerve injury
- Scoliosis surgery
- Paediatric spinal injury rehabilitation

The service has a dedicated children’s outpatient unit which has five consultation rooms with clinic support and nursing staff for paediatricians and paediatric surgeons to see paediatric patients.

*(20180517 RPIR Acute - NUH Documents – Context)*

Children’s outpatient clinics include clinics for hips, knees, ankles, psychology, paediatric pre-assessment, spinal, dietitian, clinical nurse specialist paediatric clinic, rheumatology, bone disease, phlebotomy and dressings.

The children’s service cares for children and young people from the age of six months to 18 years of age. The children’s inpatient ward consists of Coxen ward and the adolescent unit which are interlinked and located together in the same building. Coxen ward and the adolescent unit consists of 26 beds including two single ensuite rooms and an additional three side rooms for private
patients. Coxen ward cares for patients aged from six months to 12 years of age and consists of bed bays and cot spaces. The adolescent unit cares for children aged 13 to 18 years of age.

The children’s high dependency unit is a four-bedded level 2 unit providing care for children requiring more intensive observation, treatment and nursing care than is possible in a general ward. Acute ventilated patients and children requiring additional specialist care are stabilised and transferred to a neighbouring paediatric intensive care unit using children’s acute transport services (CATS).

A hospital school provides educational support for children of school age and enables children and young people to continue their education while having treatment in hospital.

The children’s inpatient ward is scheduled to move to a new children’s facility in the Royal National Orthopaedic Hospital’s newly built hospital building. We visited the new children’s inpatient facility which included spacious bed bays, facilities for parents, patients and siblings as well as a children’s gym to aid rehabilitation.

The trust had 762 spells from June 2017 to May 2018.

Emergency spells accounted for 1% (8 spells), 51% (390 spells) were day case spells, and the remaining 48% (364 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from June 2017 to May 2018, Royal National Orthopaedic Hospital NHS Trust:

![Bar chart showing percentage of spells in children's services by type of appointment and site]

Total number of children’s spells by Site, Royal National Orthopaedic Hospital NHS Trust:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>This trust</td>
<td>762</td>
</tr>
<tr>
<td>England average</td>
<td>1,122,195</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

We visited children and young people’s services over three days during our unannounced inspection on the 30 October to 1 November 2018. We visited Coxen ward, the adolescent unit, children’s outpatient unit and the children’s high dependency unit. We also visited the children’s
wards in the new hospital building which were not yet in use.

We reviewed seven patient care records and observed care provided. We spoke with five parents, two patients and 33 members of staff including nurses, paediatricians, play specialists, physiotherapists, pharmacists and administrative staff. We also reviewed the trust’s performance data and looked at trust policies for paediatrics.

**Is the service safe?**

**Mandatory training**

The trust provided a structured induction and mandatory training programme for staff. Staff working in paediatrics also received additional training courses. Courses specific to paediatrics included modules in chronic pain, physiotherapy and occupational therapy skills, recognition of sepsis, identifying and managing swallowing issues, medical gas training and spinal deformity. Staff also undertook a medicines management study day which was led by the pharmacy team.

Staff received their mandatory training through face-to-face sessions and online courses and received protected time during their week-long induction to complete the courses. Temporary (agency) staff had a local induction process which included orientation on the wards.

We saw competency workbooks which adult trained nurses working on Coxen ward and the adolescent unit were required to complete prior to working on the children’s ward. Completion was monitored by the clinical nurse educator.

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of August 2018 for nursing and medical staff in children and young people’s services is shown below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>31</td>
<td>32</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>30</td>
<td>32</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>28</td>
<td>30</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>28</td>
<td>32</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Awareness</td>
<td>27</td>
<td>32</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Deprivation of Liberty</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - Level 2</td>
<td>23</td>
<td>32</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>22</td>
<td>32</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP</td>
<td>21</td>
<td>32</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Immediate Life Support</td>
<td>14</td>
<td>26</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>17</td>
<td>32</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mentor Update</td>
<td>16</td>
<td>32</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Level 3</td>
<td>14</td>
<td>31</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Nursing staff failed to meet the trust’s 95% completion target for 14 out of 15 mandatory training modules. The lowest scoring module was resuscitation level 3, with 45%.

Updated data received from the trust showed that 59.8% of nursing staff had completed paediatric immediate life support which was below the trust target of 95% compliance. Updated data received from the trust showed that 63.3% of nursing staff had completed resuscitation level 3 training, however this was below the trust target of 95% compliance.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate (%)</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>13</td>
<td>16</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP</td>
<td>13</td>
<td>16</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - Level 2</td>
<td>10</td>
<td>13</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Deprivation of Liberty</td>
<td>9</td>
<td>12</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>12</td>
<td>16</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>9</td>
<td>12</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling for Inanimate Load Handlers</td>
<td>11</td>
<td>16</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>7</td>
<td>12</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>9</td>
<td>16</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>8</td>
<td>16</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Awareness</td>
<td>5</td>
<td>11</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>4</td>
<td>9</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Immediate Life Support</td>
<td>1</td>
<td>8</td>
<td>13%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff failed to meet the trust’s 95% completion target for all 13 mandatory training modules. The lowest scoring module was paediatric immediate life support with 13%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Updated data received from the trust showed that 75.6% of medical staff had completed paediatric immediate life support training. However, this was below the trust target of 95% compliance.

The trust provided mandatory training in key skills to all staff however, completion rates were still low for nursing and medical staff in modules such as paediatric immediate life support.

The divisional leadership team were aware of the low levels of mandatory training compliance. They told us that this was because many of the medical staff had taken part in other training courses such as the advanced paediatric life support (APLS) and the European paediatric advanced life support (EPLS) course which was of a higher level than paediatric immediate life support but that this was not captured in the mandatory training competencies list. The divisional leadership team had begun to capture the additional training courses that staff had undertaken to internally validate the data. We received limited data from the trust which showed that one member of medical staff and one administrative staff had undertaken safeguarding level 4. Six nursing staff members and seven medical staff had undertaken APLS. However, it was not clear how the divisional leadership team planned to monitor completion of these additional courses and increase
completion rates for mandatory training.

Nursing staff told us they received reminders by email to complete their mandatory training. However, there was no clear plan for ensuring attendance and completion of mandatory training for nursing staff.

**Safeguarding**

We reviewed the trust’s safeguarding children policy which was in date and available on the trust intranet. The policy detailed individual responsibilities and processes for reporting and escalation of concerns about child welfare.

There was a named lead children’s safeguarding nurse and named designated safeguarding children doctor who were contactable by telephone. The team also now had an administrator to support the safeguarding team. A pack containing safeguarding telephone numbers, letter templates and flowcharts of what steps to follow was available in all consulting rooms in the children’s outpatient unit and on the inpatient wards and children’s high dependency unit.

All staff we spoke with demonstrated a good understanding of safeguarding children and young people. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral. We were given examples of concerns they had identified and where referrals were made. Staff knew who the named safeguarding leads were and how they would raise safeguarding concerns or seek advice. Staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) and child sexual exploitation (CSE) which was part of mandatory training within safeguarding level 3. Staff knew how to escalate concerns to the senior nurse and safeguarding team. Staff also told us they had taken part in the preventing radicalisation of vulnerable people programme (PREVENT).

Safeguarding information was recorded on a proforma at the front of a child’s paper medical record and also recorded on the electronic patient record system. Records of children admitted with safeguarding concerns were appropriately flagged and we observed detailed documentation which showed a multidisciplinary approach taken to support the child to remain safe while on the ward.

Between June to November 2018, Royal National Orthopaedic Hospital reported 15 safeguarding referrals to the relevant local authority.

The safeguarding team attended weekly safeguarding children team meetings where cases for the week were discussed. The named children’s safeguarding nurse attended morning handovers where information on children with safeguarding needs such as looked after children and children in need were flagged and shared. The named children’s safeguarding nurse also attended the weekly paediatric multidisciplinary team meetings which were held with a wide range of internal and external practitioners such as paediatricians, social workers and paediatric clinical psychologists to help coordinate the care of vulnerable children and young people.

Royal National Orthopaedic Hospital cared for children and young people from all over the UK which meant that patients were often residents in many different local authorities. This meant that the service was reliant on parents and carers and the referring hospital to inform them about child protection issues and social worker involvement at the preoperative assessment stage. This
information would then be inputted into the trust’s alert system so that all staff caring for the child would be made aware. At pre-assessment and on admission to the ward, a series of questions in the admission booklet are also asked to check if a child has social care involvement. The process is audited as part of the safeguarding processes audit. Staff are also advised to check if a child is flagged on the electronic patient system with regards to child protection and safeguarding concerns.

Safeguarding supervision for staff had still not yet been fully implemented in the service. Safeguarding supervision is a Department of Health requirement, as detailed in ‘Working Together to Safeguard Children’ (2015). A safeguarding supervision policy had recently been ratified and the safeguarding team planned on implementing more formal safeguarding supervision. The safeguarding team told us they planned to roll out safeguarding supervision as one to one and group sessions depending on staff needs.

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of the August 2018 for nursing staff/medical staff in children and young people’s services is shown below:

### Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 3</td>
<td>22</td>
<td>26</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff failed to meet the trusts 95% completion target for all four safeguarding modules.

### Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 3</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>9</td>
<td>13</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>2</td>
<td>3</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 4</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff failed to meet the trusts 95% completion target for all four safeguarding modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The safeguarding team acknowledged that safeguarding training levels were still not meeting the trust target but stated that it was an improving trajectory and that figures fluctuated with new starters arriving at the trust needing to book on to training. The team had now created a dashboard which recorded training attendance and completion for all staff. They emailed individuals when their safeguarding training was due. Safeguarding level 3 training was now offered five times a year as
face to face training by the safeguarding team. Staff could also access the training through the local safeguarding children training board.

We viewed the minutes of the safeguarding sub-committee meetings which were now detailed and included an action log where progress could now be tracked. This had improved since our last inspection.

The trust had a Missing Patient policy which was in date and covered protocols for what to do in the event of a child or young person going missing on the hospital estate. The safeguarding team had also just written an abduction policy. We observed robust security arrangements on the children’s wards with CCTV, buzzer entry and double doors to access some of the wards. However, we did see visitors tailgating through the doors of Coxen ward and the adolescent unit.

**Cleanliness, infection control and hygiene**

All of the children and young people clinical areas we visited were visibly clean and free of clutter. Hand sanitisers were available in all areas including at the point of entry to wards however there was no signage informing visitors to use hand sanitisers.

Throughout our inspection all staff were observed to be ‘bare below the elbow’ and adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting wards and bed spaces. There was easy access to personal protective equipment (PPE), such as aprons and gloves throughout the wards and at the entrances to cubicles. We witnessed staff using PPE effectively.

Infection prevention control (IPC) was part of mandatory training and trust records showed a compliance rate of 72% for nursing staff and 77% for medical staff which was below the trust target of 95%.

All nursing and medical staff we spoke with were able to articulate the IPC training they had received however not all staff were able to identify the IPC link nurse for their area.

Hand hygiene audits were conducted monthly. Between April 2018 to September 2018, compliance results for hand hygiene for Coxen ward and the adolescent unit was 100% for all months except July 2018 and August 2018 where compliance rates were 86% and 56% respectively. The audit noted that the drop in compliance rates was due to lack of hand washing after contact with a patient, after contact with a patient’s environment and bare below the elbow practices. Recommendations from the infection control team following the audit included collaboration with clinical educators to carry out teaching opportunities and continued monitoring of compliance rates of wards on a monthly basis.

IPC standard operating procedures were accessible by staff on the hospital intranet. We observed housekeepers working throughout the day following a detailed schedule of cleaning tasks to maintain the cleanliness of the wards.

We reviewed patient areas across the children’s wards, children’s high dependency unit and children’s outpatient unit and found the waiting areas, dirty utility rooms, treatment rooms and play areas to be visibly clean. Parents we spoke with were satisfied with the level of cleanliness.

We observed staff using hand sanitiser between patients. Staff on the children’s outpatient unit
showed us a toy cleaning schedule. Staff explained that toys in the waiting areas would be cleaned with antibacterial wipes at the end of the day to adhere to IPC procedures.

We saw green ‘I am clean’ stickers being used to identify equipment that had been cleaned and ready for use. We inspected various items of equipment including hoists, a commode, blood pressure cuffs and bed tables and found a good level of cleanliness. We also checked a sample of toilets and shower rooms and found them to be visibly clean.

Ward managers told us that cubicles would be used for patients with infections. There were posters about handwashing above basins.

Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.

There were no reported cases of MRSA since 2007. There were no cases of Clostridium difficile in the reporting period in children’s services at the hospital.

**Environment and equipment**
Coxen ward, the adolescent unit, the children’s high dependency unit and the children’s outpatient unit had secure entry with CCTV and buzzers to let visitors in. The children’s outpatient unit also had two secure doors where staff could control the inner door and only opened it once the outer door had shut to prevent other visitors from tailgating into the unit.

The environment on the children’s wards was bright and child friendly. The walls on Coxen ward which cared for children up to the age of 12, were brightly coloured and decorated with cartoon characters. The waiting area in the children’s outpatient unit had colourful chairs, brightly coloured walls, toys and electronic tablet computers for children to play with.

There were two separate paediatric recovery areas which provided children and young people with a dedicated space away from adult patients after surgery. However, the recovery area was small and had not been decorated to be child friendly.

Treatment rooms were locked with a keypad lock to prevent unauthorised entry. Linen cupboards and storage rooms were appropriately stocked and tidy.

The service did not have a playroom for young children. There was a play store cupboard which was stocked with a range of toys, games and books. Children were able to choose toys to take to their bed bays. There was also a table in the middle of Coxen ward where children could take part in arts and crafts activities organised by the play specialists. We viewed the children’s ward in the hospital’s new build which did have a dedicated playroom for younger children.

We observed high door handles, rounded corners and slam protection on doors to ensure the environment was safe for young children in the children’s outpatient unit. We viewed the children’s ward in the hospital’s new build which also had these safety features.

An emergency trolley was available on every ward, children’s high dependency unit and children’s outpatient unit. We found that they were secured with a plastic snap lock so it was clear if someone
had accessed the resuscitation equipment. Emergency trolleys were checked daily and a log was signed to confirm checks had been made. However, we found that the emergency trolley on the children’s high dependency unit had not been checked on one day of the month. We also found that the emergency trolley on the children’s high dependency unit contained an out of date printed copy of the Resuscitation Council Guidelines from 2010.

Equipment and consumables were provided in a range of sizes suitable for all age ranges. Consumables and equipment were appropriately stored and labelled. We checked various consumables such as fluids and found them to be in date and sealed. However, we found one mask on the emergency trolley in the children’s outpatient unit which was not in sealed packaging. This was pointed out to a staff member and rectified.

The emergency trolley in the children’s outpatient unit was placed in the corner of the waiting room close to where children were playing. During the inspection, we observed toys that were left in front of the trolley which blocked easy access to the trolley. This was rectified immediately and nurses said they tried to ensure that there was always easy access to the trolley and encouraged children to play with toys away from the trolley.

In our last inspection found that some equipment did not have the latest dates of when they were last safety tested. On this inspection we saw evidence that equipment had been serviced and calibrated regularly. We checked various items of equipment such as the suction machine, defibrillator and blood pressure monitors and found they had been safety tested. Oxygen tanks were stored securely and were in date. We inspected two sharps bins and found them to be correctly labelled and not filled above the maximum fill line.

At our last inspection we found that children and young people had to be taken outside of the building from the wards to access theatres which meant that children were exposed to the weather conditions. This was still the case during the inspection, however children’s inpatients were scheduled to move to a new facility in the new build of the hospital which had a connecting covered corridor leading to theatres. The move to the new build occurred before the publication of this report. This meant that children no longer needed to be taken outside of the building to access theatres.

Assessing and responding to patient risk
Staff we spoke with were able to articulate escalation protocols for deteriorating patients and the use of paediatric early warning scores (PEWS). We checked three PEWS charts and found them to be correctly filled in. However, staff were unable to show us the deteriorating child policy or pathway on the trust intranet. The trust later sent through a deteriorating child pathway which detailed the correct actions for staff to take in the case of a deteriorating child. We also viewed the operational policy for the children’s high dependency unit. The trust also took immediate steps during the inspection to ensure staff were familiar with the pathway by sharing it in the trust’s ‘message of the week’ system which was sent out to staff and discussed at clinical handovers.

Staff we spoke with said they had received training in sepsis on their induction and the sepsis six care bundle which consists of three treatments and three tests for the management of patients with presumed or actual sepsis. Staff told us they attended sepsis awareness sessions which were organised by the outreach team. Sepsis warning signs were also printed on the back of PEWS charts.
Medical and nursing handovers took place twice a day. We observed the nursing handover and found it to be detailed and comprehensive with discussion of PEWS and additional needs of the child. All nurses had a printed copy with information on the patients that were being discussed. The information sheet was disposed of in a confidential waste bin after the meeting. However, we observed a morning medical handover where information was not in printed form and was relayed verbally to the team. This meant that there was no audit trail for these handovers. Divisional leaders commented that medical staff had been issued with electronic tablet computers to record handovers electronically and should have been using this.

