

# West Hertfordshire Hospitals NHS Trust

## Hemel Hempstead General Hospital

### Quality report

Hillfield Road  
Hemel Hempstead  
Hertfordshire  
HP2 4AD

Tel: 01442 213141

Website: [www.westhertshospitals.nhs.uk](http://www.westhertshospitals.nhs.uk)

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

#### Overall rating for this hospital

Requires improvement ●

Urgent & emergency services

Requires improvement ●

Outpatients & diagnostic imaging

Good ●

### Letter from the Chief Inspector of Hospitals

West Hertfordshire Hospitals NHS Trust provides acute healthcare services to a core catchment population of approximately half a million people living in West Hertfordshire and the surrounding area. The trust also provides a range of more specialist services to a wider population, serving residents of North London, Bedfordshire, Buckinghamshire and East Hertfordshire.

This was the third comprehensive inspection of the trust. The trust was rated as inadequate overall and was placed into special measures in September 2015. The last inspection took place in September 2016, where the trust and was rated requires improvement overall. It remained in special measures.

Part of the inspection was announced taking place from 30 August 2017 to 1 September 2017 during which time Watford General Hospital, St Alban's City Hospital and Hemel Hempstead General Hospital were all inspected.

At Hemel Hempstead Hospital, we inspected and rated the core services of the urgent care centre, outpatients and diagnostic imaging. At the previous inspection in September 2016, the hospital was rated inadequate overall. However, since then the one service that had heavily

contributed to this rating had been taken over by another trust and therefore was not inspected on this occasion.

At this latest inspection, we rated Hemel Hempstead General Hospital as requires improvement overall. We rated the urgent care centre (UCC) as requires improvement and outpatients and diagnostics services as good. For the five key questions that we inspect and rate, we rated safe, effective and well-led as requires improvement. Caring and responsive was rated as good overall. This was an improvement.

There were areas of practice where the trust needs to make improvements:

- We found risks that we had identified at previous inspections did not feature on the risk register both in the urgent care centre and outpatient and diagnostics services.
- Not all staff working in clinics that saw children had the appropriate level of safeguarding training. This was raised as an issue during the inspection in September 2016.
- There were no seven-day outpatient services provided at the time of inspection. Some ad-hoc Saturday clinics had been provided, but this had not taken place since March 2017. There were no plans to introduce evening or weekend clinics.
- Friends and Family test scores for outpatient services across the trust were worse than the England average from January to June 2017. This had improved in July 2017.
- Five out of 16 specialties were not meeting the England overall performance for patients being seen within 18 weeks of referral.
- We could not be assured that the service was fulfilling its mandatory duty to report cases of female genital mutilation (FGM) as all staff we spoke with were unaware of the trust policy on identifying and assessing the risk of FGM.
- Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.

However, there were areas of good practice:

- There had been several improvements in assessing and responding to patient risk. All patients were now assessed by a triage nurse, usually within 20 minutes of arrival. This compared well to our last inspection when patients were waiting up to two hours for an initial clinical assessment.
- We observed staff maintaining patients' privacy, dignity and confidentiality. They demonstrated empathy towards patients who were in pain or distressed and were skilled in providing reassurance and comfort.
- Almost all patients (99%) were treated, discharged or transferred within four hours, with an average time to treatment of 27 minutes.

Importantly, the trust must:

- Ensure that systems and processes are in place to monitor and review key aspects of performance (for example patient waiting times) to identify areas for improvement.
- Ensure there are processes in place to monitor arrival time to initial clinical assessment for all patients.
- Develop an audit process in the UCC to monitor compliance to protocols/pathways in line with other areas of the unscheduled care division.
- Implement arrangements for identifying, recording and managing risks, issues and mitigating actions.
- Ensure that all staff caring for patients under 18 years of age complete safeguarding children level 3 training.

- Ensure staff in outpatient services are aware of the trust policy and fulfil the mandatory reporting duty for cases of female genital mutilation.
- Monitor compliance with hand hygiene and environmental infection control in the phlebotomy department.
- Ensure staff within the radiology department are up-to-date on fire and evacuation training.
- Ensure that all risks relating to outpatient services are identified, recorded and managed on the departmental risk register.

In addition the trust should:

- Consider the roles and responsibilities of the rotational leadership role with regards to defined responsibilities and consider devising a job description.
- Consider the UCC, as part of the unscheduled care division, featuring in the current strategy document.
- Consider decontaminating reusable naso-endoscopes in a washer-disinfector at the end of each clinic, to meet Department of Health Technical Memorandum (HTM) 01-06 best practice.
- Consider providing outpatient services at evenings and weekends.
- Ensure staff are up to date with Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DOLS) training.
- To consider patients across all specialties are seen within 18 weeks of referral.
- Consider using electronic systems to flag patients with mobility issues, dementia or a learning disability so that arrangements can be made in advance to meet their needs.
- Consider using hearing loop systems across the department.
- Consider ways of improving communication between divisions within outpatient services.
- Consider how effective clinical leadership is at UCC in circumstances where the matron was also responsible for a neighbouring emergency department and a minor injuries unit that was several miles away.

**Professor Edward Baker**  
Chief Inspector of Hospitals

## Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent care centre	Requires improvement ●	<p>Overall, we rated the urgent care centre (UCC) as requires improvement because:</p> <ul style="list-style-type: none"> <li>• There remained a lack of monitoring of patient outcomes and compliance with evidence-based protocols.</li> <li>• The matron was also responsible for a neighbouring emergency department and a minor injuries unit that was several miles away. This left little time for active clinical</li> </ul>

leadership in the UCC.

- There was no active medical oversight of the UCC.

However, we also found:

- There had been several improvements in assessing and responding to patient risk. All patients were now assessed by a triage nurse, usually within 20 minutes of arrival. This compared well to our last inspection when patients were waiting up to two hours for an initial clinical assessment.
- Staff used an early warning scoring system to identify patients at risk of deterioration.
- All practitioners had undertaken further training in the assessment and treatment of sick children and there was always access to a specialist children's nurse if necessary.
- There was good multi-disciplinary working and the unit met 18 of the 19 standards set out in the Royal College of Medicine (RCM) report on "Unscheduled care facilities" 2009.
- We observed staff maintaining patients' privacy, dignity and confidentiality. They demonstrated empathy towards patients who were in pain or distressed and were skilled in providing reassurance and comfort.
- Almost all patients (99%) were treated, discharged or transferred within four hours, with an average time to treatment of 27 minutes.
- An escalation plan had been introduced that provided support to the unit if patients were waiting more than two hours for treatment.
- Staff engagement had improved and clinical staff were encouraged to attend monthly clinical governance meetings.

Outpatients & Diagnostic Imaging

Good



Overall, we rated the outpatients and diagnostic imaging service as good because:

- Since our previous inspection in September 2016, an outpatient quality improvement plan (QIP) had been implemented. Performance data had improved and the service was performing in line with their planned trajectory.
- There was a positive incident reporting culture across the hospital. All staff we spoke with knew how to report an incident

and were aware of details of recent incidents and learning.

- Radiation protection in the diagnostic imaging department was robust.
- The main outpatient department had no nursing vacancies at the time of our inspection.
- Since our previous inspection in September 2016, the availability of patient notes had improved.
- Medical records were comprehensive, legible, accurate and up-to-date. They were stored safely in a locked office or in lockable trolleys when being used in clinics.
- Medicines and prescription pads were stored securely in all areas we visited.
- Waiting lists for outpatient appointments were reviewed weekly. Risk assessments and individual treatment plans were completed for patients who waited 30 weeks or more. At the time of our inspection, no clinical harm had occurred to patients because of waiting over 30 weeks.
- Care and treatment was delivered in line with evidence-based guidance, standards and best practice. Pathways were in place for the management and treatment of specific medical conditions that followed national guidance.
- There was a local audit programme in the outpatient department that included monitoring compliance with best practice.
- The diagnostic imaging department was working towards the Imaging Services Accreditation Scheme (ISAS).
- There was a comprehensive clinical audit programme in the radiology department to monitor compliance with trust policy and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- Clinics were run by specialists in their field and staff were supported to develop based on their professional and clinical interests. Multidisciplinary meetings were held to assess, plan and deliver co-ordinated patient care.
- The service communicated regularly with patients' GPs and worked with the trust's GP liaison manager to share information.
- Staff understood their responsibilities for obtaining consent and making decisions in line with legislation, including the Mental Capacity Act (MCA) 2005.

- Patients were treated with kindness, dignity, respect and compassion. In addition, staff were considerate of people's personal, cultural, and religious needs.
- Chaperones were offered and available throughout the outpatient and diagnostic imaging services.
- Staff communicated with people so that they understood their care, treatment and condition. Patients we spoke with felt well-informed about their treatment and could explain what would happen next.
- Staff recognised when people needed additional support to help them understand and took action to meet their needs.
- Patients we spoke with described being offered emotional and social support.
- During our last inspection, we were not assured that patients had timely access to outpatient treatment. The service was found to be in breach of Regulation 12 of the Health and Social Care Act Regulations 2014: Safe care and treatment, due to being worse than national standards for waiting times. During this inspection, we found that most waiting times had improved to meet national standards.
- The trust had improved its performance for cancer waiting times and was meeting the national standard in four out of five measures.
- Patients had timely access to diagnostic imaging services and the percentage of patients waiting more than six weeks was lower than the England average.
- Services were planned and delivered to take into account different people's needs. This had improved since our previous inspection with the introduction of written information in languages other than English.
- The main outpatient department was working towards gaining a Purple Star accreditation for the care and treatment they provided to patients with a learning disability.
- The phlebotomy service engaged with people in vulnerable circumstances and took actions to overcome barriers when people found it difficult to access services.
- Leaders and staff across outpatient and diagnostic imaging services were continuously striving for improvement. In addition to the QIP, local leaders had further

plans to improve services.

- The culture in across outpatient and diagnostic imaging services encouraged openness, candour and honesty. All staff we spoke with felt supported, respected and valued.
- Patients, relatives and visitors were actively engaged and involved when planning services. People were encouraged to provide feedback and we saw their comments used to improve services.
- Leadership of the diagnostic imaging department was focused on driving improvement and delivering high quality care to patients.

However:

- During our previous inspection, we found that not all staff working in clinics that saw children had the appropriate level of safeguarding training. This was still the case at the inspection in August 2017.
- We could not be assured that the service was fulfilling its mandatory duty to report cases of female genital mutilation (FGM) as all staff we spoke with were unaware of the trust policy on identifying and assessing the risk of FGM.
- Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.
- Compliance with fire safety training in the radiology department was worse than the trust target of 90%.
- Staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training was below the trust target.
- There were no seven-day outpatient services provided at the time of inspection. Some ad-hoc Saturday clinics had been provided, but this had not taken place since March 2017. There were no plans to introduce evening or weekend clinics.
- Friends and Family Test scores for outpatient services across the trust were worse than the England average from January to June 2017. This had improved in July 2017.
- Five out of 16 specialties were not meeting the England overall performance for patients being seen within 18 weeks of referral.
- During the previous inspection, it was raised

that hearing loops were not in use to aid people with hearing impairment. This was still the case at the most recent inspection.

- Staff were not always informed in advance if a new patient had mobility issues, a learning disability or dementia. This meant adjustments could not be made prior to their attendance to facilitate their journey through the department.
- At the time of inspection, there was only one risk on the outpatient department risk register. This was related to clinics being overbooked. However, during our inspection we identified other risks that should have been recognised and mitigated.

# Hemel Hempstead Hospital

Requires improvement



## Detailed findings

### Services we looked at

Urgent Care Centre, Outpatients and Diagnostic Imaging.

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### Summary of this inspection

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## Background to Hemel Hempstead General Hospital

West Hertfordshire Hospitals NHS Trust provides acute healthcare services to a core catchment population of approximately half a million people living in west Hertfordshire and the surrounding area. The trust also provides a range of more specialist services to a wider population, serving residents of North London, Bedfordshire, Buckinghamshire and East Hertfordshire.

There are 681 inpatient beds throughout the trust and over 4000 staff are employed. The majority of acute services are delivered at Watford Hospital.

Hemel Hempstead General Hospital has an urgent care centre which is open from 9am to 10pm 24 hours a day, seven days a week. In addition there is an outpatients department and diagnostic and imaging services. A local NHS community trust also operates intermediate care beds at this hospital but these were not inspected as they will be included in the inspection of the community trust.

The UCC is a nurse-led unit co-located with a 24-hour GP service and provides a service for adults and children over two years old with minor injuries and illnesses. It also provides a referral point for the trust's deep vein thrombosis (DVT) service (assessment of blood clots in veins).

All patients are assessed by a registered nurse. Those with minor injuries are treated by emergency nurse practitioners (ENP) and those with minor illnesses by a GP from the co-located GP service. We did not inspect the GP service as they were from an external provider commissioned by the local clinical commissioning group and would form part of a separate inspection.

We carried out an announced comprehensive inspection of Hemel Hempstead General Hospital from 30 August to 1 September 2017 and an unannounced inspection on 12 September 2017.

This was the third comprehensive inspection of the trust, the first taking place in April and May 2015 when it was subsequently rated as inadequate overall and went into special measures in September 2015. A further comprehensive inspection took place in September 2016, when the trust, including Hemel Hempstead General Hospital was rated inadequate and remained in special measures.

## Our inspection team

Our inspection team was led by:

**Chair:** Peter Turkington, Consultant Respiratory Physician and Medical Director, Salford Royal NHS Foundation Trust

**Head of Hospital Inspections:** Bernadette Hanney, Care Quality Commission.

The team included CQC inspection managers, inspectors and a variety of specialists: consultant in emergency care, outpatient specialist nurses, a radiographer, emergency care specialist nurse and advanced nurse practitioner, two pharmacy inspectors and an expert by experience.

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about West Hertfordshire Hospitals NHS Trust and the hospital and asked other organisations to share what they knew about the trust. These included the clinical commissioning group, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and Hertfordshire Healthwatch.

We carried out this inspection as part of our comprehensive programme of re-visiting trusts which are in special measures. We undertook an announced inspection from 30 August to 1 September 2017 and an unannounced inspection on 12 September 2017.

We talked with patients and staff from all the ward areas and outpatients departments. Some patients also shared their experiences through our website, by emails, telephone or completing comments cards.

## Facts and data about Hemel Hempstead General Hospital

Hemel Hempstead General Hospital is part of West Hertfordshire Hospitals NHS Trust.

Hemel Hempstead has a population of about 90,000 and is part of the Dacorum and the Hemel Hempstead constituency.

Dacorum is ranked 265 out of 326 in the English Indices of Deprivation Rankings. However, it is worse than the English average for both statutory homelessness and physically active adults.

The trust had 520,693 initial and follow-up outpatient appointments from February 2016 to January 2017, with 124,498 of those appointments at Hemel Hempstead General Hospital.

For the year ending August 2017, 38,000 patients had attended the urgent care centre. Of these, approximately 11,000 (30%) were children up to the age of 16 years. The co-located GP service saw 18% of these patients and the remainder by emergency and urgent care practitioners.

## Overview of ratings

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Urgent care centre</b>	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
<b>Outpatients &amp; Diagnostic Imaging</b>	Requires improvement	Inspected but not rated <sup>1</sup>	Good	Good	Good	Good
<b>Overall</b>	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

### Notes:

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

## Urgent & emergency services

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

### Information about the service

The urgent care centre (UCC) at Hemel Hempstead hospital is open every day from 8am to 10pm. It is a nurse-led unit co-located with a 24-hour GP service and provides a service for adults and children over two years old with minor injuries and illnesses. It also provides a referral point for the trust's deep vein thrombosis (DVT) service (assessment of blood clots in veins).

All patients are assessed by a registered nurse. Those with minor injuries are treated by emergency nurse practitioners (ENP) and those with minor illnesses by a GP from the co-located GP service. We did not inspect the GP service as they were from an external provider commissioned by the local clinical commissioning group and would form part of a separate inspection.

For the year ending August 2017, 38,000 patients had attended the urgent care centre. Of these, approximately 11,000 (30%) were children up to the age of 16 years. The co-located GP service saw 18% of these patients and the remainder by emergency and urgent care practitioners.

The UCC forms a part of the trust's unscheduled care division, which includes the emergency department at Watford General hospital and the minor injuries unit at St. Albans hospital. All three services were managed by the same division and had the same overall manager, so for this reason there may be some duplication of data in the three reports.

We carried out an announced inspection of the UCC on 1 September 2017. During our inspection, we spoke with eight members of staff and ten patients. We looked at 14 sets of patients' records.

### Summary of findings

Overall, we rated the urgent care centre (UCC) as requires improvement because:

- There remained a lack of monitoring of patient outcomes and compliance with evidence-based protocols.
- The matron was also responsible for a neighbouring emergency department and a minor injuries unit that was several miles away. This left little time for active clinical leadership in the UCC.
- There was no active senior medical oversight of clinical practice.

However, we also found:

- There had been several improvements in assessing and responding to patient risk. All patients were now assessed by a triage nurse, usually within 20 minutes of arrival. This compared well to our last inspection when patients were waiting up to two hours for an initial clinical assessment.
- Staff used an early warning scoring system to identify patients at risk of deterioration.
- All practitioners had undertaken further training in the assessment and treatment of sick children and there was always access to a specialist children's nurse if necessary.
- There was good multi-disciplinary working and the unit met 18 of the 19 standards set out in the Royal College of Medicine (RCEM) report on "Unscheduled care facilities" 2009.
- We observed staff maintaining patients' privacy, dignity and confidentiality. They demonstrated empathy towards patients who were in pain or distressed and were skilled in providing reassurance and comfort.
- Almost all patients (99%) were treated, discharged or transferred within four hours, with an average time to treatment of 27 minutes.
- An escalation plan had been introduced that provided support to the unit if patients were waiting more than two hours for treatment.
- Staff engagement had improved and clinical staff were encouraged to attend monthly clinical governance meetings.