The paediatric Glamorgan risk assessment tool for assessing risks to pressure areas was used to help predict paediatric pressure ulcer risk.

The use of the World Health Organisation surgical safety checklist was embedded in practice and staff consistently used this. The latest audits as at July 2018 showed 92% compliance for WHO checklist completion.

Due to staffing constraints, there were adult trained nurses in paediatric areas. Adult trained nurses cared for children over the age of 12 and were supervised by a registered children’s nurse and a band 6 paediatric nurse.

Not all staff were up to date with their paediatric immediate life support training (PILS) however there was always at least one staff member with PILS training on Coxen ward and the adolescent unit. Not all adult trained staff on Coxen ward and the adolescent unit had PILS training. In addition to PILS training, nursing staff on Coxen ward were in the process of booking on to European paediatric life support training. Staff on the children’s high dependency unit including adult trained nurses did have EPLS training.

There was a ‘crash team’ which consisted of an anaesthetist, paediatric registrar, nurse in charge and a critical care outreach nurse. As well as a ‘crash team’ the service was now being supported by a medical emergency team which could be called when a child triggered a high PEWS score or when staff had concerns about a patient. The team consisted of a paediatrician, anaesthetist and site manager and could be called at any time of the day. Staff commented that this was particularly helpful for when they needed assistance but did not need a ‘crash team’. For example, staff recalled calling the medical emergency team to assist in children’s outpatient when a patient or parent had fainted. Matrons said that the medical emergency team had reduced ‘crash team’ calls by 80%.

The service had a service level agreement with a local mental health trust to provide advice and support to children with pre-existing mental health conditions. Staff told us they were able to easily contact a registered mental health nurse to provide support on the wards.

**Nurse staffing**

The trust reported the following nurse staffing numbers for children and young people’s services from April 2017 to March 2018 and April 2017 to July 2018.

The trust’s fill rate remained below 90% for both reporting periods.
<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April 2017 - July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned staff - WTE</td>
<td>Actual staff – WTE</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>36.3</td>
<td>32.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From August 2017 to July 2018 the trust reported a vacancy rate of 14.2% for nursing staff in children and young people’s services which was higher than the trust target of 9.5%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From April 2017 to March 2018, the trust reported a turnover rate of 9.7% for nursing staff in children and young people’s services which was higher than the trust’s target of 15%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From August 2017 to July 2018 the trust reported a sickness rate of 4.7% for nursing staff in children and young people’s services which was higher than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From August 2017 to July 2018 the trust reported a bank and agency usage rate of 19.7% in children’s services;

The bank/ agency usage for qualified nurses by ward/area is shown below

<table>
<thead>
<tr>
<th>Staff group CYP (Qualified Nurses)</th>
<th>Total bank use hours</th>
<th>Total Agency use hours</th>
<th>Total Hours available/ Establishment</th>
<th>Total hours unfilled</th>
<th>Bank use rate</th>
<th>Agency use rate</th>
<th>Unfilled rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin &amp; Discharge</td>
<td>335</td>
<td>74</td>
<td>16,029</td>
<td>213</td>
<td>2.1%</td>
<td>0.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Children &amp; Teenage Unit</td>
<td>5,138</td>
<td>5,929</td>
<td>51,812</td>
<td>3,250</td>
<td>9.9%</td>
<td>11.4%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Outpatients Nursing Stanmore</td>
<td>2,605</td>
<td>0</td>
<td>15,600</td>
<td>279</td>
<td>16.7%</td>
<td>0.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Paediatrics Surgery &amp; Limb</td>
<td>82</td>
<td>0</td>
<td>4,875</td>
<td>25</td>
<td>1.7%</td>
<td>0.0%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P16 Total numbers – Planned vs actual)
Pre-Admission Clinic | 1937 | 15 | 20,142 | 0 | 9.6% | 0.1% | 0.0%
---|---|---|---|---|---|---|---
Grand Total | 10,097 | 6,018 | 108,459 | 3,766 | 9.3% | 5.5% | 3.5%

The bank/ agency usage for non-qualified nurses by ward/area is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total bank use hours</th>
<th>Total Agency use hours</th>
<th>Total Hours available/ Establishment</th>
<th>Total hours unfilled</th>
<th>Bank use rate</th>
<th>Agency use rate</th>
<th>Unfilled rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYP (Non-Qualified Nurses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Children & Teenage Unit | 2,301 | 0 | 2,189 | 601 | 10.7% | 0.0% | 2.8%
| Outpatients Nursing Stanmore | 2,310 | 0 | 2,317 | 458 | 9.8% | 0.0% | 1.9%
| Pre-Admission Clinic | 649 | 0 | 5,207 | 127 | 12.5% | 0.0% | 2.4%
| Grand Total | 5,260 | 0 | 50,213 | 1,185 | 10.5% | 0.0% | 2.4%

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The children’s service at the Royal National Orthopaedic Hospital used the Royal College of Nursing paediatric defining staffing levels for children and young people's services model to assess staffing levels and skill mix. The trust was also in the process of implementing paediatric safer care nursing tool to better determine staffing levels on a ward and the right skill mix.

There were daily bed meetings at midday to discuss staffing issues and ensure there was always a registered children’s nurse available in children's services. Nursing ratios within the children’s high dependency unit was one nurse to one patient which met paediatric intensive care society (PICS) standards.

There was access to a senior children's nurse for advice at all times and ward managers were fully supervisory which meant that they were not included as part of ward establishment numbers and could manage and lead the ward. Each early shift had an allocated nurse in charge who was supernumerary. During late and night shifts the nurse in charge would have a patient caseload.

Matrons expressed that staffing was a concern especially for band 5 and 6 paediatric nurses on Coxen ward and the adolescent unit. This was on the risk register and agency staff were used to mitigate this. Various efforts were also being made to recruit new staff such as attendance at recruitment drives, advertising on the radio and employment of adult trained nurses with the offer of additional paediatric training. The trust was also advertising for children’s nurses to undertake a rotation programme through the children’s wards, children’s high dependency unit, recovery and children’s outpatients. The trust was also advertising for registered nurses to work on the children’s wards and undertake children’s registered nurse training. One registered nurse had completed the training and had been appointed to start on the children’s wards in January 2019.

The matron for the children’s high dependency unit commented that the number of children’s nurses was low with three paediatric nurses on the staff but that they had adult trained nursing
staff who had completed paediatric immediate life support, European paediatric immediate life support and safeguarding level 3 training to mitigate this.

Medical staffing
The trust reported the following medical staffing numbers for children and young people’s services from April 2017 to March 2018 and April 2017 to July 2018.

The trust’s fill rate remained above 90% for both reporting periods.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April 2017 - July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned staff – WTE</td>
<td>Actual staff – WTE</td>
</tr>
<tr>
<td>Medical staff - Hospital</td>
<td>17.2</td>
<td>17.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From August 2017 to July 2018, the trust reported a vacancy rate of 2.6% for medical staff in children and young people’s services. This was lower than the trust target of 9.5%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From April 2017 to March 2018, the trust reported a turnover rate of 6.1% for medical staff in children and young people’s services. This was higher than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From August 2017 to July 2018, the trust reported a sickness rate of 0% for medical staff in children and young people’s services. This was lower than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From August 2017 to July 2018 the trust did not require any medical agency and locum staff.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locum)

The service had 24-hour paediatric consultant cover seven days a week which met the Royal College of Paediatric and Child Health standards. Children’s services now had six whole time equivalent paediatric consultants and nine paediatric anaesthetists covering elective operating lists as well as emergency on call. In theatres there was 3.8 whole time equivalent qualified paediatric nurses rostered across the week.

A paediatric registrar and anaesthetic registrar provided cover on site every day from 8am to 8pm and a paediatrician was available on call out of hours.

Staff we spoke with said there were adequate numbers of doctors during the day and night. Staff told us rotas were planned and manageable.
Paediatricians conducted two ward rounds during the week and one ward round at weekends. A paediatric consultant could be called out of hours for advice and to attend the wards.

**Records**
Staff kept appropriate records of patients’ care and treatment. All clinical notes were stored securely behind the nurse’s station. There was an electronic patient record system which documented looked after children and those with child protection plans. Paper records also contained safeguarding proformas to alert staff to information such as safeguarding concerns.

We reviewed seven sets of records in children’s wards including the children’s high dependency unit and found that they were mostly comprehensive and detailed. Records also noted children’s additional needs such as if the child had a learning disability. However, five of the seven records we reviewed did not contain pain reviews.

Care plans were in place and there was evidence that these were reviewed daily. Allergies, weight and height were also recorded on drugs charts. Care summaries were printed out when a child was discharged and given to the parent or carer. A copy would also be sent to the child’s general practitioner (GP).

Personal child health records (red books) were used and staff on the children’s outpatient unit actively encouraged parents to bring the book to their appointments.

Information governance formed part of mandatory training for nursing and medical staff. Compliance levels for nursing and medical staff were below the trust target of 95% at 53% for nursing staff and 50% for medical staff.

Records were audited on a monthly basis as part of the combined paediatric nursing audit. The average compliance rate from August 2018 to October 2018 for Coxen ward and the adolescent unit was 89.3%.

**Medicines**
Suitable arrangements were in place for the ordering, dispensing, prescribing, recording and handling of medicines.

All staff undertook a medicines management study day on induction and there were weekly medicines update hours where the pharmacy team would come down to the ward to talk about medications audits and incidents.

Medications errors featured on the risk register and the children’s service had implemented new initiatives to reduce this. For example, to reduce medications errors, all drugs were checked by two members of staff. Staff undertaking drug rounds wore red tabards to let other staff know that they should not be disturbed or interrupted. Since May 2018, the service had also implemented weekly ‘druggles’ which were based on ‘safety huddles’ to discuss and share learning around medications. Druggles were led by the pharmacist and involved paediatricians, nurses, health care assistants and agency staff. The pharmacist led discussions in common drugs errors and improvements in prescribing. As part of learning, the pharmacist also photocopied drug charts and asked staff to identify any errors.

In our last inspection, we found some medicines that were loose and out of their containers. Medicines were now stored safely in locked cupboards and fridges within keypad locked treatment
rooms. In our last inspection, we found checks for expired medicines had not been carried out. At this inspection, we found that checks for expired medicines were completed as well as the daily temperature checks of the room and the fridge used to store medicines. The fridge temperature logs that we checked were all within acceptable range. The ambient room temperature where medicines were stored were checked daily and did not exceed recommended levels.

Nursing staff were aware of the policies on the administration of controlled drugs (CDs) (medicine that is controlled under the 'Misuse of Drugs Act’ (2001). CDs were stored in line with required legislation and recorded in a controlled drugs register. The register containing details of the contents of the CD cupboard was stored within the cupboard and identified the expected stock of medicine. Two members of staff checked the CD stock levels. We checked the CD stock levels and found them to be accurate and the medicine in date. The keys for the CD cupboard were held by the lead nurse on the ward. A paediatric medicines safety qualitative and quantitative audit was carried out over five days in March 2018 which showed that administration errors concerning drug charts were either due to delayed medications, missed medications, or medications not being counter-signed. An action log had been devised with actions including teaching sessions and a re-audit booked for the following year.

Medication records for children and young people showed that the child’s weight and height was clearly documented when medication was prescribed. Allergies were clearly documented in prescribing documents. Prescription pads were stored securely and only accessed when required by a clinician. Medicines to take out (TTO) were stored securely until the patient was discharged.

Microbiology protocols for the administration of antibiotics were available on the hospital intranet and staff knew how to access these. The trust had a specialist antimicrobial pharmacist and we viewed guidelines (adult and paediatric) which were in date and available on the trust intranet.

The service did not have a dedicated paediatric pharmacist however a clinical pharmacist visited the ward every day and checked prescription charts and CD books. Staff told us they were always available to provide advice and guidance and there was an on-call pharmacist available out of hours.

Incidents
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2017 to June 2018, the trust reported no incidents classified as never events for children and young people’s services at Royal National Orthopaedic NHS Trust.

(Source: NHS Improvement - STEIS)

In accordance with the Serious Incident Framework 2015, the trust did not report any incidents (SIs) in children and young people’s services which met the reporting criteria set by NHS England from August 2017 to July 2018.

(Source: NHS Improvement - STEIS)

The duty of candour is a regulatory duty that relates to openness and transparency and requires
providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with were able to explain the duty of candour fully. Eight incidents required the application of the duty of candour between November 2017 to October 2018.

From November 2017 to October 2018 there were 315 incidents reported within the children and young people’s service at the Royal National Orthopaedic Hospital. Of these, 170 were categorised as ‘no harm’, 63 as ‘near miss’, 71 as ‘low harm’ and 10 as ‘moderate harm’. Between November 2017 to October 2018, there was one death reported at the trust.

The trust used an electronic incident reporting system to report incidents. Staff were aware of their responsibilities for reporting incidents and were able to explain how this was done. Staff told us they were encouraged to report incidents and received an email when the incident had been received. However, some staff felt that not all incidents were responded to appropriately and felt that it may lead to underreporting.

Learning from incidents was shared through email and at ward meetings. Ward managers also printed out the learning and put it in the staff room so staff who were unable to attend the meeting could still access the learning. We also viewed the minutes for quarterly quality improvement and lessons learnt meetings which were attended by all staff in the division and discussed incidents within children’s services.

Mortality and morbidity meetings were held quarterly at the trust’s quality improvement and audit presentation day. We viewed minutes of the meetings where cases were presented and learning was identified with a list of recommendations or actions. Minutes of the meetings were emailed to staff members who were unable to attend.

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

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

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcer, no falls with harm and no new urinary tract infections in patients with a catheter from July 2017 to July 2018 for children’s services.
(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment
The service delivered care in line with national clinical guidance. Staff had access to policies and procedures based on national guidance on the trust intranet. Outcome data was reviewed at clinical governance meetings by the divisional leadership team and also discussed at the quality improvement and lessons learnt meeting where everyone in the division could attend. Quality
improvement and lessons learnt meetings were held quarterly and showcased audits as well as presentations on new guidelines. The trust held audit mornings every two months for half a day where everyone was invited to view audit outcomes for the division.

We reviewed a sample of trust policies including policies for safeguarding children, epilepsy, paediatric sepsis and local safety standards for invasive procedures which were all within date and appropriately referenced national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE) and Royal College of Paediatrics and Child Health. Policies contained appropriate guidance for screening referrals and specific interventions. We reviewed a policy for the management of paediatric surgical patients with insulin dependent diabetes type 1 and type 2 on the trust intranet which referenced NICE guidelines.

The hospital participated in national clinical audits such as national comparative audit of blood transfusion, intravenous fluid therapy for children and chronic neuro-disability in children, young people and young adults. The hospital also participated in the British orthopaedic surgery surveillance national audit of cases of Perthes disease and slipped capital femoral epiphyses. We saw that there was a formal clinical audit plan in place for children’s services to evidence performance monitoring, quality measures or patient outcomes relating to children’s services. The audit plan included audits for antibiotic use in paediatric surgery, gastrostomy audit, timely referrals following muscle injections for spasticity and paediatric notes audit. The audit plan for the acute pain team included post discharge pain assessment, paediatric postoperative pain management, patient controlled analgesia, epidural and opioid use in paediatric.

The service was auditing paediatric early warning score (PEWS) chart completion. We requested results and actions from the audit but did not receive this information.

The service had completed a parent/child survey which focused assessing patients’ experience of the paediatric pre-operative assessment clinic and the results were mostly positive. However, the service had not completed an assessment using tools such as the ‘15 Step Challenge’ to gather patient feedback about the environment of children’s services. The ‘15 Step Challenge’ is an approach to quality improvement that focuses on ward ‘walkarounds’ with participation from patients, carers, staff and board members. The participants consider their first impressions of the ward or service from the perspective of the service user and records how it appears, looks, sounds and smells. The outcomes are then used to inform improvement actions at a ward or service level.

**Nutrition and hydration**

There were appropriate processes in place to ensure patient’s nutrition and hydration needs were met on the wards. The service had dedicated dietitians to support nutritional planning for children and young people. Dietitians also held clinics in the children’s outpatient unit. Children on the wards received dietetic support where required and play specialists worked with dietitians to create food charts. Details of dietitian input was also recorded in patients’ notes.

The service had recently created food menus for younger and older children with colourful pictures and designs that were age appropriate. Food menus also catered for different patient groups including those with specific dietary requirement such as allergies and intolerances. Children also had access to snack and sandwiches during the day.
The children’s high dependency unit displayed posters informing visitors of protected meal times. This meant that non-urgent activities would stop to allow nurses and staff to support children to eat their meals where necessary.

The service used evidence based tools to screen for malnutrition. A nutrition initiatives re-audit in April 2017 showed that paediatric wards underperformed in the audit which assessed the recording of information on the malnutrition screening tool. For example, 20% of the paediatric malnutrition screening tools had the correct total malnutrition risk score documented in comparison to 80% which was documented in the 2016 audit. None of the paediatric malnutrition screening tools had the correct change in weight recorded in comparison to 50% recorded in the 2016 audit. However, the re-audit noted that 100% of food record charts on the paediatric ward had patient identifiable data which was an improvement from the 2016 audit where 86% of food record charts had the patient’s name and hospital number recorded. The paediatric ward also performed better than adult wards at using the kitchen whiteboards as a means of highlighting and communicating specific dietary needs to the ward hostess.

**Pain relief**

Staff used standardised pain assessment tools to measure children’s pain. There were different pain assessment tools for different ages. Younger children could choose from smiley and sad faces to express their level of pain. Older children and adolescents had a numbering system from zero (no pain) to 10 to express their level of pain. However, the service did not have a pain assessment tool for children who were non-verbal.

We found that while pain assessments had mostly been completed, five of the seven records we reviewed did not contain pain reviews including review of pain for children using patient controlled analgesia (PCA). The acute pain team had an audit plan for the following year which included audits of PCA, paediatric post-operative pain management and post discharge pain assessments.

There was an up to date policy and guidelines for treating acute pain in paediatric inpatients which was accessible on the hospital intranet. There was an acute pain management team who supported the inpatient wards. Nurses told us they could call upon the pain team if they needed additional support and advice in managing patients’ pain.

**Patient outcomes**

The trust contributed to relevant local and national patient outcome and performance audits such as the national comparative audit of blood transfusion, intravenous fluid therapy for children, chronic neuro-disability in children, young people and young adults and post-operative pain management in children.

Due to the specialist work undertaken at the Royal National Orthopaedic Hospital, the trust produced a clinical outcomes annual review paper to demonstrate patient outcomes within the hospital. For example, the trust was a leading provider of services for babies with developmental dysplasia of the hip. A standardised treatment pathway ensuring compliance with the newborn and infant physical examination (NIPE) guideline was developed at the Royal National Orthopaedic Hospital and had reduced the time of review for referred patients to under two weeks. This improved patient outcomes and prevented delayed diagnosis. Surgeons presented cases to the British society for child orthopaedic services (BSCOS) to benchmark their practice and had contributed to eight medical journals for paediatric orthopaedic surgery in 2017 and 2018.
The service was regularly reviewing the effectiveness of sepsis management through local and national audits. We requested the results of the latest sepsis audit but were not provided with the data.

The Royal National Orthopaedic NHS Trust did not participate in the paediatric diabetes audit 2015/16.

(Source: National Paediatric Diabetes Audit 2015/16)

Data we received showed that from March 2017 to February 2018 there were either no patients aged under one and aged one to 17 years old readmitted following an elective admission, or that the numbers were too low to be used in our analysis.

Data we received showed that from March 2017 to February 2018 there were no patients aged under one and aged one to 17 years old readmitted following an emergency admission over this time period.

(Source: CQC analysis of Hospital Episode Statistics February 2017 to January 2018)

No children received treatment for asthma, epilepsy or diabetes at the Royal National Orthopaedic Hospital as it is a specialist orthopaedic trust.

(Source analysis of Hospital Episode Statistics - February 2017 to January 2018)

The trust did not participate in the National Neonatal Audit Programme.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Competent staff

From August 2017 to July 2018, staff within services for children and young people achieved an overall appraisal rate of 86%. Medical staff and nursing and health visiting staff failed to meet the trusts appraisal target of 92%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>17</td>
<td>15</td>
<td>88%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>29</td>
<td>25</td>
<td>86%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff - Hospital</td>
<td>21</td>
<td>16</td>
<td>76%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>81</td>
<td>70</td>
<td>86%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

The latest data from April 2018 to July 2018 shows a completion rate of 72% for the year so far.
### April 2018 - July 2018

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>14</td>
<td>11</td>
<td>79%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>15</td>
<td>10</td>
<td>67%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>30</td>
<td>18</td>
<td>60%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff - Hospital</td>
<td>23</td>
<td>20</td>
<td>87%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>82</strong></td>
<td><strong>59</strong></td>
<td><strong>72%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*

Mandatory training figures for paediatric immediate life support (PILS) training compliance was 54% for nursing staff and 13% for medical staff. Nurses who needed to update their PILS training had been booked on to the training course.

In addition to PILS training, nursing staff on Coxen ward were in the process of booking on to European paediatric life support training. Two staff members on Coxen ward were due to start the course and some staff members had been booked onto a course for next year. Staff on the children’s high dependency unit all had EPLS training.

Since the last inspection the number of paediatric trained recovery nurses had been increased from two to three in the paediatric theatre recovery area.

Adult trained nurses working in paediatrics were supervised by a band 6 paediatric nurse and a registered children’s nurse. Adult trained nurses cared for children over the age of 12. However not all adult trained nurses on Coxen ward and the adolescent unit had PILS training.

Clinical supervision was incorporated within the yearly appraisal. Supervision could also be requested on an ad hoc basis with one to one supervision organised through the line manager of the staff member. There was also group supervision through ward meetings where staff could discuss learning in the group setting.

All newly registered nurses were placed onto a preceptorship programme which involved a competency based assessment and regular supervision. The therapies team also received clinical supervision every two to six weeks for band 2 staff and every four to six weeks for bands 7 and 8. Supervision included peer review and watched assessments.

The service now had paediatric trained nurses in pre-assessment clinics which was an improvement from the last inspection. There was also a paediatric nurse based in the children’s outpatient unit at all times.

All consultant anaesthetists were required to maintain competence in paediatric anaesthesia and advanced paediatric life support. The service used a ‘consultant of the week’ model to ensure continuous cover over seven days.

Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and is the process nurses and midwives must follow every three years to maintain their registration.
The trust checked that nursing staff who were required to revalidate, had done so successfully.

The trust checked that medical staff were registered with the General Medical Council and completed the re-validation training. Medical re-validation was introduced in 2012 to ensure all doctors were up to date and ‘fit to practice.’

The trust supported the continued professional development of staff. We spoke with a student nurse who told us they felt very supported by staff on Coxen ward and felt there were many learning opportunities at the hospital. Surgeons received protected time for academic research and adult nurses working on the children’s wards were offered a one-year course to become a registered children’s nurse.

**Multidisciplinary working**

We saw evidence of good multidisciplinary team (MDT) working within the children and young people’s service. We attended a weekly MDT meeting which was well attended by a wide range of staff including paediatric consultants, orthopaedic surgeons, allied health professionals (AHPs), safeguarding nurse, social workers, schoolteachers, play specialists and the paediatric clinical psychologist. We observed inclusive discussions about current patients and children who were coming into the hospital.

We saw evidence of good working relationships between nurses and medical staff. Nursing staff said that consultants were always available for advice and support. The service now had strong links with a mental health trust which provided psychiatric input to children accessing services in the trust. Staff also said they were able to request the support and advice of a registered mental health nurse when required.

We observed multidisciplinary approaches to care planning for patients and families. Patient records demonstrated input from the full clinical team of doctors, nurses and allied health professionals such as paediatric physiotherapists. Clinical nurse specialists were now involved in supporting children transitioning their care from children’s to adult services.

Staff throughout the children and young people’s service reported good working relationships and timely input from occupational therapists, physiotherapy staff and speech and language therapists. The play specialist team worked closely with the hospital school teachers and provided a handover every morning with the list of children who needed to be seen.

There was evidence of effective multidisciplinary partnership working with external agencies and professionals. Letters were sent to a child’s general practitioner (GP) following outpatient clinics to share outcomes and discharge information.

Teachers from the hospital school worked closely with physiotherapists and speech and language therapists to support the reintegration of children back to school.

**Seven-day services**

The hospital delivered a full inpatient service for children and young people over seven days. There was 24-hour consultant cover and the service used a ‘consultant of the week’ model to ensure continuous cover over seven days.
The children’s outpatient unit was open from 8.30am to 6pm Monday to Friday. Evening clinics were available for children of school age to avoid missing a full school day.

Physiotherapists worked Monday to Friday with an on-call provision out of hours and at weekends. The play therapy team also worked Monday to Friday but the service was in the process of recruiting an additional play specialist to cover Saturdays.

The paediatric clinical psychologist and child and adolescent psychiatrist were available Monday to Friday during working hours. Outside of these hours, the hospital had a service level agreement with a local mental health trust which staff could contact for help and support.

Health promotion
There was a comprehensive range of information and support throughout children’s services. The children’s outpatient unit had a range of information and support available in the form of leaflets. There were leaflets about newly diagnosed cancer, hip surgery care, club foot and Ponseti technique, healthy eating and talking to children about alcohol.

We also saw posters about domestic violence and posters encouraging children to talk to the clinical psychologist about any fears they had about being in hospital.

There were examples across paediatrics of staff supporting patients and those close to them to manage their own health. For example, dietitians and play specialists supported nutritional planning and created food charts for children who stayed in hospital for long periods of time.

The service encouraged the use of personal child health record books (red books) to document children’s measurements to monitor the growth and development of the child. Staff told us that some children with additional needs used communication passports.

The children’s outpatient unit had a well-equipped gym which was used by physiotherapists to promote fitness and support children in their rehabilitation. Children attended the gym regularly for rehabilitation and were also taught exercises that they could do at home. We also viewed the children’s physiotherapy gym in the hospital’s new build which would be fully equipped with ceiling hoists and a variety of equipment to aid children’s rehabilitation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Staff spoke with were aware of their responsibilities for obtaining consent for treatment and their roles and responsibilities under the Mental Capacity Act 2005 (MCA).

The compliance rate for MCA training was 81% for nursing staff and 75% for medical staff which was below the trust target of 95%. Deprivation of Liberty Safeguards training compliance rate was 81% for nursing staff and 75% for medical staff which was below the trust target of 95%.

We observed staff obtaining consent and procedures being explained to patients, parents and carers. Staff we spoke with understood the importance of shared decision-making with patients and we saw examples of this in records we reviewed.
All patient records we reviewed demonstrated consent was sought and clearly recorded in the patients’ notes.

All medical and nursing staff we spoke with understood the Fraser and Gillick competencies which helped assess whether a child has the maturity to make informed decisions about treatment without consent of a parent. Staff were aware of situations where these principles would be applied. Medical and nursing staff were aware of the MCA and the implications for young people above the age of 16.

Is the service caring?

Compassionate care
Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff promoted privacy and patients were treated with dignity and respect. We observed all staff in children’s services to be caring and compassionate with both patients and their relatives without exception during the inspection. Comments from parents included, “Care has been fantastic” and “All staff have been providing excellent care including physiotherapists and play specialists”.

The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients’ satisfaction with the healthcare they have received. FFT results for children’s services had improved since the last inspection. Between April 2018 and June 2018, the children’s high dependency unit consistently scored 100% for positive satisfaction. Between April 2018 and June 2018, 95.2% of respondents said they would recommend Coxen ward and the adolescent unit. Between April 2018 and June 2018, 96.5% of respondents said they would recommend the children’s outpatient unit. The response rate was 24% which was in line with the England average.

There was a brightly coloured comments box at the nurse’s station on Coxen ward and in children’s outpatient where feedback forms could be submitted. FFT comments we sampled were complimentary and positive about the care received and the staff who delivered it. Comments included, “Everyone is caring despite being super busy” and “We were well looked after”.

Parents spoke highly of the service and how supportive the staff were. We observed staff talking sensitively to parents and explaining what was happening. We observed a nurse on the children’s high dependency unit spending time with a child explaining to them why it was important to eat food after their operation and encouraging the child to choose food from the menu.

Staff were passionate about their work towards children and focused on delivering patient centred care. We observed many thank you cards displayed on the walls and reception of the children’s high dependency unit with comments from parents and children. Comments included, “Grateful for your wonderful care over the past week” and “Thank you for all your help and support”.

Emotional support
We found a high level of emotional support provided by staff in all areas of children’s services. We observed staff spending time with a patient with additional needs on the ward and supporting them to move around the ward in their wheelchair when they were bored.
We also observed a consultant in the children’s outpatient unit praising a patient’s progress in their rehabilitation.

The trust had good links with a local mental health trust to support children with pre-existing mental health needs. The children and young people’s service at the Royal National Orthopaedic Hospital also had a paediatric clinical psychologist and a child and adolescent psychiatrist who supported children in the psychological management of chronic pain and the psychological impact of chronic health issues. The team also provided bereavement counselling.

The play therapy team supported children during clinical interventions but also provided a high level of emotional support to children and young people on wards. Play specialists also attended handover meetings where the psychological and emotional needs of the patients were discussed. Play specialists explained that they would organise a variety of activities such as art therapy sessions to help create a stimulating environment for children who had been in hospital for long periods of time.

Play specialists focused on alleviating children’s fear of procedures such as MRI scans by using innovative equipment such as a model MRI scanner to explain to children about what happened during a scan. Play specialists also commented that using the model MRI scanner helped reassure parents of any worries they had about their child having a scan especially if they were not familiar with MRI scan procedures.

Hospital school teachers described Christmas parties that the ward and hospital school organised together to help create a festive and fun atmosphere for children and parents who had to spend a long time on the ward.

Parents we spoke with said they felt confident leaving the ward and their child’s care with the staff on the ward.

Spiritual support was offered by multi-faith chaplains which staff could request for parents and patients.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. Records we reviewed showed discussions which involved parents and patients.

We observed nurses communicating with young children in an age appropriate way and listening to parents’ views and concerns. Parents told us that nurses always explained what they were doing, and asked for permission and agreement first. They told us they were always involved in care plans and decisions about their child’s care. Parents and carers felt they received sufficient information about the care and treatment of their child.

During our inspection we observed a paediatric orthopaedic registrar explaining to patients and their families about why their operations had been cancelled and needed to be rebooked. They answered families’ questions and spent additional time with a young child who was particularly upset.
Older children felt comfortable asking their consultant questions and felt their questions were always answered in a way they could understand.

Staff worked with children to promote their understanding and empower them to play an active role in their treatment and care. Play specialists supported children undergoing MRI scans and gave them a choice of having the scan without general anaesthetic if they wanted.

Is the service responsive?

Service delivery to meet the needs of local people

Royal National Orthopaedic Hospital cared for children and young people from all over the United Kingdom (UK) and so did not have an immediate local population. The hospital delivered a range of specialist orthopaedic services for children and young people including but not limited to, scoliosis surgery, limb lengthening, management of young adult hip, upper limb surgery, sarcoma and paediatric spinal injury rehabilitation. The children’s service cared for children and young people from the age of 6 months to 18 years. The London spinal cord injury centre (LSCIC) at the Royal National Orthopaedic Hospital is one of eight in the UK designated to receive and treat children and young people with spinal cord injuries. Children who were admitted were cared for on the children’s inpatient ward and adolescent unit. The dedicated outreach service consisted of a multidisciplinary team and provided telephone follow up, support and advice.

The children’s inpatient ward consisted of Coxen ward and the adolescent unit which were interlinked and located together in the same building. Coxen ward and the adolescent unit consisted of 26 beds including two single ensuite rooms and an additional three side rooms for private patients. Coxen ward cared for patients aged from six months to 12 years of age and consisted of bed bays and cot spaces. The adolescent unit cared for children aged 13 to 18 years of age.

Parents were still able to accompany their child to the theatre complex and play specialists also accompanied children if required. At our last inspection we found that children and young people had to be taken outside of the building from the wards to access theatres which meant that children were exposed to the weather conditions. This was still the case during the inspection, however children’s inpatients were scheduled to move to a new facility in the new build of the hospital which had a connecting covered corridor leading to theatres. The move to the new build occurred before the publication of this report. This meant that children no longer needed to be taken outside of the building to access theatres. However, divisional leaders told us that they were still in talks about whether the covered indoor corridor would also apply to the child’s journey from theatres to the children’s high dependency unit.

The adolescent unit had an adolescent room and there was a secure outdoor play area for patients and families to use. Coxen ward did not have a playroom for young children. However, we saw that the new facility which would be functional before the publication of this report, had been designed with a playroom for younger children including areas for siblings to play in as well. We also saw that the new facility had a dedicated secure garden for children and young people and an adolescent room. The new children’s inpatient facility also had a dedicated children’s physiotherapy gym to aid children’s rehabilitation.

The service now had a dedicated children’s outpatient unit. The unit consisted of five consulting rooms and was open from Monday to Friday 8.30am to 6pm. Children’s outpatient clinics included
clinics for hips, knees, ankles, psychology, paediatric pre-assessment, spinal, dietitian, clinical nurse specialist paediatric clinic, rheumatology, bone disease, phlebotomy and dressings. However, some paediatric patients on pre-existing clinic lists for sarcoma were seen in the main outpatient department. There was a paediatric nurse for children seen in the main outpatient department and a separate waiting area for children was used. All new sarcoma paediatric referrals were seen in the dedicated children's outpatient unit.