**Are urgent & emergency services safe?**

Good ●

Overall, we rated the urgent care centre as good because:

- There had been several improvements in assessing and responding to patient risk. All patients were now assessed by a triage nurse, usually within 20 minutes of arrival. This compared well to our last inspection when patients were waiting up to two hours for an initial clinical assessment.
- Staff used an early warning scoring system to identify patients at risk of deterioration.
- All practitioners had undertaken further training in the assessment and treatment of sick children and there was always access to a specialist children's nurse if necessary.
- The environment was clean, well equipped and well maintained.
- There were good safeguarding arrangements for children and adults.
- Learning from trust-wide incidents was shared and communicated to all relevant staff.
- Staff were aware of the major incident policy and their required actions if a major incident was declared.

However, we also found:

- The service level agreement for the provision of a GP to treat patients with urgent illnesses was out-of-date and did not reflect current working practices.
- Waiting times for triage assessments were not monitored. This meant that staff and managers did not know whether patients were being assessed quickly enough.
- Hand hygiene audits had not been undertaken.

### **Incidents**

- Staff were aware of their responsibility to report incidents both internally and externally and used the hospital's electronic reporting system.
- Incidents and accidents were reported using a trust wide electronic system and were graded in severity from low or no harm to moderate, severe or death. The trust had a comprehensive incident reporting policy, which described the process for grading and

reporting incidents. Staff were able to access this on the trust's internal website.

- There had been no never events reported for this service for the year ending June 2017. A never event is a serious incident that is wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- For year ending June 2017 there had been no serious incidents reported to the Strategic Executive Information System (STEIS) for the UCC.
- There had been 290 incidents reported in the year ending June 2017. Three were reported as low harm and remainder as no harm. The vast majority of reports regarded transfer of patients to other hospitals. The centre used their incident reporting system to record these so that transfers could be analysed to ensure that all possible treatment was administered to the patient before they were transferred.
- Learning from incidents was shared between all units in the unscheduled care division via a newsletter than was sent to all staff. It was also discussed at monthly clinical governance meetings. For example, silver nitrate application sticks were stored in a secure cupboard following incorrect use in another unit in the division.
- We saw that changes in practice were embedded throughout the unit following root cause analysis of incidents. For example, during the previous year treatment had been delayed for a patient on anticoagulant treatment (a type of medicine that reduces the body's ability to produce clots) who was bleeding from a head injury. The trust had developed a flowchart to ensure these patients were seen and treated in line with National Institute of Health and Care Excellence (NICE) guidelines (CG176, 2014) which included arranging a computerised tomography (CT) scan within a specific timeframe. All nursing staff were familiar with the new flowchart.
- Staff had a good understanding of the duty of candour regulation 2014. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All staff that we spoke with were aware of their responsibility to be open and honest when things went wrong and knew how this related to the duty of candour. There had been no incidents that met the threshold of the duty of candour regulation (moderate or severe harm).

### **Cleanliness, infection control and hygiene**

- There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained
- The department was visibly clean and all staff carried out cleaning tasks when required. This included daily cleaning of toys in the children's waiting area. There were cleaning schedules in place, which showed the daily cleaning times. We saw that equipment had 'I am clean' stickers on them, which displayed the date the equipment was last cleaned.
- Infection control staff carried out quarterly audits to determine the quality of infection prevention measures. We were shown the results of the last audit (June 2017) confirming a score of 96% which was better than the trust standard of 95%.
- We observed staff using antibacterial hand gel regularly and washing their hands before and after patient contact. The trust did not provide us with evidence of hand hygiene audits conducted in the UCC; staff told us that it was difficult to conduct these audits as care and treatment took place in individual consulting rooms and it would be difficult for auditors to observe practice.
- 'Arms bare below the elbow' policies were adhered to and staff wore minimal jewellery in line with the trust infection control policy. Personal protective equipment such as gloves and disposable aprons were used in accordance with the trust's infection control policy.

## Environment and equipment

- There was adequate space and seating in the waiting area of the UCC and during our inspection we saw no patients standing whilst waiting to be seen.
- Since our last inspection a new children's waiting area had been created at one side of the main waiting area. Although it contained toys suitable for different ages of children, it did not meet all the requirements of Intercollegiate Standards for Children and Young People in Emergency Care Settings, 2012. This states that all urgent and unscheduled care facilities including UCCs should have waiting areas for children that are audio and visually separated from adult patients. Staff told us that due to the layout and design of the UCC, there was limited space to have a separate waiting area for children. There had been no formal risk assessment of this arrangement but staff told us that any adult likely to disturb children would be guided away from the waiting room.
- The unit was well equipped and the equipment was checked daily to ensure that it was ready for use. We saw maintenance records showing a regular programme of maintenance and servicing was planned for and had taken place.
- There was a comprehensive range of resuscitation equipment for both children and adults. This was stored in tamper-evident resuscitation trolleys which were checked weekly, in line with trust policy.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. Used bins were sealed securely and were not overfilled.

## Medicines

- There were effective systems in place regarding the storage and handling of medicines.
- Medicines were stored in line with trust medicines management policy and fridge and room temperatures were regularly checked and temperatures recorded. The recording charts showed the fridge and room temperatures were in an acceptable range. The keys were held by the nurse in charge on the day and stored overnight in a keypad locked safe.
- We checked the storage and balance of controlled drugs, which included strong painkillers and sedatives. These were stored correctly, carefully monitored and we found that the stock balance was correct.
- Since our last inspection, all but one of the emergency nurse practitioners (ENP's) had been trained as nurse prescribers. Those that had not been trained as nurse prescribers administered selected medicines under guidance, known as patient group directions. (PGDs.) We looked at five PGDs and found them to be within date and appropriately completed. Records showed that staff were competent to use them. Local microbiology protocols were included in the PGDs for antibiotics.
- We saw that allergies to medicines were clearly documented on patient records. Staff took account of these before prescribing medicines.
- Pharmacy services were available at Hemel Hempstead hospital from Monday to Friday 9am to 5pm. Outside these hours nursing staff had access to on-call support from Watford General Hospital if they required medication advice or information. Medicines that could not be dispensed in the unit out of hours were prescribed using an FP10 prescription. These were stored securely and a record kept of the person that had used them and the medicine prescribed.

## Records

- Records were managed appropriately and confidentially, written legibly and according to best practice. Patients' registration details were recorded on the unit's computer system which then produced a paper record for staff to use.
- We looked at fourteen sets of records and found that information regarding the patient's

care and treatment was well-documented, with appropriate information to understand the treatment delivered.

- Paper records were stored behind a locked door in secured cabinets in the reception area after patients were discharged. If a patient had not returned within a year the paper copy was scanned into the computer system and the original securely destroyed.

### **Safeguarding**

- There was a clear system and process in place for identifying and managing patients at risk of abuse. Nursing and administrative staff we spoke with were able to explain the process of safeguarding a patient and provided us with specific examples of when they would do this. Records showed that all clinical staff had received level 3 safeguarding training in the last year. This included information to help staff identify women or children at risk of female genital mutilation (FGM).
- All clinical records for children contained a risk assessment tool aimed at quickly identifying any concerns regarding child welfare. These were completed correctly in the records that we reviewed.
- An up-to-date version of the local child protection register was available via the unit's computer system. Records that we looked at showed that it was checked for each child who attended to ensure that they had not been identified as at risk of abuse.
- An external health visitor attended the unit weekly to review both the records of all children aged five years or less and any safeguarding referrals.
- The UCC had a designated safeguarding lead and staff told us that they saw them regularly for training and updates. We saw that the details of the safeguarding lead and team were on display in staff areas and staff knew who to contact if they had any safeguarding queries.

### **Mandatory training**

- Staff received effective mandatory training in the safety systems, processes and practices
- Mandatory training for staff consisted of a range of topics, which included health and safety, information governance, conflict resolution, equality and diversity and infection prevention and control. Courses for mandatory training were delivered online or via face to face sessions.
- The trust's target for mandatory training completion was 90% of all staff. Records showed that 92% of UCC staff had completed this training in the last year.
- Records showed that all clinical staff had successfully completed immediate life support training and paediatric immediate life support training in the last year. Additional training about sepsis had also been provided.

### **Assessing and responding to patient risk**

- Standards jointly developed by the Royal College of Emergency Medicine (RCEM), the Emergency Nurse Consultant association and the Faculty of Emergency Nursing state, "All patients should be assessed in a timely manner. If there are delays in a healthcare professional assessing the patient then some form of initial assessment will be required to detect those at risk of deterioration or potentially serious conditions".(Unscheduled Care Facilities 2009). During our last two inspections, we found delays of up to two hours before patients were assessed. At this inspection several improvements had taken place. The improvements are described below.
- Reception staff had been provided with a clear guide to 'red flag' conditions such as chest pain, difficulty breathing, and severe bleeding in line with the RCEM: triage position statement (2011) guidance for non-clinical staff. Reception staff we spoke with were familiar with this guidance and we observed clinical staff being rapidly alerted when a

patient arrived with a red flag condition.

- All patients were assessed by a triage nurse as soon as possible. The nurse undertook a methodical clinical assessment in order to establish the severity of the problem. First aid was performed if necessary and pain relief administered if required. During our inspection the majority of patients were triaged within five minutes. We looked at 14 records of patients seen in the last six days and found that 86% had been triaged within 20 minutes.
- We asked the trust to supply us with data for waiting times to initial clinical assessment over the last 12 months. However, although nurses recorded the assessment time on the patients' record document, it was not possible to record it on the computer system. As a result, the trust did not collect the information.
- There was no paediatric team at Hemel Hempstead hospital and the UCC was designed to see patients of two years and older. Staff told us that if a child under the age of two years old presented at the UCC they would be assessed by an ENP and then directed to their GP or transferred by ambulance to Watford General hospital, if necessary. They could contact children's doctors and nurses at the emergency department at Watford General hospital if they needed specialist advice.
- Staff had recently been trained in the use of the national early warning system (NEWS) and the paediatric early warning system (PEWS). This was a quick and systematic way of identifying patients whose clinical condition was at risk of deteriorating. On the whole, this system was being used appropriately. We reviewed nine records of patients who had recently attended the centre and should have had an early warning score calculated. Six of the nine (67%) had a correct score documented. None of the patients were seriously ill and so no escalation action was necessary.
- We saw evidence that staff were aware of the process for managing sepsis and had appropriate risk assessments and guidance, which was on display in all areas. They were able to describe cases of sepsis that had recently been diagnosed in the department and the emergency transfers to an emergency department that had resulted.

## **Nursing staffing**

- Patients were treated by ENPs and emergency care practitioners (ECP). ECPs were ambulance paramedics who had gained further qualifications in order to treat patients in a hospital setting. In addition there were qualified nurses who carried out wound care, administered medication and measured patients' vital signs. They were supported by health care assistants and receptionists.
- We reviewed the staffing rota for the month prior to our inspection. This demonstrated that there were always a minimum of one emergency nurse practitioner (ENP) and one other qualified nurse on duty. In the middle of the day staffing levels rose to three ENPs and ECPs with two qualified nurses and a health care assistant. Although these staffing levels met the minimum standards recommended by the Royal College of Emergency Medicine (Unscheduled care facilities 2009) there had been no analysis of patient waiting times compared to staffing levels. Therefore it was not clear whether staffing levels met the needs of all patients who attended.
- At our last inspection there was not always a nurse present in the UCC with the full range of competencies to assess children's needs. Since then all of the ENPs and ECPs had undertaken further training in the assessment and initial treatment of children.
- Staff had access at all times to specialist children's nurses at the emergency department at Watford General hospital.
- Although there was a staff nurse vacancy during the inspection, a new member of staff had been appointed and was expected to start within two months.
- There was minimal use of bank (temporary) staff in the UCC and no agency staff were used. Bank staff were provided through a dedicated specialist service and staff told us that induction was conducted by the specialist service and assurances of competencies

provided to the trust. Bank staff were then given a local induction when they arrived at the UCC.

### Medical staffing

- During our last inspection we had noted that there had been several occasions when the external provider had not been able to supply a GP to treat patients with minor illnesses. This problem had increased throughout 2016, particularly at nights and in the evenings. At the end of 2016 it was decided that the UCC should close at night when very few patients attended, usually four to five patients between 10pm and 8am. This meant that the remaining GPs could staff the unit at the times when most patients attended.
- Since January 2017 there had been no recorded episodes of a GP being absent from the UCC. However, the service level agreement with the external provider had not been updated to reflect the new working patterns.
- If necessary, clinical staff were able to obtain advice from a consultant in emergency medicine based at Watford General hospital.

### Major incident awareness and training

- During our last inspection in 2016, staff were not fully aware of the trust's major incident plan or their role within it. During this inspection all staff we spoke with were familiar with the plan and had received training. They were aware that the ambulance service was likely to bring patients with minor injuries from a major incident. They had plans in place to call in extra staff should this be necessary. A major incident exercise was due to take place in October 2017.
- The unit had a CBRN (chemical, biological, radiological, and nuclear) protection kit and staff were familiar with its use.

## Are urgent & emergency services effective?

Requires improvement 

Overall, we rated the urgent care centre (UCC) as requires improvement for effectiveness because:

- There remained a lack of monitoring of patient outcomes and compliance with evidence-based protocols. We had been shown clinical audit plans during our last two inspections but they had not been implemented
- UCC patients were not included in relevant national audits that were being conducted in the unscheduled care division.
- Pain scores were not always used to assess pain levels in children although action was being taken to improve this.

However:

- Staff were familiar with the evidence-based clinical guidelines which were accessible on the trust's intranet.
- The learning needs of staff were assessed at annual appraisals. All emergency nurse practitioners had completed, or were taking part, in a training programme to improve their skills in the assessment and treatment of sick children.
- Pain relief was given to patients in a timely fashion.
- There was good multi-disciplinary working and the unit met 18 of the 19 standards set out in the Royal College of Medicine (RCEM) report on "Unscheduled care facilities" 2009.

## **Evidence-based care and treatment**

- Staff in the UCC had access to evidence based clinical guidelines via the trust's intranet. For example, we saw that there were clinical pathways for chest pain and complex fractures, which were based on National Institute for Health and Care Excellence (NICE) guidelines. Nursing staff that we spoke with were familiar with the guidelines and could speak confidently about the action that needed to be taken.
- During our last two inspections we found there was no local clinical audit programme to check that treatment of patients followed best practice. Although some audits had been planned for this year, none had yet taken place.
- Records we saw showed that clinical assessment was methodical, appropriate and clearly documented in the majority of cases.
- The UCC met 18 of the 19 principles set out by the RCEM document 'Unscheduled care facilities' 2009.
- All x-rays were reviewed by a specialist radiology doctor within five days. This ensured that, if there were any discrepancies in diagnosis, the patient would be recalled and re-assessed in a timely manner.
- Records showed that, where appropriate, patients were referred back to their own GP once their urgent care needs had been met.
- There was a wide range of information leaflets available to help patients manage their injury or illness. We reviewed a random sample of these and found that they followed current national guidance.

## **Pain relief**

- We observed pain relief being administered to patients in the UCC. Most staff used a pain scoring system to assess the level of pain. This helped staff to re-assess patients once pain relief had been given.
- RCEM management of Pain in Children (revised July 2013) recommends that all children should be offered pain relief within 20 minutes of arrival and those in severe pain should be reassessed every hour. This had not occurred during our previous inspections. However, a change in practice had occurred during the last year. All children were now assessed as soon as they arrived and pain relief was given if necessary.
- Pain scores were not always used to assess pain in children. Only two of the six children's records that we looked at had a pain score. This made it more difficult to re-assess pain and to judge whether the pain relief had been effective. The lead nurse explained that some staff were not familiar with the symbols use to assess children's pain. Small posters displaying the symbols had arrived on the day of our inspection and were being placed in each consulting room.

## **Nutrition and hydration**

- Data showed that 95% of patients spent less than three hours in the unit, therefore meals were not provided.
- Staff spoke confidently about recognition of signs of malnutrition and dehydration.

## **Patient outcomes**

- Patient's care and treatment outcomes were not monitored. At our last two inspections we

found that there was no formal monitoring of patient outcomes. During this inspection we found no improvement had taken place. For example, there had been no audits of pain assessments, early warning scores or sepsis assessments. This had not been specifically addressed in the trust's quality improvement plan.

- UCC patients were not included in relevant national audits that were being conducted in the unscheduled care division.
- A low rate of unplanned re-attendances is often used as an indicator of good patient outcomes. During the last year the UCC had an average monthly rate of 7.5% compared to a national average for urgent and emergency care of 6%. There had been no analysis of these poor results and the staff could not fully explain them.

### **Competent staff**

- There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs
- Staff who were new to the department took part in a structured orientation programme. Staff we spoke with told us that they found it informative and effective.
- The orientation programme for nurse and emergency care practitioners lasted for a minimum of four weeks and practice during this time was always supervised. Thereafter, new practitioners would work with experienced practitioners to ensure that there was someone to give advice if necessary.
- At our last inspection very few of the staff had received a recent appraisal and so specific learning needs had not been identified. The trust sent us data showing that by June 2017 84% of nursing staff and 80% of reception staff had had an appraisal in the last year. During our inspection the matron for the unit and the lead nurse confirmed that all staff had received an appraisal in the last year.
- All nurse practitioners had completed, or were currently undertaking, an on-line paediatric assessment course organised by Health Education England. In addition they rotated to the children's emergency department at Watford General hospital in order to maintain and extend their practical paediatric skills.
- The clinical nurse educator from the emergency department at Watford General hospital had undertaken a learning needs analysis for the UCC at the beginning of 2017. As a result there were now monthly in-house teaching sessions which were run by emergency department consultants and included topics such as sepsis, domestic violence and the treatment of burns.

### **Multidisciplinary working**

- There were good working relationships with community services, with the emergency department at Watford General Hospital and with the minor injuries unit at St. Albans City hospital.
- Practitioners could discuss complicated injuries or X-rays with a senior doctor at the neighbouring emergency department.
- Direct referrals could be made to physiotherapists for conditions such as soft tissue injuries or ligament strains. There were therapy departments based at the hospital which enabled face-to-face discussions about individual patient needs.
- Emergency nurse practitioners could refer patients directly to specialist doctors in orthopaedics, ophthalmology and burns services in accordance with agreed clinical pathways.
- There were effective links with other services such as health visitors, sexual health clinics, district nurses, and social services.

### **Seven-day services**

- The UCC was open seven days a week from 8am to 10pm.