The children's outpatient unit had a child friendly waiting room which had colourful chairs and brightly coloured walls. There were a range of toys for all ages as well as a television and tablet computers that children used to play games. A water dispenser was available in the waiting area for patients and carers. There were a variety of leaflets available in the waiting area such as a hip surgery care guide, general anaesthetic for children, parents’ online support group. The waiting area also had posters signposting patients and families about the option to have a chaperone in consultations and a poster about talking to a paediatric clinical psychologist.

The children’s high dependency unit was a four-bedded level 2 unit providing care for children requiring more intensive observation, treatment and nursing care than is possible in a general ward. Acute ventilated patients and children requiring additional specialist care were stabilised and transferred to a neighbouring paediatric intensive care unit using children’s acute transport services (CATS).

Parents could stay overnight with their child. However due to space limitations on Coxen ward and the adolescent unit, a chair bed was provided for one parent. We viewed the facilities for parents in the new children’s inpatients facility which was more spacious and included a pull-down bed for parents by each bedside.

All areas of children’s services had access to Wi-Fi for use by patients and their families.

We visited the hospital school which provided educational support for children of school age and enabled children and young people to continue their education while having treatment in hospital. The school had undergone an inspection earlier in the year by the inspectorate for schools and had achieved a Good rating. We spoke to teachers who explained that they received handovers every morning from the play specialist who identified children with educational support needs. They would also work closely with the speech and language therapy team and play team when teaching patients with additional needs. The schoolroom was well-equipped and tutoring could also take place by the bedside. Teachers liaised with a child’s school to make sure the child did not fall behind with schoolwork. Teachers described using different methods of teaching so children could continue their learning in hospital. For example, teachers described using a mounted tablet computer positioned to suit a child who was immobile or scribing for children who were not able to write due to the treatment they were receiving.

**Meeting people’s individual needs**

The service took account of the individual needs of children and young people. The children’s outpatient unit and children’s high dependency unit were bright and welcoming and had been designed with children and young people in mind. Coxen ward which cared for younger children had cartoon characters on the walls of the bays while the adolescent unit was more neutrally decorated to suit older children.
Staff knew how to arrange translation services to support patients and their families whose first language was not English. Staff confirmed that it was easy to book translation services which could be arranged face to face, or by telephone. Information leaflets on specific conditions and how to make a complaint were available, however these leaflets were not available in languages other than English.

There was still limited provision for children with learning disabilities, autism, sensory and behavioural needs. The service did not have a dedicated learning disability link nurse or learning disability champion. However, the trust was looking into implementing learning disabilities training for staff and appointing a learning disabilities nurse. Play specialists devised photobooks to help children with learning disabilities understand procedures and communicate their needs to the team. The service did not have access to British sign language (BSL) services for children and young people with hearing impairments. However, a healthcare assistant had undergone some BSL training. Play specialists were also able to use some Makaton (the language programme which uses signs and symbols to help people communicate).

The hospital had a service level agreement with a mental health trust which supported children and young people who had pre-existing mental health needs in both the inpatient and outpatient settings. Where a mental health problem was identified and required ongoing input, staff said they would refer the child to a local child and adolescent mental health service. The children and young people’s service at the Royal National Orthopaedic Hospital also had a paediatric clinical psychologist and a child and adolescent psychiatrist who supported children in the psychological management of chronic pain, needle phobias and the psychological impact of chronic health issues. The team also provided bereavement counselling.

There were different children’s food menus for young children and older children. Menus were bright and colourful and had options for specific cultures and preferences. For example, there were halal options as well as vegetarian and gluten free. Menus also carried a detailed list of allergens.

There was now a kitchen for parents and staff kept label stickers so that parents could label their food which they stored in the fridge. The parents’ kitchen had a fridge, microwave, kettle and a seating area.

Snacks could be prepared in the parents’ kitchen and children were able to access snack boxes of sandwiches, fruit, juice and biscuits at any time of the day. Staff also told us that children who had to stay on the ward for a long time could go to the staff canteen to choose food that they would like if they were bored of the menu provided on the ward. Dietitians supervised the choices and how often a patient could go to the canteen.

There was a quiet room which was used for sensitive conversations. However, the room was sparsely decorated and had multiple uses. However, when we viewed the new build there was a dedicated quiet room in the children’s wards as well as a baby feeding room. The new children’s inpatient ward had accessible wet rooms and toilets to meet the needs of patients. In addition to standard accessible toilets, the new facility also had a new changing and toilet facility for those who had a profound and multiple learning disabilities, or who had other disabilities which severely limited mobility. This facility was different to a standard or accessible toilet and included an extra wide, height adjustable changing bench, shower facilities and a hoist system.
There were two play specialists and a play assistant on the play team who worked from Monday to Friday. The service was also in the process of employing another play assistant who would cover Saturdays. Play specialists and the play assistant provided a range of activities to meet children’s ages and needs. This included art and craft activities and distraction through play. Play specialists would also accompany children to scans and used distraction techniques to keep them calm.

A play specialist had designed and developed a 3D printed miniature model MRI scanner with the hospital’s clinical engineering team to help children understand what happens during an MRI scan. The model made noises like that of a real scanner and played recordings of what scanning technicians were likely to say. Children could use dolls to simulate a scan procedure. This helped reduce a child’s anxiety about having a scan and helped them know what to expect when they were in the scanner. The use of the model scanner had significantly reduced the number of children requiring general anaesthetic when undergoing MRI scans. In 2017, of the 43 children aged under 12 requiring an MRI scan, 37 children underwent the scan without general anaesthetic by being supported by the play specialist team using the model MRI scanner.

The aim of the play service was to use the model scanner to reduce the number of general anaesthetics children required during their treatment plans, avoid the risks associated with anaesthetics and provide a more holistic approach for the child and the family. Play specialists spent time with children and their families prior to a scan to explore fears and help alleviate anxieties using the model scanner.

There was no playroom in the children’s ward however a play storeroom contained a variety of toys, DVDs and games which children could choose from and play with at their bed bays. There was a table in the middle of Coxen ward which young children used to take part in arts and crafts activities. There was a separate room for adolescents which contained sofas, a large television, a pool table and a CD player. We viewed facilities for children’s services in the new build of the hospital and found that there was a playroom and a separate room for adolescents. Staff we spoke with were excited about the move to the new build and spoke of being able to hold ‘movie nights’ for the children in the playroom. The trust had also planned to use an interactive robot in the new children’s inpatient wards to welcome children and be used as part of distraction therapy.

Access to multi-faith chaplaincy was available and we saw leaflets directing patients and families to this.

Divisional leaders told us that they were currently developing transition care for young people moving from children’s to adult services within the trust. The service had started the ‘Ready, Steady, Go’ programme which was a structured transition programme where the medical team worked towards equipping young people with the skills to make a successful transition to adult services. The programme covered issues such as medical knowledge, independence, health, career options and lifestyle. While most children were likely to see the same surgeon into their adult lives, divisional leaders had begun to introduce transition as part of the job description for clinical nurse specialists to ensure that all children were supported when they moved to adult services.

**Access and flow**

There was timely access for children and young people’s services at the Royal National Orthopaedic Hospital. Data provided by the trust showed that there was consistently good overall compliance of 94% referral to treatment times between April 2018 and September 2018.
The flow within children and young people’s services from admission, through to theatres, wards and discharge was managed effectively. We followed the patient journey through theatres and found that children and young people were transferred from the paediatric recovery area to the ward appropriately and without delay. Surgeons had mixed lists due to their specialisms but children on the lists were prioritised.

There were daily bed management meetings which discussed bed capacity. Bed occupancy levels between April 2018 to September 2018 were 68% for Coxen ward and the adolescent unit and 69% for the children’s high dependency unit.

Referral protocols were available on the trust intranet and included internal and external referral processes for different services including safeguarding, social services, mental health and general practitioner (GP).

Parents in the children’s outpatient unit commented that they were able to access appointments easily and staff were very flexible with appointment times. Appointments were confirmed in letters and parents received text message reminders to ensure appointments were not missed. Parents we spoke with felt the text message reminder system was useful. Schedulers also placed reminder calls to parents and carers one to two days prior to an appointment.

Staff in the children’s outpatient unit were knowledgeable about protocols to follow when a child was not brought to an appointment. There was a policy for children who were not brought to appointments which was in date and available on the trust intranet.

If a child did not attend their appointment, follow up calls would be made and letters would be sent to the patient’s parents or carers. Consultants would follow this up with the patient’s GP if a child was not brought in for a second consecutive appointment. The safeguarding team was also notified if a child had missed an appointment twice consecutively. The did not attend (DNA) rate for appointments in the children’s outpatient unit was 6.4% which was better than the trust target of 10%. The DNA rate for children for paediatric surgery was 0.7%.

**Learning from complaints and concerns**
From August 2017 to July 2018 there were 13 complaints relating to the children’s, outpatients, imaging and access division at the trust. The hospital took an average of 114 days to investigate and close complaints. This was not in line with the trust’s complaints policy, which states complaints should be completed within 25 days.

Five complaints related to poor communication and medical staff.

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

From August 2017 to July 2018 the trust received 12 compliments for the children’s outpatients imaging and access division at the Royal National Orthopaedic Hospital.

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

Complaints were discussed at clinical governance meetings and we saw evidence of discussion of complaints within the minutes of the clinical governance meetings. Learning from complaints was
also shared at quality improvement and lessons learnt meetings which all children’s services staff could attend. Minutes of these meetings were disseminated to staff through email.

Patients and families were encouraged to fill in feedback forms. Comments boxes were placed at the reception desk on the wards and children’s outpatient clinic. Feedback forms were brightly coloured and featured a picture of a dartboard. Children were invited to mark with an ‘x’ on areas of the dartboard which best described whether they would recommend the service to friends and family. The back of the feedback form featured cartoon characters and questions for children to answer about their experience at the hospital.

Children and their families said they felt comfortable about speaking directly with staff if they wanted to complain. Nurses said they tried to address concerns as they arose by speaking to patients and families directly and explaining how they would address their concerns. Formal complaints could be made through the Patient Advice and Liaison Service (PALS) and there were leaflets and posters on walls directing patients and relatives to PALS. A parent commented a complaint they had made was taken seriously and acted upon.

**Is the service well-led?**

**Leadership**

Children and young people’s services was part of the children, outpatients, imaging and access division. The divisional leadership team consisted of a director of children’s services and outpatients, divisional head of nursing and general manager. In the last inspection we found that there was a lack of ownership of the issues faced by the department. The team now demonstrated a clear understanding of risks, issues and priorities for the service.

Staff were able to identify the divisional management team and commented positively on changes that had been made since the change to a divisional structure. Staff said that the leadership used to be very clinician-led and that now nursing staff had a greater voice. However, some staff commented that management felt top-down and they were not always consulted when decisions were made.

All staff spoke highly of ward managers and said that they were approachable. Both nursing and medical staff of all grades across children’s services spoke of good teamwork. Staff told us ward managers, divisional head of nursing, matrons and lead nurses were visible on the wards.

Consultant anaesthetists told us they felt listened to and encouraged by the leadership team.

There was clear representation of children and young people’s services at trust board level. There was now a non-executive director who was a champion for children.

**Vision and strategy**

The leadership team had a clear vision and strategy which was documented. The strategy was discussed at monthly divisional performance review meetings and the bi-monthly operational group meeting. The children’s strategy group also reported into the quality committee which took place bi-monthly.
The team described the priorities for children’s services was to grow the rheumatology service, to keep bed occupancy up and even throughout the year, to improve the environment for patients and parents by moving into the new build, increase staffing and maintain and grow the service.

Staff we spoke with were aware of the children’s service’s vision to improve the environment for patients and their families and were looking forward to the children’s inpatient wards moving to the hospital’s new build facility which would occur before the publication of this report.

Culture
Staff were passionate about their work and spoke of good teamwork in a child-focused environment on the inpatient wards and children’s outpatient unit. There was an open and honest culture and staff were knowledgeable about the duty of candour. Staff knew about the trust’s processes and procedures and could give examples of how they applied the duty of candour and the learning that was shared from an incident.

At the last inspection, we found that some staff felt bullied by certain staff groups. Staff commented that this had improved since the last inspection but there were still pockets of bullying in the division.

Most staff felt supported by their managers however, some staff we spoke with expressed that they felt undervalued and were not consulted when decisions were made.

Consultant paediatricians told us there was a supportive culture among clinicians and an approach to challenge and peer review. We attended a weekly multidisciplinary team meeting which was well attended by clinical teams and allied health professionals. We saw that there was respect for each member of the multidisciplinary team and the contribution they made.

Governance
Governance structures were in place at the trust for children and young people’s services.

The divisional leadership team attended weekly triumvirate meetings and bimonthly clinical governance meetings. Clinical governance meetings were minuted and were led by the clinical lead who discussed policies and protocols, incidents, drug errors, complaints and audit results. Weekly triumvirate meetings were attended by the clinical director, head of nursing and general manager and included discussions on business planning and business cases in development.

The leadership team also attended bimonthly operational group meetings where there was wider discussion about how services are delivered and how to improve patient care. The meeting was multi-disciplinary and included representatives from pharmacy, therapies, surgery, anaesthetics, radiology and children’s services.

Matrons also attended bimonthly paediatric governance meetings which fed into the clinical governance meetings and fed back on incidents, complaints, friends and family test results, policies and themes.

The children’s outpatient unit had a monthly ‘business as usual’ meetings which discussed incidents, learning, late running clinics and ‘did not attend’ rates.
The children’s high dependency unit had monthly meetings where themes from incidents were discussed and learning was shared. Minutes were shared with the team and learning from the meeting was also discussed at morning handover. There were also quarterly quality improvement and lessons learnt meetings where everyone the division was invited. Discussions at these meetings included learning from incidents, showcasing of audits and presentations on new guidelines.

**Management of risk, issues and performance**

The service kept a risk register which was reviewed regularly and discussed at clinical governance meetings. Risks to the service had been taken into account in planning and delivery. For example, the division had implemented a number of initiatives to reduce medications errors including the introduction of double checking of all medicines by two members of staff and the use of a red tabard when doing medications rounds to prevent staff being interrupted during the round. However, it was still not clear how the divisional leadership team planned to monitor and increase completion of low mandatory training rates.

Weekly paediatric multidisciplinary team meetings were well attended by a wide range of staff including paediatric consultants, orthopaedic surgeons, allied health professionals (AHPs), safeguarding nurse, social workers, schoolteachers, play specialists and the paediatric clinical psychologist. We observed inclusive discussions about current patients and children who were coming into the hospital.

The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these and the risks outlined on the risk register.

Divisional performance review meetings were held monthly which included discussions around strategic plans of the children and young people’s service. The meeting was attended by the executive team, human resources, finance and quality teams. Discussions also covered patient flow and referral to treatment targets.

Mortality and morbidity meetings were held quarterly at the trust’s quality improvement and audit presentation day. We viewed the minutes of these meetings where serious incidents were discussed and learning was identified with a list of recommendations or actions. Learning points and minutes from the meeting were shared with staff by email.

A dashboard had been developed by the children’s safeguarding team which provided information including referrals, audit results and monitoring of training levels. The safeguarding team were able to identify the training needs of staff members and emailed individuals to remind them when their training needed to be completed.

**Information management**

Staff had access to patient’s health records and the results of investigations and tests in a timely manner. Children and young people’s services used a combination of paper and electronic records. Paper records were well organised and stored securely. There were clearly labelled drawers at the nurse’s station where staff could access forms and assessment tools.
There were computer stations throughout children’s services and staff told us there were sufficient numbers of computers to access when they needed. We observed staff logging off after using computers.

The trust’s electronic learning management system did not record staff completion of additional training modules such as advanced paediatric life support training (APLS) or European paediatric advanced life support (EPLS). Divisional leaders told us they had begun work on capturing and internally validating training courses that staff had attended that were not included in the mandatory training list. They now had a spreadsheet with this information and were able to monitor staff completion however data we received contained limited information.

Senior leaders told us they used a ‘message of the week’ system to convey important messages from incidents and learning points to be discussed at every clinical handover for a full week.

The trust had Wi-Fi for public use. Patients, parents and families said they were able to easily access the Wi-Fi service.

There were information posters on how to access the Patient Advice and Liaison Service (PALS) and multi-faith chaplains.

**Engagement**

Patients and families on wards were encouraged to share their views on the quality of the service through friends and family feedback forms. All areas of children’s services had child friendly feedback forms and there was evidence that comments had been listened to. For example, the trust took account of comments from parents that the sofas in the children’s high dependency unit were uncomfortable and had just received delivery of new sofas to replace them.