- X-ray facilities were available throughout the opening hours of the UCC.
- There was an on-site pharmacy available at the hospital from Monday to Friday 9am to 5pm and staff had access to a weekend pharmacy at the Watford General hospital from 10am to 4pm. Outside of these hours staff had access to an on-call pharmacist for advice.
- A stock of frequently required medication was kept in the unit which could be dispensed to patients when the pharmacies were closed.

### Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary. Paper copies of clinical guidelines were kept in a several files so that they could be accessed if a computer failure occurred.
- Previous X-rays and their results were always available via the trust's computer system.
- Patients who were discharged from the service were given written information to share with their GPs.

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

- Patient's consent was obtained in line with hospital policy and statutory requirements.
- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children. The nursing staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (Gillick competency). Otherwise, consent would be sought from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.
- The staff we spoke with had sound knowledge about consent and mental capacity. Although practitioners had not been trained to undertake mental capacity assessments, none could remember an example of when this was needed. They were able gain telephone advice from local psychiatric crisis teams if this was necessary.

## Are urgent & emergency services caring?

Good 

Overall, we rated the urgent care centre (UCC) as good for caring because:

- Feedback from patients and those close to them confirmed that staff were caring and kind.
- We observed staff maintaining patients' privacy, dignity and confidentiality. They demonstrated empathy towards patients who were in pain or distressed and were skilled in providing reassurance and comfort.
- Patients were kept informed and given information about their condition and their care and treatment. Their social and cultural needs were taken into account and they were helped to maintain their independence whenever possible.
- Communication with children and young people was age-appropriate and effective.

### Compassionate care

- Confidentiality was maintained at the reception desks by means of signs asking people to stand back from the desk when someone was being registered.
- The UCC had examination and treatment rooms with doors to ensure privacy when

patients were being examined. We saw that staff knocked and waited to be called before entering.

- We observed staff introducing themselves and explaining what was about to happen before examining patients.
- All staff wore name badges which clearly stated their name and role. This helped to ensure that patients were aware of the professionals involved in their care.
- We saw several examples of patients being treated with compassion, dignity and respect. Staff spoke in a respectful but friendly manner and made allowances when people were distressed or worried.
- Practitioners took time to distract and comfort children during examinations and wound cleaning. Parents were involved in the assessment and treatment of their children and clear explanations were given.
- We spoke with ten patients and their families. They all reported a positive experience. One said; “The staff here are very friendly”.
- Results from the Friends and Family test for the year ending July 2017 were consistently good. They showed that between 96% and 99% of people would recommend the unit. However, response rates were low (between 0.9% and 2.8% of attendances) and so it was difficult to know how representative these views were.

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

- We spoke with six patients whose care and treatment we followed on the day of our inspection including two children and their parents. They all told us they were satisfied with the care they received and the staff who provided it. They had been involved in how and where their ongoing treatment took place.
- We observed staff interacting with patients and family members. Staff talked to them in a way that patients could understand and described what they were going to do.
- Staff also checked that patients had understood what they’d been told and what needed to happen next.

### **Emotional support**

- Staff that we spoke with were aware of the impact that a person’s treatment, care, or condition could affect them both emotionally and socially.
- We observed one nurse talking to a tearful child. The nurse employed humour to explain what was going to happen next and the child’s tears soon turned to laughter. Further explanation and reassurance was given to the parents.
- Another nurse took time to phone the husband of a patient who had been injured whilst out shopping. The patient said that he would be worried because she had not returned home at the usual time. The nurse explained what had happened and then handed the phone to the patient so that she could reassure her husband.
- We saw that patients who needed extra time for their treatment due to communication needs were supported by staff.
- Staff directed patients to relevant external organisations for support when required.

**Are urgent & emergency services responsive?**

Good 

Overall, we rated the urgent care centre (UCC) good for responsive because:

- Services were planned to meet the needs of all patients, including those who were vulnerable or who had complex needs.
- The unit was easy to access and there was sufficient space for the number of people using them.

- Almost all patients (99%) were treated, discharged or transferred within four hours.
- The average time to treatment was 27 minutes.
- An escalation plan had been introduced that provided support to the unit if patients were waiting more than two hours for treatment.
- The needs of people with complex needs were well understood and addressed appropriately. Patients living with dementia or learning disabilities received care and treatment that was sympathetic and knowledgeable.
- Improvements were made to the quality of care as a result of complaints and concerns.

### **Service planning and delivery to meet the needs of local people.**

- Staff were aware that the trust had consulted the local population on extending urgent care facilities within West Hertfordshire ('Your Care, Your Future' Autumn 2016). However, no definite plans had yet been published.
- Patients told us that they appreciated having a local urgent care centre that meant they did not have to travel to an emergency department.

### **Meeting people's individual needs**

- Staff took account the needs of different patients including those in vulnerable circumstances.
- The unit was well signposted from the entrance to the hospital site. Patients told us that it was easy to find. There was a drop-off point immediately outside and wheelchairs were available just inside the entrance. This meant the patients with leg injuries or limited mobility could access the unit easily.
- Drinks and snacks were available from a vending machine in the waiting room and water was available on request from the receptionists. However, patients told us that the products from the vending machine were expensive and they would not buy them.
- Staff that we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There were close links with community services to provide support.
- All nursing staff had undertaken training in the specific needs of patients living with dementia and learning disabilities and the involvement of families was encouraged. The appointment of a trust-wide learning disabilities team had improved awareness and staff felt able to contact them for advice.
- Staff were able to describe the care and treatment of patients with learning disabilities or living with dementia who had recently attended the department. They recognised that the hospital environment could be confusing and distressing and so gave priority to this group of patients.
- The computer system featured a flagging system for patients with learning disabilities so that staff could be alerted to their special needs.
- Staff had compiled a book to help communicate with patients who had cognitive impairment. This consisted of photographs that illustrated common practices in the unit such as having an X-ray taken or a dressing applied. This helped patients to understand the treatment that had been planned for them.
- Translators could be accessed via the telephone translation system provided by the hospital. Staff told us that a translator was usually available within minutes, whichever language was required.
- The computer system featured a flagging system which alerted staff to patients whose first language was not English. It recorded which language the patient preferred to use.
- We observed that staff adapted their practice and communication styles to meet the needs of individuals who attended the unit.
- Staff gave information leaflets to patients that clearly stated who they should contact if they

had any concerns or worrying symptoms after treatment. There was information throughout the department relating to support groups for patients with specific conditions to access local support networks.

- The UCC was on a single level and there was sufficient space for wheelchair users to move around easily. There was designated disabled parking bays outside the unit and there was always one available during our inspection.

### Access and flow

- The unit consistently exceeded the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at UCCs. Annual performance for the year ending July 2017 was 99%.
- While waiting no more than four hours from arrival to departure is a key measure of UCC performance, there are other important indicators, such as how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a wait of below 60 minutes. The median(average) waiting time at the UCC in year ending July 2017 was 35 minutes.
- The percentage of patients who leave without being seen is often used as an indicator of the responsiveness of a unit. The lower the percentage the better. An average of 2% of patients left without being seen during year ending July 2017. This compared well to emergency departments where the average in England was 3%.
- During our last inspection we found that there were no clear escalation processes in place to manage the service during periods of high demand or excessive waiting times. At this inspection there was a clear escalation policy that was displayed on a staff noticeboard. It stated that the duty matron and the operations team at Watford General hospital were to be contacted if the waiting time for patients to be treated exceeded two hours or if there were more than 15 patients waiting for treatment. These breaches were recorded, but the trust was unable to supply us with this data. However, staff told us that this rarely happened but that senior managers were supportive when they were contacted.

### Learning from complaints and concerns

- There were leaflets and posters in the waiting area with contact details for the trust's Patient Advisory Liaison Service (PALS) for patients and relatives to raise concerns or make a complaint.
- Staff told us that if a patient made a verbal complaint to them they would try and resolve the concern at the time and record the details on the electronic system if there were opportunities for learning.
- In the year ending August 2017, there were nine complaints recorded for the UCC, although two appeared to be complaints about treatment in other hospitals. The majority of the complaints regarded aspects of clinical care. We saw that complaints were investigated, opportunities for learning identified and action taken when required. For example, more information was now given to patients about services at other hospitals.

Are urgent & emergency services well-led?

Requires improvement 

Overall, we rated the Urgent care centre (UCC) as Requires Improvement for well-led because:

- Overall leadership was provided by the matron of the emergency department at Watford General Hospital who also managed the urgent care centre at Hemel Hempstead Hospital. Although liked and respected by staff at the UCC the matron was able to spend very little time at the unit.

- There was no active trust medical oversight of the unit.
- On-site leadership was by means of a rotational post between different emergency nurse practitioners (ENP). There was no job description for this post and so the responsibilities of the lead nurse were unclear.
- There remained a lack of understanding of the risks that could impact on the delivery of good quality care and very little monitoring of performance measures.
- Although the UCC was part of the unscheduled care division it did not feature in their current strategy document.

However, we also found:

- There had been improvements in clinical governance with all staff encouraged to attend monthly clinical governance meetings.
- Staff enjoyed working at the unit and told us that they felt respected and valued by their colleagues. They were supported during difficult circumstances.
- There was a good sense of teamwork and a patient-centred culture.

### **Leadership of service**

- The UCC was a part of the unscheduled care division which also included the emergency department (ED) at the Watford General Hospital and the minor injuries unit at St. Albans Hospital. The overall management of the division included a divisional director, divisional general manager, and divisional lead nurse.
- Direct management of the UCC was the responsibility of the ED matron based at Watford. She was supported by a lead nurse in the urgent care centre who co-ordinated clinical activity on a day-to-day basis.
- The matron told us that she tried to visit the UCC twice a week. However, the pressures of the emergency department meant that this was normally reduced to once a week for two to three hours at a time.
- It had been anticipated that each of the emergency nurse practitioners (ENP) would rotate into the lead nurse role for six months at a time. However, in practice, most of the ENPs were reluctant to leave their clinical roles and so the nominated lead nurse had been undertaking this role for several years.
- There was no separate job description for the lead nurse role and so the responsibilities were unclear. The ENP who was leading the department was the same grade as the other ENPs and so was not able to undertake their annual appraisals. Instead, their appraisals were carried out by the matron from the emergency department who had limited experience of individual's clinical practice or learning needs.
- The matron and lead nurse were liked and respected by all staff. Staff told us that they trusted them and knew that they would be listened to if they raised concerns.
- The lead nurse was highly visible within the unit and took an active part in clinical practice. Nursing staff told us that the matron was supportive and knowledgeable and they were impressed by the improvements that she had made since the last inspection.
- Trust documents state that the clinical director of the emergency department at Watford General Hospital had clinical and managerial responsibility for the urgent care centre. However, staff told us that due to the shortage of consultants at the emergency department, the clinical director was not able to visit the centre and did not have direct knowledge of the clinical practice that took place there. This meant there was no active medical oversight of the UCC. It was hoped that the situation would improve in October 2017 when a new consultant was due to commence employment.

### **Vision and strategy for this service**

- Staff were aware that the trust were in favour of keeping, and potentially expanding, urgent

care and minor injury services as close as possible to local population hubs including Hemel Hempstead. (Your care, your future 2015).

- However, there was no specific documented strategy for the UCC. When we asked the trust to send us details we were referred to the strategy for the Unscheduled Care division. The only reference to the UCC was that clinical pathways would be reviewed at some point in the future. There were no dates for this to be completed.

### **Governance, risk management and quality measurement**

- There had been some improvements in clinical governance since our last inspection. Aspects of clinical safety were now monitored on a monthly basis using a “Test your Care” audit tool. This looked at infection control measures, safeguarding procedures, medicines management and the readiness of resuscitation equipment.
- Monthly clinical governance meetings were held jointly with the minor injury unit at St. Albans Hospital. Minutes from meetings in May and June 2017 showed that complaints, incidents, risk and new working processes were discussed and acted upon.
- There was now clear guidance for staff on key areas of service delivery such as eligibility criteria for ambulance transfers and a flowchart to support reception staff in identifying patients who needed immediate treatment.
- There remained a lack of understanding of the risks that could impact on the delivery of good quality care, despite the fact that we had raised this at our last two inspections. We asked the trust to send us risks associated with urgent and emergency care that had been entered onto the appropriate risk register. Risks that we found on inspection had not been identified by the service. For example, the lack of effective monitoring of the time to initial clinical assessments.
- Although the UCC monitored the four hour admission to discharge target, there was no formal process in place to monitor other elements of performance, such as compliance to protocols or time to initial assessment or waiting times for treatment. This meant that the unit was not consistently identifying areas for improvement or compliance with best practice.
- At our last inspection we found that there was no programme for clinical or internal audits to measure patient outcomes or compliance with evidence-based guidelines. Although four audits had been planned for this year, none had been carried out. Nor had the unit been included in relevant audits that were taking place elsewhere in the unscheduled care division such as the use of head injury proforma and hand injury management.

### **Culture within the service**

- Staff told us that they felt respected and valued by their colleagues and immediate managers. They told us that there was a “no blame” culture that made it easier to admit mistakes and to learn from them.
- Staff that we spoke with told us that they enjoyed working at the unit and several of them had been in post for many years. They felt that they worked in a supportive environment and that there was a good sense of teamwork.
- It was also apparent that the culture within the UCC was centred on the needs and experience of patients who used the service. Several staff told us “It’s the patient who’s important.”
- The safety and wellbeing of staff was considered important. Flexible working was in place to allow for child care arrangements and there were regular checks by security staff to make sure that staff felt safe in the unit.
- Staff told us that if they witnessed another member of staff displaying behaviours that were not in line with the trust’s vision and values; they would challenge this or bring it to the attention of a senior manager.

### **Public engagement**

- There were questionnaires in the waiting and reception area of the unit asking patients to provide feedback about their experience at the UCC.
- Patients, carers, and relatives were able to leave feedback using the trust's public website.
- There had been consultations with the local population about the future of services at the UCC through their 'Your Care, Your Future' plans.

### **Staff engagement**

- Engagement with staff had improved since our last inspection. Regular staff meetings were now being held and concerns were listened to. They were kept informed of changes in the trust that would affect them and were consulted about future changes in the UCC.
- We were shown minutes of the last two meetings, which were well attended. Professional issues such as medicines management and best practice guidelines were discussed, as well as operational management of the centre and training opportunities.

### **Innovation, improvement and sustainability**

- Staff had taken photographs of the unit in order to compile a book to help communicate with people who had cognitive impairment. This consisted of photographs that illustrated common practices in the unit such as having an X-ray taken or a dressing applied. This helped people to understand the treatment that had been planned for them.

# Outpatients & Diagnostic Imaging

Safe	Requires improvement	●
Effective	Inspected but not rated	●
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

## Information about the service

West Hertfordshire Hospitals NHS Trust has outpatients and diagnostic imaging departments at three hospital sites: Watford General Hospital, Hemel Hempstead General Hospital and St Albans City Hospital. The trust had 520,693 initial and follow-up outpatient appointments from February 2016 to January 2017, with 124,498 of those appointments at Hemel Hempstead General Hospital.

Outpatients includes all areas where patients undergo physiological measurements, diagnostic testing, receive diagnostic test results, are given advice or receive care and treatment without being admitted as an inpatient or day case. They provide outpatient services across a wide range of specialities, including but not limited to, cardiology, gynaecology, urology, dermatology and rheumatology.

The outpatients department at Hemel Hempstead General Hospital has 14 consulting rooms and three treatment rooms. There is a large reception desk and two electronic booking in stands.

There is a separate outpatient department for children. Children and young people aged 0 to 18 years are also seen in dermatology and ear, nose and throat (ENT) clinics. The phlebotomy department took blood from children age five years and upwards.

The general outpatients department is managed within the trust's medical division. The clinical support services division managed phlebotomy and pathology. Divisional managers had oversight of all three trust sites, so there are similarities between the findings in this report, the St Albans City Hospital and Watford General Hospital reports.

During this inspection, we visited the following specialties at Hemel Hempstead General Hospital: cardiology, respiratory, gastroenterology, phlebotomy, pathology, fracture and ENT clinics. We also visited the diagnostic imaging department, which carries out routine x-ray, ultrasound scanning, fluoroscopy, magnetic resonance imaging (MRI), computed tomography (CT) and nuclear medicine investigations.

We spoke with 26 members of staff including nurses, doctors, healthcare assistants, radiographers, administrators and domestic staff. We spoke with 13 patients and relatives, considered the environment and looked at eight care records. We also reviewed the trust's outpatients and diagnostic imaging performance data.

The service was previously inspected in September 2016 and was rated good for safe, caring, and well-led and requiring improvement for responsive. We inspected but did not rate the service

for effectiveness, as we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging. The service was rated good overall.

## Summary of findings

Overall, we rated the outpatients and diagnostic imaging service as good because:

- Since our previous inspection in September 2016, an outpatient quality improvement plan (QIP) had been implemented for issues raised from the last inspection. Performance data had improved and the service was performing in line with their planned trajectory.
- There was a positive incident reporting culture across the services provided. All staff we spoke with knew how to report an incident and details of recent incidents and learning.
- Radiation protection in the diagnostic imaging department was robust.
- The main outpatient department had no nursing vacancies at the time of our inspection.
- Since our previous inspection in September 2016, the availability of patient notes had improved.
- Medical records were comprehensive, legible, accurate and up-to-date. They were stored safely in a locked office or in lockable trolleys when being used in clinics.
- Medicines and prescription pads were stored securely in all areas we visited.
- Waiting lists for outpatient appointments were reviewed weekly. Risk assessments and individual treatment plans were completed for patients who waited 30 weeks or more. At the time of our inspection, no clinical harm had occurred to patients because of waiting over 30 weeks.
- Care and treatment was delivered in line with evidence-based guidance, standards and best practice. Pathways were in place for the management and treatment of specific medical conditions that followed national guidance.
- There was a local audit programme in the outpatient department that included monitoring compliance with best practice.
- The diagnostic imaging department was working towards the Imaging Services Accreditation Scheme (ISAS).
- There was a comprehensive clinical audit programme in the radiology department to monitor compliance with trust policy and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- Clinics were run by specialists in their field and staff were supported to develop based on their professional and clinical interests. Multidisciplinary meetings were held to assess, plan and deliver co-ordinated patient care.
- The service communicated regularly with patients' GPs and worked with the trust's GP liaison manager to share information.
- Staff understood their responsibilities for obtaining consent and making decisions in line with legislation, including the Mental Capacity Act (MCA) 2005.
- Patients were treated with kindness, dignity, respect and compassion. Staff were considerate of people's personal, cultural, and religious needs.
- Chaperones were available throughout the outpatient and diagnostic imaging services.
- Staff communicated with people so that they understood their care, treatment and condition. Patients we spoke with felt well-informed about their treatment and could explain what would happen next.
- Staff recognised when people needed additional support to help them understand and took action to meet their needs.
- Patients we spoke with described being offered emotional and social support.
- During our last inspection, we were not assured that patients had timely access to outpatient treatment. The service was found to be in breach of Regulation 12 of the Health and Social Care Act Regulations 2014: Safe care and treatment, due to being worse than

national standards for waiting times. During this inspection, we found that most waiting times had improved to meet national standards.