The trust had created ‘I delivered great care’ badges which were included in the patient welcome pack when patients were admitted. Patients could then give a badge to a member of staff that they felt had delivered great care to them during their stay. There was also an employee of the month nomination form available on wards and the children’s outpatient unit where patients and staff could nominate a member of staff.

The divisional leadership team told us that it was difficult to engage young people in the development of the service because patients were often not local to the hospital. However, they were able to involve children and their families in the design and development of the new children’s inpatient wards in the new build with events such as a visit to a museum to choose interactive play equipment for the new wards and playroom.

There was a patient representation group for outpatients that had suggested bone shaped footprints on the floor leading to the children’s outpatient unit to make the journey there easier and more child friendly. The service had listened to the group and had ordered the equipment to create the footprints.

**Learning, continuous improvement and innovation**

The trust continued to be involved in academic research studies. Surgeons were given dedicated research time and the trust were encouraging more nurse-led research. The trust was actively participating in clinical research studies. Staff at the trust continued to be involved in national and
international studies for example in genetic bone disorders, hip interventions for children with cerebral palsy, developmental dysplasia of the hip and investigating the use of the medical device, medical interactive recovery assistant (MIRA) in adolescents with shoulder instability.

A play specialist had designed and developed a 3D printed miniature model MRI scanner with the hospital’s clinical engineering team to help children understand what happens during an MRI scan. The model made noises like that of a real scanner and played recordings of what scanning technicians were likely to say so children would know what to expect when they were in the scanner. This helped alleviate children’s fears and anxieties and had significantly reduced the number of children requiring general anaesthetic when undergoing MRI scans. In 2017, of the 43 children aged under 12 requiring an MRI scan, 37 children underwent the scan without general anaesthetic by being supported by the play specialist team using the model MRI scanner.

### Outpatients (Stanmore)

#### Facts and data about this service

The trust operates across two sites: Stanmore (inpatient and outpatient services) and Bolsover Street (outpatient services). The main outpatient department in Stanmore provides services for all adult patients seeing clinical staff across all specialties. This facility provides 19 consultation rooms. Co-located but separate to the main department is a dedicated paediatric OPD, which has five consultation rooms.

(Source: Routine Provider Information Request)

**Total number of first and follow up appointments compared to England**

The trust had 135,870 first and follow up outpatient appointments from June 2017 to May 2018. The graph below represents how this compares to other trusts.
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from June 2017 to May 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal National Orthopaedic Hospital (Stanmore)</td>
<td>109,614</td>
</tr>
<tr>
<td>Royal National Orthopaedic Hospital (Bolsover Street)</td>
<td>34,309</td>
</tr>
<tr>
<td>This Trust</td>
<td>143,923</td>
</tr>
<tr>
<td>England</td>
<td>106,785,632</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics - HES Outpatients)
Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from June 2017 to May 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Royal National Orthopaedic Hospital NHS Trust from June 2017 to May 2018 by site and type of appointment.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory Training

The trust set a target of 95.0% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses as at August 2018 the trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Basic Life Support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>20</td>
<td>21</td>
<td>95.2%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>20</td>
<td>21</td>
<td>95.2%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>20</td>
<td>21</td>
<td>95.2%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Awareness</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
In outpatients the 95.0% target was met for five of the 10 mandatory training modules for which qualified nursing staff were eligible.

The trust provided training data which showed there were no medical staff for their outpatient services.

A breakdown of compliance for mandatory training courses from August 2018 for qualified nursing staff in the outpatient department at Stanmore is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric Immediate Life Support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Awareness</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>10</td>
<td>13</td>
<td>76.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Level 3</td>
<td>8</td>
<td>11</td>
<td>72.7%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Mentor Update</td>
<td>8</td>
<td>13</td>
<td>61.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - Level 2</td>
<td>7</td>
<td>13</td>
<td>53.8%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Stanmore outpatient department the 95.0% target was met for one of the six mandatory training modules for which qualified nursing staff were eligible.

The trust provided training data which showed there were no medical staff categorised as outpatient services.

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

Courses were available to complete on the trust intranet and e-learning functions and staff we spoke with told us that there were enough computers for staff to access. Extra courses were advertised to staff by the matron and senior nurses.

‘Grapevine’ was the intranet portal where staff accessed online training. ‘Grapevine’ had a ‘traffic light’ training records system, which indicated when training was due. Staff would receive a notification by email, or through staff meetings, of upcoming training sessions that required their
attendance.

**Safeguarding**
The trust set a target of 95.0% for completion of safeguarding training. Staff we spoke with demonstrated a good understanding of safeguarding and could describe the trust safeguarding process and who to contact if they were concerned about a patient.

There was a trust safeguarding lead who was the point of contact for safeguarding concerns and enquiries. Staff could access safeguarding information on the trust intranet.

Staff were able to give examples of past safeguarding referrals they had made or knew colleagues had made. Staff told us they felt supported in the process.

A breakdown of compliance for safeguarding training courses from as at August 2018 for qualified nursing staff in the outpatient department at Stanmore is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>1</td>
<td>5</td>
<td>20.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Stanmore outpatient department the 95.0% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible.

The trust provided training data which showed there were no medical staff categorised as outpatient services.

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

**Cleanliness, infection control and hygiene**
At the previous inspection the service was reliant on a monthly Patient Led Assessment of the Care Environment (PLACE) audit to monitor cleanliness in the department. This had improved and there were a range of cleanliness audits undertaken regularly including hand hygiene for which outpatients scored 100% in the month prior to inspection.

There were automatic sensor-operated antibacterial gel dispensers on walls throughout the department which had signs above them to draw attention to hand hygiene. We observed staff and patients using the dispensers and all dispensers were found to be stocked with gel.
There were posters in the department describing the ‘5 moments’ of hand hygiene and indicating areas of the hands frequently missed during hand washing.

At the previous inspection there were problems with the standard of cleanliness in the outpatient department and staff had felt that the external provider of cleaning services was not keeping the department clean. This had improved at this inspection and the department was visibly clean throughout. We heard from managers we spoke with that there was closer monitoring of the service level contracts and that the department was satisfied with the cleaning service. We saw that cleaning schedules throughout the department were completed.

On inspection all clinical staff we observed were bare below the elbows and compliant with appropriate procedures to protect patients from infection. We saw that clinicians washed their hands before touching patients and wore protective gloves where necessary.

There were sharps bins available in the phlebotomy room with temporary closure mechanisms. We saw that these were emptied regularly.

There was an infection control link nurse available to give advice and their contact details were displayed around the department, this included out of hours cover. There was a trust infection prevention and control (IPC) policy and IPC was part of the mandatory training for staff.

**Environment and equipment**

We saw that electrical equipment around the department such as blood pressure machines, computers and scanners had portable appliance tests (PATs) which were in date.

The department contained one resuscitation trolley with one further trolley nearby in the children’s outpatients department. We examined both trolleys and found that they were fully stocked for both adults and children. The equipment was checked daily, and we saw that this was documented in a folder containing instructions for staff.

Portable Appliance Testing (PAT) was managed by the site estates team and the equipment that we looked at was up to date, with future testing dates indicated.

The walls and floors were visibly clean, unmarked and free of hazards. There were however, cracks and stains on some ceiling tiles above the waiting areas. We heard that the waiting area had become overheated during the summer and portable air conditioning units had tripped the electricity so could not be used.

**Assessing and responding to patient risk**

We saw that there was emergency equipment accessible in all areas of the outpatients department. Staff were present throughout the department where patients would be waiting for clinics and all waiting areas were visible to staff. Staff we spoke with understood policies and protocols relating to assessing and responding to patient risk in the department, they told us that it was a common occurrence in the department and so staff were aware of what to do.

There was a clear protocol for escalation of deteriorating patients. There was a medical assessment team of three doctors who staff could call if a patient was becoming unwell but was
not serious enough to require a crash call.

**Nurse staffing**
The outpatients department was staffed by registered nurses and clinical support workers supported by senior sisters. There are no national recommended methodologies for identifying nurse staffing levels or skill mix within an outpatient setting.

The trust has reported their staffing numbers for outpatients below for the period April 2018 to July 2018 for outpatients. A breakdown by site is below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolsover</td>
<td>6.4</td>
<td>6.4</td>
</tr>
<tr>
<td>Stanmore</td>
<td>18.3</td>
<td>11.9</td>
</tr>
</tbody>
</table>

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

From August 2017 to July 2018, the trust reported a vacancy rate of 18.6% for qualified nursing staff in outpatients. This did not meet the trust target of 9.5% for vacancy.

- Stanmore: 27.1%

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

From August 2017 to July 2018, the trust reported a turnover rate of 5.0% in outpatients, the trust did not provide turnover broken down by site.

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

From August 2017 to July 2018, the trust reported a sickness rate of 2.9% in outpatients.

- Stanmore: 3.9%

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

From August 2017 to July 2018, the trust reported a bank usage rate of 9.7%, an agency usage rate of 0.0% and 0.6% unfilled in the outpatient department.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

The department used around four regular bank nurses to cover shifts and there was no use of agency staff.

**Medical staffing**
The trust provided staffing data which showed there were no medical staff categorised as outpatient services.
Consultants and surgeons ran outpatient clinics but were not considered outpatient staff. Consultants we spoke with felt there was good support in the department and that staff worked well together to deliver clinics. No out of hours cover was required as clinics closed at 8pm. No locum cover was required.

**Records**

Patient records in clinic were paper based and were used to record all patient interactions while they were onsite such as appointments and scans. The department used an external company to upload records electronically after each day. Clinical support workers were responsible for preparing and collating patient notes for each clinic.

Records were audited for accuracy and the performance of the electronic scanning company was monitored monthly. We examined eight sets of patient notes and saw that documentation such as drug charts and GP letters was included in all records.

All paper patient notes in clinic were kept in lockable trolleys and we saw that these were supervised and kept locked. All computers were locked and password protected.

**Medicines**

There were no controlled drugs kept or administered in outpatients. Keys to medicines cabinets were kept in a key cabinet and we saw that cabinets were locked when not in use. FP10s were kept in a cabinet along with a log and prescriptions were recorded on paper in clinic and scanned electronically afterwards.

Medicines were examined and were in date and there was a fridge temperate log which showed that temperatures stayed within the appropriate range. Nurses were responsible for restocking medicines in the department from the pharmacy. Medicines prescribed in clinic were recorded in patient notes and included in records.

**Incidents**

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

From September 2017 to August 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from September 2017 to August 2018.

(Source: Strategic Executive Information System (STEIS))

Incidents were reviewed at the monthly ‘business as usual’ management meeting to identify
trends and share learning that might be pertinent. There was limited sharing of learning from incidents which occurred in other parts of the hospital. For instance, there had been a never event in surgery and staff we spoke with in the outpatients department did not seem aware of it.

There was an electronic incident reporting system available through the trust intranet. Staff we spoke with told us that it was an easy system to use, although the forms could be lengthy, and that they knew how to report incidents if they needed to. Staff who had reported incidents told us that they had been given feedback.

**Safety Thermometer**
The NHS Patient Safety Thermometer is a national tool to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. This information is intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide.

**Is the service effective?**

**Evidence-based care and treatment**
Outpatients at RNOH was a tertiary referral centre. Senior medical staff were responsible for ensuring that the department’s practice remained up to date with new guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. This work was specialty-led. New practice was disseminated through emails and training.

We observed consultations and patient notes and saw that treatment and procedures were carried out in line with best clinical practice.

**Nutrition and hydration**
There was a water fountain in the waiting area available for patients and staff we spoke with informed us that they could arrange packed lunches from the canteen for patients with lengthy waits in the department. There was also a cafe and shop which sold a range of food and drinks in the department.

**Pain relief**
Specialist pain nurses were integrated into clinics to give patients treatment and advice about managing pain. In consultations we observed patients were asked about their level of pain and pain management medication and techniques were discussed. There was a dedicated pain team run by a consultant and clinical nurse specialists which ran pain clinics assessing pain and educating patients on pain management. Pain relief was not frequently necessary in the outpatient department, but nurses could dispense paracetamol if necessary.

**Patient outcomes**
From June 2017 to May 2018,
- the follow-up to new rate for The Royal National Orthopaedic Hospital (Stanmore) was higher than the England average, except for March 2018 when the rate dropped lower than the England average.
Follow-up to new rate, Royal National Orthopaedic Hospital NHS Trust.

(Source: Hospital Episode Statistics)

Competent staff
From April 2017 to March 2018, 41.4% of staff within outpatient department at the trust received an appraisal compared to a trust target of 92.0%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>6</td>
<td>13</td>
<td>46.2%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>4</td>
<td>13</td>
<td>30.8%</td>
</tr>
</tbody>
</table>

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

We saw that sub specialty clinics were run by staff with the appropriate competencies and qualifications in the field.
All staff we spoke with informed us that they had received their appraisal and that professional support and development was available to them.

At the previous inspection we had found that reception staff did not receive customer service or conflict resolution training which would help them perform their roles. This remained the case, however reception staff we spoke with told us that they received a comprehensive induction including shadowing of reception staff members which helped develop their proficiency in this area.

Multidisciplinary working
There were several joint clinics running in outpatients where patients could see consultants from
different specialties in one appointment. This was particularly utilised in the bone clinic where there was input from a microbiology consultant.

There was input from physiotherapists to orthopaedic outpatients to support patient recovery from surgery and nurse led clinics in a range of specialties including oncology, urology and rheumatology.

**Seven-day services**
At the previous inspection we found that the department operated Monday to Friday only, despite available capacity to deliver a weekend service. This remained the case however managers we spoke with told us that weekend clinics had been trialled. When this happened there had been little uptake from patients and running the clinics did not prove financially or practically viable for the department.

**Health Promotion**
There was minimal health promotion information displayed around the department as new notice boards had just been installed and had not yet been filled. Managers told us that the notice boards would be used for this purpose.
There were patient information leaflets on a range of health issues such as use of antibiotics, surgical site infections, Clostridium difficile (C. diff) and methicillin-resistant Staphylococcus aureus (MRSA).

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**
Staff we spoke with had a good understanding of their responsibilities and the issues surrounding consent and mental capacity. Staff were aware of the Mental Capacity Act 2005 and we saw assessments of capacity recorded in patient notes.

Consent forms were completed in clinic and scanned into electronic patient records. We were told by staff we spoke with that where patients could not consent for themselves, family members would be involved in best interest decisions for the patient.

**Nursing staff**

**Trust level**
The trust reported that as at August 2018 Mental Capacity Act (MCA) training was completed by 90.5% staff in outpatient services compared to the trust target of 95.0%. The trust also reported that Deprivation of Liberty Safeguards training was completed by 90.5% of staff in outpatients, compared to the trust target of 95.0%. A breakdown of training completion can be found below.

<table>
<thead>
<tr>
<th>Module</th>
<th>Eligible</th>
<th>Trained</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Liberty</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
Stanmore outpatient department

The Stanmore outpatient department reported that as at August 2018 Mental Capacity Act (MCA) training was completed by 89.3% staff in outpatient services compared to the trust target of 95.0%. The Stanmore outpatient department also reported that Deprivation of Liberty Safeguards training was completed by 89.3% of staff in outpatients, compared to the trust target of 95.0%. A breakdown of training completion can be found below.

<table>
<thead>
<tr>
<th>Module</th>
<th>Eligible</th>
<th>Trained</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Liberty</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Is the service caring?

Compassionate care

On inspection we spoke to patients and their family members about the care they had received in the outpatients department. Patients told us that staff were caring and considerate and went out of their way to provide good care. We observed friendly, helpful interactions between staff and patients and saw staff going out of their way to assist patients in the department. Patients we spoke with told us that staff were very helpful and took time to help them get around the hospital and with transport.

Friends and Family Test (FFT) data provided by the trust showed that between May and November 2018 98.5% of patients would be likely to recommend the service, against 0.7% who said they would be unlikely, with a response rate of 12.7%. Managers we spoke with told us they had tried to improve the response rate by ensuring that all patients attending the department were giving the form to fill in before they left.

Consultations and procedures took place in private rooms with the doors closed which maintained patient privacy and dignity. Receptions in both waiting areas were very close to seating areas where other patients could overhear conversations. Receptionists we spoke to said that they would take patients to a room if they wanted to have a private conversation.

There were posters around the department advertising the availability of chaperones to accompany patients in their appointments if they wished. The trust chaperone policy set out the rights of patients to have a chaperone present at their appointment. Staff we spoke with confirmed that patients could be provided with a chaperone of the same gender when a consultation took place with a consultant of the opposite gender.
Emotional support
Staff demonstrated a good understanding of the emotional effect of long-term treatment and described ways that they would support patients emotionally such as use of side rooms to break bad news.

Patients we spoke with told us that staff treated them sensitively and there was good emotional support. There was a dedicated quiet room that staff could take patients to if they were visibly upset or if there was a need to have a difficult conversation.

There was a range of information leaflets available offering and advertising support available to patients to help deal with their conditions. These included leaflets about living with cancer.