- The trust had improved its performance for cancer waiting times and was meeting the national standard in four out of five measures.
- Patients had timely access to diagnostic imaging services and the percentage of patients waiting more than six weeks was lower than the England average.
- Services were planned and delivered to take into account different people's needs. This had improved since our previous inspection with the introduction of written information in languages other than English.
- The main outpatient department was working towards gaining a Purple Star accreditation for the care and treatment they provided to patients with a learning disability.
- The phlebotomy service engaged with people in vulnerable circumstances and took actions to overcome barriers when people found it difficult to access services.
- Leaders and staff across outpatient and diagnostic imaging services were continuously striving for improvement. In addition to the QIP, local leaders had further plans to improve services.
- The culture in across outpatient and diagnostic imaging services encouraged openness, candour and honesty. All staff we spoke with felt supported, respected and valued.
- Patients, relatives and visitors were actively engaged and involved when planning services. People were encouraged to provide feedback and we saw their comments used to improve.
- Leadership of the diagnostic imaging department was focused on driving improvement and delivering high quality care to patients.

However:

- During our previous inspection, we found that not all staff working in clinics that saw children had the appropriate level of safeguarding training. This was still the case at the inspection in August 2017.
- We could not be assured that the service was fulfilling its mandatory duty to report cases of female genital mutilation (FGM) as all staff we spoke with were unaware of the trust policy on identifying and assessing the risk of FGM.
- Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.
- Compliance with fire safety training in the radiology department was worse than the trust target of 90%.
- Staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training was below the trust target.
- There were no seven-day outpatient services provided at the time of inspection. Some ad-hoc Saturday clinics had been provided, but this had not taken place since March 2017. There were no plans to introduce evening or weekend clinics.
- Friends and Family Test scores for outpatient services across the trust were worse than the England average from January to June 2017. This had improved in July 2017.
- Five out of 16 specialties were not meeting the England overall performance for patients being seen within 18 weeks of referral.
- During the previous inspection, it was raised that hearing loops were not in use to aid people with hearing impairment. This was still the case at the most recent inspection.
- Staff were not always informed in advance if a new patient had mobility issues, a learning disability or dementia. This meant adjustments could not be made prior to their attendance to facilitate their journey through the department.
- At the time of inspection, there was only one risk on the outpatient department risk register. This was related to clinics being overbooked. However, during our inspection we identified other risks that should have been recognised.

## Are outpatients & diagnostic imaging services safe?

Requires improvement



We rated safe as requiring improvement because:

- During our previous inspection, we found that not all staff working in clinics that saw children had the appropriate level of safeguarding training. This was still the case at the inspection in August 2017.
- We could not be assured that the service was fulfilling its mandatory duty to report cases of female genital mutilation (FGM) as all staff we spoke with were unaware of the trust policy on identifying and assessing the risk of FGM.
- Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.
- Compliance with fire safety training in the radiology department was worse than the trust target of 90%.

However:

- There was a positive incident reporting culture across the services provided. All staff we spoke with knew how to report an incident and details of recent incidents and learning.
- The main outpatient department had no nursing vacancies at the time of our inspection.
- Since our previous inspection in September 2016, the availability of patient notes had improved.
- Waiting lists for outpatient appointments were reviewed weekly. Risk assessments and individual treatment plans were completed for patients who waited 30 weeks or more. At the time of our inspection, no clinical harm had occurred to patients because of waiting over 30 weeks.

### Incidents

- Incidents were reported and managed using an electronic system. All staff we spoke with knew how to report an incident and what should be reported. Staff knew about recent incidents that had occurred in the department and what actions had been taken to prevent re-occurrence. The monthly audit of compliance with nursing standards included checking staff awareness of how to use the electronic incident reporting system. Compliance at the time of inspection was 98%.
- There was a positive incident reporting culture in the department; staff were encouraged to report and received feedback when they did. All staff we spoke with knew how to report an incident and what should be reported. They could describe recent incidents that had occurred in the department and what actions had been taken to prevent re-occurrence. For example, there had been a number of recent incidents related to patients being kept waiting in the department for long periods due to delayed transport services. Staff were aware of this issue and contacted the transport provider as early as possible to arrange return transport for patients who required to minimise their waits and keep them informed.
- The trust provided data at the time of inspection that showed 1,325 incidents had been reported in outpatient and diagnostic imaging services from June 2016 to July 2017. However, after the inspection the trust deemed this information to be incorrect and provided data to show the total number of incidents reported in this time period was 344. Of the 344 incidents, 88 were reported in the outpatient services and 256 in diagnostic imaging. In diagnostic imaging, one incident was graded as catastrophic harm/death, one as severe harm and two as moderate harm. The remaining incidents were no to low harm. We verified this information against the national reporting and learning system (NRLS) to

ensure the dataset was correct.

- Data on incidents was for all three of the trust's outpatient sites as reports did not always specify which location they occurred at. The incidents graded as severe and catastrophic harm/death did not occur at Hemel Hempstead General Hospital.
- From June 2016 to July 2017, the trust reported no never events reported at Hemel Hempstead General Hospital. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SI) in outpatients at Hemel Hempstead General Hospital that met the reporting criteria set by NHS England from June 2016 to May 2017.
- The trust radiology department reported four incidents to CQC under Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) requirements. IR(ME)R states that NHS trusts must notify CQC when a patient receives radiation exposure that is much greater than intended. Of the four incidents reported from May 2016 to June 2017, one took place at Hemel Hempstead General Hospital. This incident involved a request for a CT chest scan being undertaken on the patient's kidney and bladder area. The request form was completed correctly but the scan was carried out on the wrong area. Immediate actions included explaining the error to the patient and sharing information on the incident with all staff. On inspection, we found that radiology staff were aware of the incident and could describe the learning points.
- Radiation incidents were discussed on a monthly basis at the radiation protection panel. Meetings minutes showed incident analysis to identify themes and communication of up to date IR(ME)R guidance for staff to follow. Staff could access hard copies of minutes in folders in staff areas.
- Staff could describe their responsibilities regarding the duty of candour requirements. They informed patients when things went wrong and there was evidence of apology in incident investigations we reviewed. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Monthly meetings were held for staff across the trust's outpatient services. We saw minutes dating back to December 2016. Each month included a discussion on safety, incidents and learning. The most recent meeting from August 2017 also included a briefing session on duty of candour requirements.
- If there was a safety issue affecting a particular clinic, briefing sessions were held with relevant staff. This included staffing levels and incidents.

## **Radiation Protection**

- The medical physics department supported diagnostic imaging staff by providing radiation protection services. This team included radiation protection advisor (as required under Ionising Radiation Regulations 1999 [IRR99]), medical physics experts (as required under Ionising Radiation (Medical Exposures) Regulations 2000 [IR(ME)R]) and radioactive waste advisors. The medical physics teams provided scientific support to radiology departments in a number of areas, such as monitoring specialist radiology equipment, monitoring staff radiation doses and providing guidance on the various specialists' regulations surrounding the use of imaging equipment.
- A radiation protection supervisor (RPS) was available for each diagnostic imaging modality as required by IRR99. The purpose of these roles was to ensure that staff followed local rules and adhered to radiation protection procedures in the department. Local rules

summarised the key working instructions to restrict exposure in radiation areas and were displayed in all areas we visited. Staff we spoke with knew who their RPS was and could contact them for advice.

- Risk assessments had been carried out on all imaging equipment and staff wore radiation badges to monitor any occupational doses. The radiation protection policy was regularly reviewed and the radiation protection team carried out regular audits. Results from audits demonstrated compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Radiation warning signs were clearly displayed outside all appropriate rooms in the diagnostic imaging department.
- There were systems in place to protect patients, visitors and staff from harm in the nuclear medicine department. For example, there was a designated toilet for patients to use post-procedure as radioactive waste posed a risk to other people. This toilet had a sign to indicate only post-procedure patients could use it. The toilet was monitored for radioactivity and levels were recorded. If the levels remained high at the end of a clinic, a sign was placed on the door to advise domestic staff not to enter the room until advised by a radiographer that it was safe to do so.