The department ran a ‘book a buddy’ scheme where patients could arrange for a volunteer to accompany them to their appointment and wait with them in clinic.

Understanding and involvement of patients and those close to them
Patients we spoke with told us that clinicians involved them in the planning of their care and took time to answer their questions. Patients were provided with a range of information leaflets to help them understand their conditions. Patients and their relatives were involved in care planning and supported to make decisions about their care and treatment. We observed patients’ consultations with clinicians and saw that doctors took time to explain care and treatment to patients and answer their questions.

Patients were given information to go home with such as leaflets and had a good understanding of their follow-up appointments, contact with GPs and who to contact if they were worried. Patients were copied into letters sent to their GPs. However, some patients did tell us that the department could be difficult to reach on the phone. There were ‘Preferred Priorities for Care’ forms available for patients to indicate their preferences and needs for care at the end of their lives.

Is the service responsive?

Service delivery to meet the needs of local people
At the last inspection we found that the waiting areas in outpatients often became overcrowded. This remained the case; we observed on inspection that waiting areas became very busy when there were multiple clinics running. Managers we spoke with told us that they were concerned about the impact of this on the patient experience and were planning to rearrange the space to improve waiting times and flow.

The service received referrals from a nationwide catchment area. Managers we spoke with described extensive measures for supporting patients travelling from around the country to the site. There was a car park available for patients and a patient transport service.

From June 2017 to May 2018, the ‘did not attend’ rate for The Royal National Orthopaedic Hospital (Stanmore) was lower than the England average.

The chart below shows the ‘did not attend’ rate over time.
Proportion of patients who did not attend appointment, Royal National Orthopaedic Hospital NHS Trust.

(Source: Hospital Episode Statistics)

Some services made use of telephone clinics and managers we spoke with told us that they were hoping to roll out greater use of Skype and telephone clinics in the department.

Meeting people’s individual needs

There were orthopaedic chairs available in both patient waiting areas. There was a patient buggy service available to help patients with mobility problems to get around the hospital which ran each day that clinics were scheduled.

Patients with additional needs such as mental health problems, a learning disability or dementia were prioritised in clinics. There were dementia and learning disability lead nurses to support clinics.

We were told that prisoners attending the hospitals would arrive and leave the site with an escort and would wait in a clinic room for their appointment to be separate from other patients.

There were fully accessible toilets with dementia friendly signage including contrasting colours and pictures of toilets on the doors.

There was flexibility which allowed the service to respond to the needs of patients. Staff we spoke with described measures that could be taken such as bypassing the queue or scheduling patients at the end of the list. Patients with a learning disability could wait in private rooms.

There was a portable hearing loop in the department to support patients with hearing loss. The department used a telephone translation service for patients who did not speak English and could also book translators in advance of appointments. There were leaflets available in the five most common foreign languages spoken by patients and further languages could be requested.

Access and flow

We observed mostly good flow through patient clinics although the reception and waiting areas frequently became busy when many patients arrived for different clinics simultaneously.
Managers we spoke with told us they planned to stagger arrival times to address this problem. At the previous inspection we had found that there was not adequate seating for the volume of patients attending clinics, but this had improved.

There was an electronic notice board in the main patient waiting area which was used to inform patients about clinic delays.

Data provided by the trust showed that there was an average ‘did not attend’ (DNA) rate of 8.4% across all specialties between April and September 2018. The service used an automated text reminder service to try and reduce DNAs. Managers we spoke with informed us that they had recently added the cost to the NHS of missed appointments to the text and this seemed to be having an effect.

Referral to outpatient clinics was managed through the electronic referral system (ERS). From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been consistently worse than the England overall performance. The latest figures for July 2018, showed 85.1% of this group of patients were treated within 18 weeks versus the England average of 88.3%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Royal National Orthopaedic Hospital NHS Trust.

(Source: NHS England)

Three specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>100.0%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Specialty grouping</td>
<td>Result</td>
<td>England average</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Other</td>
<td>90.2%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>84.2%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>83.9%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>73.6%</td>
<td>81.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for incomplete pathways has been consistently better than the England overall performance. The latest figures for July 2018, showed 89.8% of this group of patients were treated within 18 weeks versus the England average of 87.3%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Royal National Orthopaedic Hospital NHS Trust.

(Source: NHS England)

Eight specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).
### Specialty grouping

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>100.0%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>97.5%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Urology</td>
<td>97.4%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>95.5%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Other</td>
<td>95.2%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>89.5%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>89.5%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

*(Source: NHS England)*

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral from July 2017 to June 2018. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Royal National Orthopaedic Hospital NHS Trust**

*(Source: NHS England – Cancer Waits)*

The trust is performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) from October 2017 to June 2018. The performance over time is shown in the graph below.
Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Royal National Orthopaedic Hospital NHS Trust

From July 2017 to June 2018 the trust is performed worse than the 85% operational standard and the England average for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Royal National Orthopaedic Hospital NHS Trust

Referral to treatment time (RTT) performance was monitored by each specialty and overseen by the service manager and an elective access manager. There was a weekly patient tracking list meeting attended by the specialties which ensured there was a plan for each patient on an RTT pathway. There was also a weekly access improvement task force meeting attended by senior operational managers and specialties to look at divisional performance and access problems in the department such as appointment slot issues.

Learning from complaints and concerns
For the period August 2017 to July 2018 there were no recorded compliments within outpatients.

The trust had stated that they were currently reviewing how compliments were captured and that they believed the number of compliments that has been reported is only a small proportion of the actual number of compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
A patient representative attended the monthly 'business as usual' meeting to provide the patient’s perspective on the running of the department and to feed into discussions about proposed changes and improvement work.

The department operated a scheme where patients could feed back about good care in the department via a dedicated form. The recipient of the positive feedback would then receive a badge.

The Patient Advice and Liaison Service (PALS) was located next to the outpatient department and was open Monday to Friday.

**Is the service well-led?**

**Leadership**
The outpatients department sat within the Children’s, Outpatients, Imaging and Access Division of the trust. The department was led by a management triumvirate including the general manager, head of nursing and the director of children’s services and outpatients who acted as the clinical lead. Below the triumvirate was a service manager and a lead nurse who respectively managed operational and clinical aspects of the service.

There were photographs of departmental and executive-level management displayed on the walls of the waiting area. Staff we spoke with felt familiar with departmental level management but told us that they did not often see executive management in the department.

Staff at all levels described their managers as friendly and approachable and told us they felt comfortable going to them with problems and suggestions. Managers told us that they promoted an open-door policy to staff and this seemed to be borne out in an open culture. Leaders of the service demonstrated to us in interviews a good understanding of the challenges facing the department and coherent strategies to address them. For instance, there was stronger leadership across the department on quality and performance and more robust ways to measure this than at our previous inspection.

**Vision and strategy**
Managers we spoke with had a clear strategy to continue to improve the quality and efficiency of the department and deliver sustainable care. The main priorities for managers were to continue to improve clinic utilisation to find further clinical capacity in the system and to improve cohesion between the Stanmore and Bolster Street sites. The service manager told us that his vision for the service was for the outpatients service to have oversight over clinic templates. We were told that previously the sub-specialities were devising their own templates, but greater efficiencies could be achieved if the outpatients service were responsible for templating. Templates looked at clinic slot timings and would take into consideration new and follow-up patients. Patients being assessed for the first time would need a longer appointment time.

The trust had four key values which were patients first, excellence, trust, honesty and respect, and equality. The trust values were advertised on posters around the department and staff we spoke with knew what the values were and had they applied to their work.
Progress against departmental strategy was reviewed at regular departmental level management meetings, both at a formal monthly meeting and informal meetings throughout the week.

Staff we spoke with were not able to describe the future plans for the department but were aware of the immediate priorities such as reducing patient waiting times.

**Culture**
Staff we spoke with told us that the outpatients team “works very well together” and the interactions between staff members of different levels of seniority we observed on inspection supported this. Staff told us that they felt supported by their colleagues and managers and they were positive about working for the trust and the care that patients received at the hospital. They told us that as it was a small hospital, everyone knew each other, and it was a “family atmosphere”.

There was a culture of openness and continual improvement in the department and staff were keen to put patients’ needs first. Nurses we spoke to told us that they got on well with consultants and it did not feel hierarchical but that everyone was part of the team. All staff we spoke with said they would feel comfortable raising concerns and reporting incidents. Staff who raised concerns were supported and told us that they were given feedback and that there was learning.

**Governance**
The triumvirate management team met weekly to discuss the running of the department. There was a weekly clinic room utilisation meeting which looked at outpatient activity across the week and monitored used of rooms and clinical capacity.

The elective access manager chaired a patient tracking list meeting which looked at the department’s referral to treatment times.

The monthly ‘Business as Usual’ meeting was chaired by the service manager. This meeting included representation from the patient group, nursing staff and volunteering services. Topics discussed in this meeting included estates, incidents, clinic times, outpatient activity, did not attend (DNAs), quality and safety.

There was a monthly ‘audit morning’ meeting for all staff to attend. This meeting included teaching sessions, news about the service, team building and discussion of incidents. It was also an open forum for staff to give feedback and ideas to departmental managers.

**Management of risk, issues and performance**
At the previous inspection we found that there was not adequate oversight of performance at a departmental level and that performance had been left to individual specialties to manage. This had now improved and there was now clearer governance of performance in the department. We heard from staff and managers we spoke with that the weekly clinical utilisation meeting had greatly improved oversight of problems such as late starting clinics and waiting times in clinic. There was also an opportunity to identify patterns of poor performance and address these with individual specialties.

There was a departmental risk register which was reflective of the risks we identified on inspection. The highest scoring risk for the outpatients department was that the department,
along with others close by, used too much power which could result in power outages. The risk register listed clear actions to mitigate the risk along with review dates and staff responsible.

There was a lone working policy in place and managers we spoke with were aware of the importance of keeping staff safe. Staff were not left alone in the department and security was made aware when patients who were known to be aggressive would be attending an appointment. However, in some consultation rooms computers were located in the corner away from the door meaning that patients would be between the door and the member of staff. Managers were aware of the risk this posed to staff safety and it was on the department’s risk register.

**Information management**
Managers of the service gathered information to inform performance monitoring and planning of the service. Since the previous inspection service managers had improved the outpatient clinic utilisation report to more efficiently gather informing on the use of rooms in the department.

Previously this information had been available on the trust patient administration system but could only be viewed by looking at individual clinics and managers were reliant on specialties to update them. More accurate data management also allowed managers to identify clinics which routinely ran over time or started late. Managers told us that late starts had improved 15% since the new system was put in place.

**Engagement**
One member of staff we spoke with told us “whenever there are changes happening, managers ask the opinions of staff” and it felt like “suggestions from staff would be considered”.

Managers had recently undertaken an extensive consultation relating to changes in the job roles of clerical staff and clinical support workers. They described how they had listened to staff views about the changes and tried to bring staff along with the plans.

The department used the friends and family test to gather patient feedback although there was an awareness that this was a “blunt instrument” for gathering views and there was a plan to develop a custom approach.

**Learning, continuous improvement and innovation**
Managers we spoke with told us that the new method for monitoring outpatient room utilisation had greatly improved their ability to make improvements to the service and find extra capacity. Managers had been invited by NHSi to present the tool to other trusts.
Royal National Orthopaedic Hospital NHS Trust

Evidence appendix (Bolsover Street)

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bolsover-street-london-w1

Date of inspection visit:
30 October to 29 November 2018

Date of publication:
22 March 2019

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

Facts and data about this service

The trust operates across two sites: Stanmore (inpatient and outpatient services) and Bolsover Street (outpatient services). The main outpatient department in Stanmore provides services for adult patients seeing clinical staff across all specialities. This facility provides 19 consultation rooms. Co-located but separate to the main department is a dedicated paediatric OPD, which has five consultation rooms. Bolsover street in central London provides outpatient, diagnostic and therapies services and consists of 11 consultation rooms.

(Source: Routine Provider Information Request)

Total number of first and follow up appointments compared to England

The trust had 135,870 first and follow up outpatient appointments from June 2017 to May 2018. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site
The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from June 2017 to May 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal National Orthopaedic Hospital (Stanmore)</td>
<td>109,614</td>
</tr>
<tr>
<td>Royal National Orthopaedic Hospital (Bolsover Street)</td>
<td>34,309</td>
</tr>
<tr>
<td>This Trust</td>
<td>143,923</td>
</tr>
<tr>
<td>England</td>
<td>106,785,632</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from June 2017 to May 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Royal National Orthopaedic Hospital NHS Trust from June 2017 to May 2018 by site and type of appointment.

(Is Source: Hospital Episode Statistics)

Is the service safe?

Mandatory Training

The trust set a target of 95.0% for completion of mandatory training.

A breakdown of compliance for mandatory training courses as at August 2018 for qualified nursing staff in outpatient department at Bolsover outpatient department is shown below:
At Bolsover outpatients department the 95.0% target was met for five of the seven mandatory training modules for which qualified nursing staff were eligible.

The trust provided training data which showed there were no medical staff categorised as outpatient services.

Some mandatory training was completed through attendance at taught sessions, with most training being completed online. ‘Grapevine’ was the intranet portal where staff accessed online training. ‘Grapevine’ had a ‘traffic light’ training records system, which indicated when training was due. Staff would receive a notification by email, or through staff meetings, of upcoming training sessions that required their attendance.

A clinical support worker told us that the Band 6 nurses, who worked beneath the Band 7 senior nurse, were very good at organising training for all the staff. They ensured that training was delivered at the hospital in an environment and clinical setting that was familiar to those who worked there, instead of having to travel to Stanmore to undertake their training.

### Safeguarding

The trust set a target of 95.0% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from as at August 2018 for qualified nursing staff in the outpatient department at Bolsover is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Safeguarding Adults
Level 3

|   | 0 | 1 | 0.0% | 95.0% | No |

At Bolsover outpatients department the 95.0% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible. The senior nurse had not yet completed her Safeguarding Adults Level 3 training but had a date confirmed for the end of the year to get it completed. We were told that recent changes in who completed Safeguarding Adults Level 3 training meant that the senior nurse was showing as non-compliant because previously they hadn’t needed to complete it.

The trust provided training data which showed there were no medical staff categorised as outpatient services.

We observed good information on safeguarding on the intranet, and laminated posters in the ‘pod’ area (a central clinic area for staff to meet) of the department, as well as in the consulting rooms. Staff were trained to Level 2 and knew who to contact if they needed to escalate concerns.

The senior nurse told us that there had been a lot of new guidance released in relation to safeguarding, specifically around domestic violence, with a greater awareness of vulnerable adults.

**Cleanliness, infection control and hygiene**

Daily room cleaning checks were carried out by clinic staff setting. Records of these were seen on inspection and they were fully completed and up to date. Personal protective equipment (PPE) was available in all consulting rooms and areas, which included: aprons, gloves and masks.

There were handwashing facilities in all rooms, and hand gel dispensers outside each consulting room. We did however see that one gel dispenser had been out of order since August 2018. This had been reported to estates regularly but had still not been resolved. However, there were alternative gel dispensers on the sink within the clinic room.

Cleaning was managed by an external facilities provider, who maintained a presence at the hospital throughout the day; we spoke with the supervisor from this provider, as well as a porter who was also employed under the provider. The provider was responsible for re-stocking of hand gels, washing soap and PPE. The staff working directly for the provider were trained by their own company to manage hospital cleaning, including spillages of bodily fluids and drugs. Nurses working for the trust were responsible for cleaning an initial spill, and then the external provider would follow-up with another clean. A spill kit was also available.

The external provider was also responsible for Legionnaires testing, which they were completing.

All areas were cleaned daily, and a deeper clean took place after 4pm when there were fewer patients in the department. Clinic curtains were changed every 6 months, and we were shown a log of this. The toilets were checked every two hours and more often if requested. Records in each toilet were up to date. Toys that were available for children to play with in the patient waiting areas and were cleaned after use, as well as weekly, and we were shown a log to evidence this.
Hand hygiene audits were completed monthly and the results for September 2018 showed 95% compliance and were visibly displayed across the hospital.

Clinical waste and dirty laundry were held in a locked store until collected by a waste management company.

**Environment and equipment**
We inspected the resuscitation trolley on the second floor of the clinic. Records looked at showed that daily checks were completed; a tamper-proof tag was replaced following a daily check being completed. The trolley had a folder of instructions for staff to follow, which would support them in completing their daily checks. All expiry dates for drugs kept in the trolley were logged and one registered nurse was responsible for re-ordering drugs which were soon to expire.

There was a cardiac ‘grab bag’ in the ‘pod’ (a central clinic area in the hospital for staff to meet) and this was checked weekly. We saw evidence of this.

Portable Appliance Testing (PAT) was managed by the estates team and the equipment that we looked at was up to date, with a future testing scheduled for August 2019. The equipment looked at included: a blood pressure machine, treadmill (for physiotherapy patients), suction machine, centrifuge, exercise cycle, echocardiogram (ECG) and a scale.

A moving and handling chair was available in the stairwell for the evacuation of patients in case there was a fire, or the lifts were out of order. Major incident equipment was available on the ground floor of the hospital and this included: high visibility vests, a megaphone and log book. Major incidents were managed by the most senior person by salary banding in the hospital. A senior person from each floor would be assigned and would be responsible for the evacuation of floor within the hospital in the event of a major incident.

**Assessing and responding to patient risk**
All policies and procedures pertaining to patient risk and care were available on the intranet, with some hard copies being kept in the pod areas.

Patients deteriorating in clinic would be moved into a consulting room and would be monitored by a nurse and 999 would be called for patients needing a hospital admission.

Patients living with mental health problems or a learning disability would have been identified prior to their attendance and would be accompanied by their carer. We were told by a medical member of staff who told us that they had not had to deal with a patient who had been living with mental health problems and such patients were identified early, with enough time organised for consultation. Patients with special needs or those with mental health problems would usually have their own support worker when they attended.

If patients presented with stress-related issues from chronic pain, there were services available for the patient to access support and the patient would be referred to the psychology team on site.
Facilities were available to provide longer appointment times if required, and larger rooms to accommodate wheelchairs and equipment.

**Nurse staffing**

The senior nurse working in the service told us that e-rostering had helped manage staffing levels and skill mix and the service had the right mix of RGNs and CSWs.

The service would usually have one clinical support worker (CSW) on training. The role of the CSW encompassed administration and clinical duties, with their induction into the organisation reflecting this. They would receive a basic induction at Stanmore Hospital and a local induction would take place on the ground floor and first floor of Bolsover Street Hospital.

CSWs would be expected to work in the medical records and treatment rooms and the Band 5 registered nurses (RGNs) would be expected to team lead in their role.

The induction was individualised according to need. Band 7s were nurse practitioners.

We saw that the whiteboard had information from the handover that morning which showed staff breaks and sickness for all the team to see.

The trust has reported their staffing numbers for outpatients below for the period April 2018 to July 2018 for outpatients. A breakdown by site is below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolsover</td>
<td>6.4</td>
<td>6.4</td>
</tr>
<tr>
<td>Stanmore</td>
<td>18.3</td>
<td>11.9</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From August 2017 to July 2018, the trust reported a vacancy rate of 18.6% for qualified nursing staff in outpatients. This did not meet the trust target of 9.5% for vacancy.

- Bolsover: surplus of 5.5%
- Stanmore: 27.1%

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

At the time of our inspection, the senior nurse told us that there were no current vacancies within the service.
Turnover rates
From August 2017 to July 2018, the trust reported a turnover rate of 5.0% in outpatients, the trust did not provide turnover broken down by site.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From August 2017 to July 2018, the trust reported a sickness rate of 2.9% in outpatients.
- Bolsover: 0.8%
- Stanmore: 3.9%
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage
From August 2017 to July 2018, the trust reported a bank usage rate of 9.7%, an agency usage rate of 0.0% and 0.6% unfilled in the outpatient department. The trust only reported bank and agency usage figures for Bolsover Street.
(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)
The senior nurse told us that the service did not use agency staff but bank staff from the Stanmore Hospital would be used if needed.

Medical staffing
The trust provided staffing data which showed there were no medical staff categorised as outpatient services.

We spoke with an ST3 (speciality trainee doctor) who felt that there was good support and training provided. All patients would see a consultant. They did however state that there was no facility for internal referrals for other conditions because the clinical commissioning group would not support this, which was felt to represent poor patient care.

No out-of-hours cover was required on-site as the clinic closed at 8pm. No locum cover was used.

Records
Patient notes were prepared one week before attendance. All investigations, referral letters and information were collated and if necessary, chased up to be available for the clinic consultation.

All notes were checked by a CSW before each clinic to ensure that all notes, x-rays and investigation results were present. Any outstanding tests that a patient needed would have been ordered.

We examined seven sets of electronic notes and we saw that drug treatment charts were completed and we saw GP letters and copies that would have been sent to patients and other agencies were available within the patients’ files. We also examined venous thromboembolism (VTE) assessments which were completed where appropriate.
We were told that no patients were ever seen without their notes. Staff told us that the electronic system for accessing patient records was very user friendly for staff to navigate.

**Medicines**

Very few medicines were kept onsite, with paracetamol available for mild pain. Keys to open medicines cupboards were kept in a key press cabinet which registered general nurses (RGNs) had access to. FP10s were kept in a separate cabinet with a log that had been completed. Photocopies of any prescriptions were also kept.

Any medicines prescribed in a clinic were written on a prescription chart which was scanned into the electronic patient record system.

The contents of the medicines kept in medicines cupboards that we looked in were all in date. Fridge temperature checks were completed daily, and we saw a log to evidence this. We were told that if the fridge temperatures fell out of range, the issue would be reported to the estates team.

RGNs were responsible for re-ordering medicines and there was a courier that ran a service between Stanmore and Bolsover Street Hospital twice a day.

**Incidents**

**Never Events**

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

From September 2017 to August 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from September 2017 to August 2018.

(Source: Strategic Executive Information System (STEIS))

The incident reporting system was easily accessible through the intranet, and there was an option on the form to request feedback for any incident report submitted. Feedback from incidents were cascaded to staff via staff meetings or via email.

All staff were aware of how to report incidents and what circumstances would constitute when an incident would need to be completed. We were shown a completed incident form by a member of staff.
Is the service effective?

Evidence-based care and treatment
The outpatients centre at Bolsover Street is a tertiary referral centre and we saw evidence of the service following National Institute of Health and Care Excellence (NICE) guidance, including complex fractures assessment and management, VTE prophylaxis and infection control appropriate for this outpatient setting. We saw evidence of sarcoma multidisciplinary team working and written protocols available with a specialist team.

Local policies and procedures were available on ‘Grapevine’ which was accessible from all staff computers. We asked the sister in charge, a nurse and a clinical support worker (CSW) to show us how they would access policies and guidelines, and they went through the steps of showing us how they could view these.

There were ongoing internal audits for hand hygiene, waiting times and clinic start times. We saw evidence in one of the clinic rooms of the hand hygiene audit that was taking place, with 95% compliance in this measure for September 2018.

The structure of the clinic and an interview with an ST3 doctor showed evidence of an individualised management plan for patients. This was also reflected in the detailed letters following consultations seen in the seven electronic medical records that we looked at.

Research activity did not happen at this outpatient setting, and we did not see evidence of mental health assessments. On looking at notes, most patients were referrals from other centres and it is likely that mental health assessments had already been completed. GP letters held most of the information and the seven medical records that we looked at did not have any mental health assessment completed, though it appeared that these patients did not need one.

Nutrition and hydration
There was a shop available in the entrance lobby, which sold a variety of food including gluten-free, as well as lactose-free food items. There was a water fountain available in the waiting area on the first floor of the building.

The nature of the outpatient setting meant that nutritional management plans were not pertinent.

Pain relief
As Bolsover Street was not an acute setting, the need for generic pain relief was low. If needed, prescriptions were issued on an FP10, where medication like paracetamol would be dispensed in-house.

There was a pain clinic that occurred on a Friday. This was run by a pain consultant and specialist nurse team. The pack for this clinic included assessment and management tools for pain. Recorded pain scores were seen from the electronic medical records of patients.

Patient outcomes
Outcome data was routinely collected and fed into the central systems at the main RNOH site at Stanmore. Audits were led by individual specialties.
The complex nature of patients, such as in relation to peripheral nerve injuries, meant that this hospital site set the benchmark for other institutions internationally who do similar work. Most peer-reviewed papers on this condition were from this hospital.

**Follow-up to new rate**
From June 2017 to May 2018,
- the follow-up to new rate for Royal National Orthopaedic Hospital (Bolsover Street) was higher than the England average, except for March 2018 when the rate dropped lower than the England average.
- the follow-up to new rate for The Royal National Orthopaedic Hospital (Stanmore) was higher than the England average, except for March 2018 when the rate dropped lower than the England average.

**Follow-up to new rate, Royal National Orthopaedic Hospital NHS Trust.**

(Source: Hospital Episode Statistics)

**Competent staff**

**Appraisal rates**
From April 2017 to March 2018, 87.5% of staff within outpatient department at Bolsover Street Hospital received an appraisal compared to a trust target of 92.0%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
</tbody>
</table>
We interviewed two nurses and three CSWs who confirmed that they had received regular appraisals and continuing professional development (CPD). CPD opportunities were made available to them, with funding available for external courses. Consultants' appraisals and revalidation happened at Stanmore Hospital.

Annual appraisals had been carried out and any other training needs or requests were identified.

There were specialist nurses for pain, sarcoma and rheumatology.

We were told by a staff nurse working in medical records that new starters would receive an organisational induction at the Stanmore site, followed by an induction on site at Bolsover Street.

There were currently no vacancies in the service and the only new inductees into the service were clinical support workers (CSWs). The CSWs had clerical duties attached to their clinical roles and we were told that their onsite induction was individualised to the needs of that staff member.

**Multidisciplinary working**

MDT working occurred in a multidisciplinary setting with consultants of different sub-specialities mirroring their job plans, and therapists and specialist nurses being available at the same time. Discussion with consultants and trainees indicated other forms of joined up working with oncology teams and electro-physiology teams linked into meetings with dial in facilities.

**Seven-day services**

There were no weekend clinics taking place at the hospital, though the service did trial weekend working for three months previously. A senior nurse told us that the hospital did not receive much business during this trial and that to continue would not have been financially viable.

**Health Promotion**

We did not see any leaflets on health promotion displayed around the clinic however the senior nurse told us that leaflets and information sheets were kept in boxes in clinic rooms because the hospital were not allowed to hang posters on the wall due to any wall surfaces being made from glass, as well as the hospital’s lease agreement. In addition to this, leaflets could be downloaded from the internal trust intranet to give to patients. We saw evidence of health promotion in the electronic patient records system and pre-operative assessment documentation, i.e. asking for smoking history. We saw a nurse talking to a patient about contraception, weight reduction and smoking cessation.

There were no crisps or sweets on immediate display in the hospital cafeteria. This was a conscious decision supporting national priorities.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

A senior nurse told us that there was no dementia champion on-site, but all staff have had DoLS and MCA training which was up to date.
There was a flow chart to assess mental capacity which was kept in the 'pod' (a central clinic area for staff to meet) and staff we spoke with were aware of the escalation pathway.

A policy was accessible on the intranet and was also displayed in clinical areas. Discussions with the sister in charge showed that she was aware of the difference and similarities of the safeguarding, DoLS and MCA policies.

Consent forms were signed and scanned onto the electronic patient records system. A comprehensive letter would precede the consent form. We were told by a consultant that if there was an issue with consenting patients then two consultants would assess the patient and consent for the patient would be carried out in the patient’s best interest in collaboration with family members where applicable.

The Bolsover outpatient department reported that as at August 2018 Mental Capacity Act (MCA) training was completed by 100.0% staff in outpatient services compared to the trust target of 95.0%. The Bolsover outpatient department also reported that Deprivation of Liberty Safeguards training was completed by 100.0% of staff in outpatients, compared to the trust target of 95.0%. A breakdown of training completion can be found below.

<table>
<thead>
<tr>
<th>Module</th>
<th>Eligible</th>
<th>Trained</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Liberty</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Is the service caring?**

**Compassionate care**

We spoke with a mother who was attending an orthotics clinic with her son. They described the hospital as being “superb” and that they were very happy with the quality of care that their son was receiving, stating that reception staff, consultants and therapists were all involved in their son’s care. They stated the hospital was “second to none” and that they had been to other hospitals where they found care to be lacking. The parent said that they would recommend the hospital to anyone.

We asked a patient who had been visiting the hospital since they were 18 months old what they would tell other people about Bolsover Street Hospital. They responded by saying that they liked attending the hospital because it was bright and clean and staff members were “so nice”. They felt they could talk to the doctor and that they were very kind.

A patient told us that Bolsover Street was the best hospital to receive care, and that they wouldn’t want to go elsewhere. The patient told us that they had requested to attend the hospital via their GP. They confirmed that their treatment was working well for them and being able to see the same consultant on each visit meant that they received continuity of care. Their consultant was described as “good” and the information they received was of a good quality. This patient told us that they had not been encouraged to complete a Friends and Family Test (FFT) survey.
We saw FFT survey slips available at the main reception for patients to complete, as well as an ‘Outpatients Feedback’ form. We asked a receptionist working at the orthotics clinic whether they encouraged patients to fill in the FFT surveys. They told us that they did not encourage as much because it would be offered at the main reception.

Staff at the hospital were described as “brilliant” and “knowing their stuff” by patients. Patients confirmed that their carers or family members would always be invited into the patient’s appointment. This patient told us that they were encouraged to complete the FFT survey, but it was not pushed on them. We found that because many patients were returning patients, having already completed the FFT survey at a prior visit, they would be less compelled to complete a new survey for each episode of care, and as a result was contributing to the low uptake of the FFT response rate.

Emotional support
A patient told us that counselling support was offered to them, though they did not require it. They told us that there was always a chaperone in the room with them when they see the doctor and the hospital would provide them with a female physiotherapist as per their request.

Patients who had received distressing news such as a cancer diagnosis were seen with a nurse with specialist qualifications and skills in cancer care. The service also had these specialist nurses available for appointments with paediatric patients if needed. There were quiet rooms that patients could go into with the nurse to process the information following their consultation.

Understanding and involvement of patients and those close to them
We spoke with a patient waiting for a consultation outside the shoulder clinic. They told us that their condition had been ongoing for six months, having previously been treated at a local hospital but had been dissatisfied with their care. Following the patient’s consultation, they told us that their consultation had gone well. They were happy with the outcome of the clinic and all options had been explained by the doctor, with a care plan put in place.

A patient told us that they had received good quality care, having had many appointments at the hospital. They confirmed that information had been provided to them in a way in which they were able to understand, with pictures being drawn for them to help them understand their condition. They stated that they were often shown their MRI and X-ray scans and were given an interpretation of what the results of these scans meant.

Is the service responsive?

Service delivery to meet the needs of local people
The service delivered services to a nationwide catchment, with patients attending from all over the country. There was no car park available at this site for patients or for staff. There were however seven allocated car parking spaces available for the consultants who worked at the hospital. Bolsover Street Hospital is based in Central London, and had good transportation links to the hospital, with two mainline train stations within a 0.7 and 1.5-mile radius. Signposting in the hospital was visible and clear and we observed volunteers helping and assisting patients on the first floor of the hospital.
The hospital had a service level agreement with a transportation provider. Eligible patients could arrive to and from the hospital using this transportation provider.

The hospital was open between 7.30am and 8pm. Evening clinics were available for patients who worked business hours. All patient appointments were planned to be 30 minutes long, but doctors could request to over-book their clinics in urgent cases for patients. We were told by a clinical support worker that patients had greater flexibility over their appointments, particularly those patients who would attend the brain tumour clinic and may have had additional appointments at the Bolsover Street Hospital or a hospital elsewhere.

We were told that there was the option to change appointments if spaces were available in other clinics and patients could also be moved to the Stanmore site if spaces were available in those clinics. Staff told us that follow-up clinics for patients occurred six weeks post-surgery and then following this, every three to six months, then reducing to yearly, two-yearly clinics. A clinical nurse specialist-run telephone clinics existed for patients being seen for chronic pain. The service manager told us that the service wanted to increase the use of telephone consultations, especially for those patients who travelled from afar, as well as for appointments that could achieve the same outcomes over the phone.

We observed reception staff calling patients to remind them of their appointments, providing them with directions to the hospital, and advising patients as to which floor their appointment was on.

We found letters sent to patients about their appointment times to be very informative, listing the date and time of appointment; the contact number of the department they needed to visit - not the general reception desk number; the address of the hospital, with instructions on how to access information about transportation on the trust’s website. A note in the letter also informed patients that they could expect to receive a text message reminder about their forthcoming appointment. A map was enclosed with the letter for new patients visiting the hospital for the first time. Patients were asked to arrive 30 mins before their appointment in the event that a diagnostic scan was required. The electronic patient record system would flag up in red if a patient required any adjustments, or for staff to follow any particular precautions, for instance for a patient who was infected with MRSA, needed an interpreter, was deemed vulnerable and at risk, or had a brain tumour.

**Meeting people’s individual needs**

There were televisions available in the clinic waiting areas, though they were on mute with English subtitles. There was reading material available for all age groups including young children.

Toys were available in the waiting areas for children attending the department. The toys seen included colourful children’s chairs and a box of hard colourful plastic toys. The main children’s play area was located on the lower ground floor of the hospital. If paediatric patients wanted to play in this area, family members could take a hospital issued pager and allow their children to play in the waiting area with the child until the pager alerted them that they were due next to be seen for their appointment. The pagers also worked within 10 metres of the hospital so if patients wanted to go outside they could do so. Staff would always take note of the patient’s mobile number to contact them for their appointment if that patient chose to leave the hospital for a short while.
Patients and relatives had access to a small café on the ground floor of the hospital. Patients benefited from a choice of gluten free sandwich and brownie options, vegetarian options, and cow’s milk replacements such as soya milk. There were water dispensers available to patients on all floors. We saw that cups were available with all the dispensers.

Patients with specialist needs such as those living with dementia, mental health problems or with a learning disability were prioritised for clinics, often being seen first. There were no dementia champions or link nurses for safeguarding or learning disabilities on-site, but they were based at the Stanmore Hospital, which staff could access if they needed. We were told that prisoners visiting the hospital would arrive with an escort and would be kept in a clinic room until it was time for their appointment, so that their presence did not distress other patients or put them in direct contact with children. These patients were also prioritised and seen first.

The chairs in the waiting areas for adults were a mixture of high and low-backed chairs. In addition to this, there were low seated chairs and sofas, with and without armrests, suitable for patients with reduced mobility. There were no chairs available for bariatric patients. There was a hoist available to lift patients if needed and we were told this was kept in the imaging department on the lower ground floor, to which we were told that there were never any issues in accessing. However, most patients were weight bearing and were mobile so any need to use the hoist was seldom.

We saw information leaflets were available on the first floor of the hospital. Some of the information leaflets included: ‘A patient guide to using alcohol gel’; ‘Arthritis research UK’ and ‘Information for local residents – for reviewing adult elective orthopaedic surgery in North Central London and we’d like your views…’. These information leaflets were in English only. Staff told us that information was provided in English because this suited the needs of those visiting the hospital. However, a consultant told us that they had access to information in different languages, both on the intranet and internet, and that these could be easily printed off.

Support leaflets for adults were available if required and could be printed off for patients when needed. Children would often visit the hospital with a family member so would have their family to support and advocate for them, as well as a paediatrician trained in psychological support.

If a patient was to barricade the door, the consultant would be able to call for help by using the phone or by pushing an emergency call button for assistance.

A clinician told us that the arrangement of seating outside the clinical rooms was good in preventing overcrowding in the waiting areas, and reduced the amount of time used to call the next patient in.

A consultant told us that if a patient presented with signs of dementia then they would complete a mental health assessment for that patient.

If a consultant assessed a patient and was to refer the patient for physiotherapy, then the patient could see a physiotherapist on that same day.
The hospital could book interpreters with an interpreting agency and patients needing an interpreter would be flagged on the appointment system – with access to telephone interpreters and face-to-face interpreters. Staff told us that where applicable, interpreters were always booked in advance. We were given an example of where if an interpreter was required promptly, then a consultant would use a service called ‘Word Call’ for over-the-phone translation services. Staff told us that they would not use family members for their interpretation requirements.

We observed that there were unisex toilets available, with foot-operated bins. Disabled toilets were available with large hand rails and emergency call bells and motion sensor operated bins. All disabled toilets were furnished with baby changing facilities.

Nursing staff told us that fire doors were left open for easy access for patients with mobility constraints. However, they would automatically shut if the fire alarm was to go off. We were told that if a consultant was to request an urgent surgical intervention for a patient, then basic screening for surgery could be carried out on site, with baseline observations taken.

There were one-stop clinics for patients to see a consultant post-surgery who required their dressings to be changed. They would first see their consultant and then visit the ground floor to get their dressings changed or receive a plaster.

The senior nurse told us that every clinic had an allocated nurse or clinic support worker who would act as a chaperone to a patient. There were chaperoning leaflets in some of the clinic rooms that we visited.

Access and flow

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been consistently worse than the England overall performance. The latest figures for July 2018, showed 85.1% of this group of patients were treated within 18 weeks versus the England average of 88.3%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Royal National Orthopaedic Hospital NHS Trust.**

--- This Trust --- England Avg.
Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Three specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>100.0%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>92.1%</td>
<td>88.5%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>90.2%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>84.2%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>83.9%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>73.6%</td>
<td>81.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for incomplete pathways has been consistently better than the England overall performance. The latest figures for July 2018, showed 89.8% of this group of patients were treated within 18 weeks versus the England average of 87.3%.

(Source: NHS England)
Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Royal National Orthopaedic Hospital NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Eight specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>100.0%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>97.5%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Urology</td>
<td>97.4%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>95.5%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Other</td>
<td>95.2%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>89.5%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>89.5%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)
The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral from July 2017 to June 2018. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Royal National Orthopaedic Hospital NHS Trust**

![Graph showing percentage of people seen by a specialist within 2 weeks of an urgent GP referral.](image)

(Source: NHS England – Cancer Waits)

**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

The trust is performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) from October 2017 to June 2018. The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Royal National Orthopaedic Hospital NHS Trust**

![Graph showing percentage of people waiting less than 31 days from diagnosis to first definitive treatment.](image)

(Source: NHS England – Cancer Waits)

**Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

From July 2017 to June 2018 the trust is performed worse than the 85% operational standard and the England average for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.
Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Royal National Orthopaedic Hospital NHS Trust

Did not attend rate

From June 2017 to May 2018,

- the ‘did not attend’ rate for Royal National Orthopaedic Hospital (Bolsover Street) was similar to the England average, with the exception of March 2018 when the rate dropped lower than the England average.
- the ‘did not attend’ rate for The Royal National Orthopaedic Hospital (Stanmore) was lower than the England average.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Royal National Orthopaedic Hospital NHS Trust.

(Source: Hospital Episode Statistics)

We spoke to medical staff who told us that their own DNA and cancellation rates were quite low but recognised that the hospital overall had a high DNA rate. The last cancellation they recalled for themselves was due to a patient experiencing transportation issues.

(Source: NHS England – Cancer Waits)
The service manager told us that DNA rates were discussed at the monthly ‘Outpatients Meeting’ and weekly ‘Business as Usual’ meeting where DNA rates were looked at on a scorecard. DNA rates were higher at the Bolsover street location, and the reasons given were that it could have been due to the location of the hospital, which falls within the congestion charging zone, making it expensive and difficult for patients to find parking. It was recognised that patients preferred to drive and would opt to visit the Stanmore Hospital because parking was available at that site. It was also cited that seasonal variations played a factor in the high DNA rates, with DNA rates peaking in August, potentially because of summer holiday season. The hospital was looking at a trial in the specialities that had the highest DNA rates, sending a text message to patients three days before their visit to remind them of their impending appointment.

We spoke to a consultant who told us that 70% - 80% of referrals came from other consultants within the NHS, where surgeries have not given a patient a desired outcome. 20% of referrals come directly from GPs and named referrals, with some referrals coming from the ‘choose and book’ option (a service where patients can choose their hospital or clinic and book their first appointment).

A medic told us that there was never an issue with clinic room space, and there was always a room available. There were never any issues with logins to access the IT systems and if there was an issue IT support was a phone call away.

The service manager we spoke with told us that the hospital had been very compliant in meeting 18-week referral to treatment (RTT) targets, and this had been the result of work undertaken around capacity monitoring. Capacity monitoring had been introduced to assess the level of clinic room usage at the hospital and weekly meetings that would monitor capacity would look at variables such as the number of patients booked in for a clinic, under-booking and/or overbooking of clinics and cancellations of clinics.

We sat and observed the clinic areas and saw that patient flow was good. Seven patients that we observed did not have to wait long for their appointment after checking in. Patients were invited to have investigations and were accompanied by a CSW or other member of staff. Staff told us that they would always inform patients of delays where applicable.

**Learning from complaints and concerns**

We spoke to a consultant who told us that the last complaint that they had received was in relation to poor communication from nursing staff and a junior doctor. The patient had left a message with the consultant’s secretary (the patient has been under the care of this consultant for some time), to which the consultant called the patient back and resolved the matter over the telephone. We were told that this complaint was been logged formally and this was corroborated with the service manager. The patient had received a written response within the 28-day time frame set out in the trust’s complaints policy.

Staff told us that complaints were minimal and the theme of the complaints that they were aware of pertained to patients not receiving a discharge slip when being discharged from the hospital. There were feedback leaflets available in the waiting area on the first floor, entitled ‘if you think so…say so’. This leaflet encouraged patients and their carers to make suggestions, comments and compliments about their time in the service.
The senior nurse told us that complaints were often about waiting times and not being kept informed of any delays in being seen for their appointment. We were told that it was the responsibility of the person running the clinic to deal with the complainant face to face for informal complaints made on the day of the patient’s visit. Following this, the complaint could then be escalated to the nurse in charge and then further up the reporting channels to the sister in charge if deemed necessary. We were told that it was very rare for the service to receive formal complaints.

Waiting times for transportation was also highlighted as a theme of the informal complaints that were received. We were told that the trust had just extended their contract with a transportation provider, and the extension of this contract included a new ‘specifications and transport policy’. Within this policy, it stated the provider’s responsibility to respond to formal complaints made to the Patient Advice and Liaison Service (PALS), and to respond to queries and incidents; all to be completed within the trust’s specified timeframes. The transportation provider had also created a new team within their service to deal with the quality of transport. In the future, the trust was hoping to be able to share additional information with the transportation service and allow the transportation drivers to access the patient administration system (PAS). This system could be used to see the location of a patient within the hospital, such as the ward and the floor the patient was on, as well as information regarding clinic cancelations, and patient cancelations.

The service manager told us that the process for managing formal complaints were that they would be flagged to the divisional leadership team and then to the clinical director. Complaints would have a 28-day turnaround time for response, which the hospital was meeting. The hospital was also meeting the two-day acknowledgement time for formal complaints received.

Is the service well led?

Leadership
The outpatients service sat within the ‘Children’s, Outpatients, Imaging and Access Division’. This department was overseen by a Director for Outpatients, with reporting lines upwards to this person from a lead nurse, service manager, head of nursing and general manager. A lead nurse oversaw the day-to-day running of the outpatients department.

The senior sister at Bolsover Street had recently increased her working week to three days. Working under her, were two Band 6 nurses who worked full time.

Staff told us that the lead nurse and the head of nursing for outpatients seldom visited, and that the last time that they had was some five months prior. We were told that this was probably due to the fact that Bolsover Street was seen as a “safe environment”, with very few problems. To address this the service manager told us that he visited the service once a week and this had been corroborated by other staff working at the hospital.

The senior nurse at Bolsover Street Hospital was responsible if things went wrong, with the triumvirate team being available over the phone if the senior nurse needed assistance. The senior nurse told us that if she had any operational issues, then she would call the general manager and if there were any nursing issues then they would contact the lead nurse.

Vision and strategy
The service manager told us that there had been an outpatients away day recently and discussions on this day centred around pushing for an improvement in clinic utilisation and patient experience. We were told that this was currently being looked at through the weekly ‘Outpatients Utilisation’ meeting, with the service taking a two week forward looking view at outpatients activity across the two hospitals within the trust and monitoring which consultants were occupying which clinic rooms. There had previously been huge waiting times for patients, but the trust was trying to get the sub-specialities to be accountable for their clinics and how they were run so that there were fewer clinics overrunning.

The service manager told us that his vision for the service was for the outpatients service to have oversight over clinic templates. We were told that previously the sub-specialities were devising their own templates, but greater efficiencies could be achieved if the outpatients service were responsible for templating. Templates looked at clinic slot timings and would take into consideration new and follow-up patients. Patients being assessed for the first time would need a longer appointment time.

The trust values went by an acronym PETE, which stood for: Patients first; Excellence; Trust and Equality. Staff were able to tell us what the values were and what these values meant to them and how they would apply them in their work. We were told that the value ‘Patients first’, was the value that garnered the most focus, and we were given an example of where statistics for a particular month showed that 90% of clinics were routinely starting on time, and this demonstrated that patients were being put first. We were told that the last two values in the acronym were encompassed in the trust’s chartered programme, which was an initiative being led by the HR department, which would encourage staff to have more effective communication with one another.

**Culture**

We spoke with the senior sister in the service who told us that she loved working at the Bolsover Street site, with the purpose-built building further enhancing why she loved working in the building and service. They described the team of staff that they had as being “fantastic” and being able to rely on every single member of staff. The senior sister further described the team as being “supportive”, “welcoming” and doing anything to make staff and patient life better. We were given an example of where a staff member who had experienced a bereavement had to go off on compassionate leave, and other members of staff all coming together to determine how they could provide cover in their colleague’s absence, all demonstrating a keenness to help the senior sister cover that post.

The senior sister described fostering a culture in which staff took ownership and responsibility of what they did, which would lead to better outcomes for the patient. Where appropriate, staff felt confident to have a certain degree of autonomy.

**Governance**

An Outpatients Utilisation meeting took place weekly, which looked at outpatients activity that took place at the two hospitals, which we were told was a way for the service to monitor which consultants were in which clinic rooms.

A Business as Usual (BAU) was chaired by the service manager. This meeting had representation from a patient group, operational staff, nursing staff, and volunteering services.
Topics discussed in this meeting were about the estates, incidents, start and finish times, outpatient activity, DNAs, quality or anything that needs to be discussed on the risk register and transportation. This meeting normally took place at the Stanmore Site, but the service was looking at holding one out of every three of these meetings at the Bolsover Street Hospital.

The service manager would also chair a patient tracking list meeting which would look at how referral to treatment time targets could be achieved and sustained.

The divisional triumvirate team would meet weekly and there was a monthly operational meeting with an external transportation provider.

We saw team meeting minutes for the outpatients team at Bolsover Street. Items discussed in this meeting which took place on the 28 September 2018 included: incidents, shortages of staff at the Stanmore Hospital and how staff at Bolsover Street could be asked at short notice to go and work there on a rotational basis, Friends and Family Test and complaints in relation to the transportation provider and how those complaints should be managed.

Management of risk, issues and performance
We observed that the hospital had six risks on their risk register. The senior nurse was sighted on these risks and provided us with mitigations for some of the risks that we identified that could compromise patient care. One of the risks identified were patient areas being unsupervised and causing risk to patients who may be steady or unwell. The senior nurse told us that the estates team had commissioned a company to appraise the department and provide a quote regarding CCTV monitoring, as this would allow the receptionists working in the hospital to view the waiting areas of their floors, which were designed in a horse shoe shape. We were told that with the implementation of the CCTV monitoring, the porters would be able to view footage of all floors of the hospital.

A patient lift was malfunctioning approximately every month. This had been listed on the risk register and we were told by the senior nurse that the staff lift could be used as a backup, with staff escorting patients in and out of this lift.

Blockages in the drainage system were causing water and sewage to overflow into rooms of the basement at the hospital. We were told that this was an ongoing issue and every time it occurred, it would be reported to estates who would source contractors to get it cleaned. The senior nurse told us that the cause of this problem was to do with the flats above and to the side of the hospital, and each time it happened, it would be reported straight away.

Information management
Staff told us that there were never any issues with IT or data security. We were given an example of where a staff member had to call IT to resolve an issue for them because they had been on annual leave for an extended period and had forgotten their password. They described IT as being very responsive and resolving the issue within a matter of minutes.

Engagement
The senior nurse described going out into the patient waiting areas of the hospital to capture the views and experiences of patients and their carers. A patient forum would take place annually, where existing and former patients would attend and give their view on how the service could be
improved. A member of the patient forum would attend the ‘Business as Usual’ meetings. The senior nurse told us that she would use patients’ negative feedback to make improvements in the service.

The senior nurse told us that it was sometimes difficult to engage staff to complete the staff survey because staff felt that they were identifiable through the barcode that was attached to the paper copy of the survey. We were told that managers were hoping to have a better uptake with completing the survey, as the communications team within the trust were going to introduce completing the survey on an iPad, which would the process a lot more quickly and in a more user-friendly way.

Staff were engaged through several different forums. The senior sister told us that there were audit mornings which took place every two months where there were no clinics. On these days, we were told that staff were engaged to undertake training collectively, which ended in a staff lunch before clinics started up again in the afternoon.

We were told that the hospital sometimes held a ‘Diversity Day’, where staff members brought in a dish from their nationality and in the summer, staff came together at attend the open-air theatre at Regents Park.

**Learning, continuous improvement and innovation**

A senior nurse told us that improvements had been made in the engagement between the hospital and a transportation provider, with the relationship between the two being described as “good”. Incident reports were completed for patients who were dropped off and picked up late, with clear processes in place to escalate to the general and service manager. We were told that since this had been introduced, late drop-offs and pickups had improved.

Pain questionnaires had been rolled out for patients who were attending to see the pain consultant. We were told that nurses gathered the information for the consultant from the patients before the clinic started, and that this was working well.

We were told that the innovations in the service came from how the department monitored their outpatient utilisation and activity. We were told that another NHS regulator had been impressed with the monitoring tool that the trust used and that they had been invited to other trusts to deliver presentations. The service manager told us that the tool had been the start of a journey, with lots of good steps that had been made thus far but that there was still a lot more to achieve.