### **Cleanliness, infection control and hygiene**

- All outpatient areas we visited were visibly clean and there was evidence of regular cleaning schedules. Domestic staff were present in the department and responded quickly to issues such as spillages.
- During our previous inspection, it was highlighted that the cleaning methods for reusable naso-endoscopes used in ear, nose and throat (ENT) clinics did not meet best practice. We found that this was still the case at the inspection in August 2017. However, they did use a three-step cleaning technique to decontaminate scopes between patients, which was appropriate to maintain cleanliness. Because the scopes did not have lumens, the manual cleaning technique met Department of Health Technical Memorandum (HTM) 01-06 essential requirements. Best practice is to run the scopes through a washer-disinfector at the end of each clinic. The department had access to a washer-disinfector within the trust's endoscopy services but were not using this at the time of inspection. Senior staff recognised that this was an area for improvement. The cleaning methods used at the time of inspection were appropriate to keep patients safe.
- Naso-endoscopes were appropriately tracked and traced, in line with best practice. Once a scope was used on a patient, the unique identifying number was recorded in a log book and in the patient's notes. This allowed identification of patients who may be affected if cross-infection occurred. We observed this process at the time of inspection and found staff complied with trust policy.
- The eight re-usable naso-endoscopes were tested for leaks after each use, in line with the manufacturer's guidance to ensure they were safe for use. If a scope failed a leak test, they were removed from practice and sent for repair.
- Infection control audits were carried out in line with The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance. Information on the code of practice was displayed in patient waiting areas. The outpatient department achieved the trust target of 95% in every code of practice audit since January 2017. Sinks in clinical areas were compliant with infection control standards, for example no-touch taps and not having removable plugs.
- The main outpatient services monitored compliance with hand hygiene and infection control; however, audits were not carried out in the phlebotomy department. Phlebotomy was managed by clinical support services, therefore was not included in the main outpatient hand hygiene audit programme. We raised this with senior staff at the time of inspection and were advised that audits would be introduced. We did not observe any non-compliance with hand hygiene or infection control concerns in phlebotomy during our inspection.

- The weekly hand hygiene audit programme in the main outpatient department was introduced in January 2017. A hand hygiene competency assessment tool was implemented in March 2017. The main outpatient department achieved the trust target of 95% consistently since December 2016. Outpatients nursing staff achieved 100% compliance at the time of inspection. All staff we observed during our inspection followed hand hygiene best practice.
- Each clinic room had individual checklists in place that included infection prevention and control areas, such as availability of hand gel, soap and personal protective equipment (PPE) and ensuring changeable curtains were in date. We saw that checklists had been completed appropriately in the clinical areas we visited. PPE was available in all areas and we observed staff using it correctly.
- The trust tested water outlets in clinical areas for legionella (a bacterial disease) and pseudomonas aeruginosa (a bacterium ) as water supply can be a source of infection. The bi-annual infection and control report for October 2016 to March 2017 stated that all outlets in clinical areas were returning negative results for pseudomonas aeruginosa and there were no cases of legionella identified.
- From December 2016 to May 2017, the outpatients department reported no incidents of MRSA or hospital acquired *Clostridium difficile*. The appointment system was used to flag patients who carried MRSA to inform clinic staff in advance.
- There were disposable privacy curtains in the department that should be changed at a minimum every six months. Curtains were dated with when they were last changed and all were in date.
- The outpatient service had appointed a link nurse for infection prevention and control. Link nurses act as a point of communication between clinical teams and specialist nurses, for example infection control nurses. This allowed best practice to be shared and issues to be raised. A healthcare assistant had also been appointed as an infection control link for the department.
- Evidence of cleaning radiographic cassettes was displayed in diagnostic imaging areas.

## Environment and equipment

- The design and use of the facilities in the outpatient department generally kept patients safe. There were maintenance systems in place and staff could describe how to report any issues. The maintenance log book documented faults being reported and resolved promptly.
- There was a proactive approach to managing the health and safety risks to the environment. For example, there were issues with the heating and ventilation of environment and temperatures in the department often exceeded a comfortable range. All staff we spoke with were aware of the issue, the implications of the risk and could explain mitigating actions they took. We saw evidence of incident reports completed when temperatures increased beyond 25 degrees celsius.
- A health and safety assessment had been completed for the outpatients department. This was due for review at the time of inspection. The area was found to be compliant in 60 of the 65 points reviewed. Points of non-compliance included the issues with the heating and ventilation system. On inspection we saw that the heating and ventilation systems were included on the estates risk register and air conditioning units had been brought into the department. Further air conditioning units had been ordered, in addition to the ones we observed on inspection.
- All equipment we observed had evidence of electrical safety testing where appropriate. The magnetic resonance imaging (MRI) scanner was last serviced seven weeks prior to inspection, which was in line with the recommendation of testing every six to eight weeks.
- Adult and paediatric resuscitation equipment was available throughout the department and there was evidence of appropriate daily and weekly checks. The service submitted their

checklist records to the trust resuscitation officer so they could monitor compliance. Oxygen cylinders and emergency medicines were all in date at the time of our inspection.

- There were emergency call bells in each clinic room and a panel for staff to identify where the bell had been pressed.
- Clinical waste was appropriately separated and colour-coded for general waste, clinical waste and sharps. Sharps bins were dated, not overfilled and had temporary closures in place.
- In nuclear medicine, radioactive waste was managed and stored in line with safety guidance. Waste was stored in labelled lead-lined bins for one week and levels of radiation were monitored to ensure the radioactivity was decreasing to a safe level. After one week, waste was transferred to a locked store room for a further week before being disposed of. For radioactive products that took longer to decay to a safe level, waste was stored for one month before being disposed of. Waste safety limits were displayed in the nuclear medicine department.
- Needle safe devices were available for staff to use in phlebotomy, but this was not mandatory as staff were given a choice. Needle safe devices, such as detachable sheaths or devices where the needle retracts into the barrel after use minimise the risk of needle-stick injury to staff. Staff we spoke with could describe the trust policy for managing needle-stick injuries and knew to report this as an incident. There had not been a needle-stick injury reported in the six months prior to the inspection. A safer sharps procedure was displayed in the clinical area
- We observed phlebotomists taking blood from patients during our inspection. Specimens were appropriately labelled with the patient's NHS identification number and managed according to guidance.
- There was specialist personal protective equipment (PPE) in the diagnostic imaging department. This included five lead aprons for staff to wear during examinations. Lead aprons were checked for cracks on an annual basis. The most recent checks were completed in August 2017 and results showed no issues.
- Checklists in each room were completed to ensure the environment was safe for staff and patients. This included checking lights, bed brakes, plugs and call bells worked and that clinical waste were safely stored. It also included assessing the area for falls hazards, such as wires or cables on the floor. The checklists we reviewed had been completed appropriately for the month prior to the inspection.

## Medicines

- Medicines were managed in line with trust policy. Stock was rotated to ensure all medicines were in date and fridge and ambient room temperatures were recorded appropriately. There was evidence of checks completed daily.
- If temperatures of fridges or rooms where medicines were stored exceeded recommendation, staff knew what action to take. Due to heating and ventilation issues of the environment, the ambient room temperature of one medicines store had repeatedly exceeded 25 degrees celsius. The shelf-life and efficacy of medicines that are meant to be stored at room temperature can be affected if temperatures are outside of the recommended 15 to 25 degrees celsius range. Staff had recognised this issue and contacted the pharmacy team for advice on each occasion. To mitigate this risk, a decision was made to move the medicines store to another area. All staff we spoke with on inspection were aware of the issue and how the actions taken to improve.
- We checked medicines the outpatient department to ensure they were in-date and appropriate for use. All medicines in clinical areas and stores were found to be in-date. Staff dated the packaging of medicines to indicate it had been opened, where appropriate. This meant other staff members using the medicines could identify if it was safe to use and when it should be disposed of.

- All medicines were stored in locked cupboards or fridges during our inspection. In the main outpatient department, areas where medicines were stored had coded-access. Codes were changed every three to six months to minimise the risk of unauthorised people gaining access. There were no controlled drugs in the department.
- Medical gases, such as oxygen, were stored securely in appropriate brackets with empty cylinders stored separately. There were signs on doors advising where compressed gases were stored. The dermatology service used liquid nitrogen for some procedures. Small canisters were filled from the central store which was external to the building, in line with national guidance. Only appropriately trained staff could fill the small canisters for storage and use in the main outpatient department. We observed that canisters were stored upright in a separate container in a locked utility room and certificates to show staff were appropriately trained.
- In the radiology department, contrast media was stored separately in a locked cupboard. Radiology patients requiring contrast (chemicals that improve pictures of the inside of the body) were screened using safety questionnaires. Risks and potential side effects were also discussed with patients prior to administration.
- Staff administered radioactive materials to patients in line with national guidance and had the appropriate qualifications issued by the Administration of Radioactive Substances Advisory Committee (ARSAC certificate). ARSAC is a national body set up under the Medicines (Administration of Radioactive Substances) Regulations 1978. We saw copies of staff certificates during our inspection.
- Radiopharmaceuticals used in nuclear medicine were managed and stored in line with national safety guidance. We reviewed processes and saw evidence of the appropriate documentation to show the radioactivity of the medicine had been monitored and recorded at each stage of the delivery and storage process. Records were reviewed as part of the department's quality assurance.
- FP10 prescription pads were stored securely. FP10 prescription forms are used by medical and non-medical prescribers for outpatients and can be taken to any pharmacy. We saw that monitoring systems were in place to ensure that all prescriptions were accounted for. For example, recording the patient details, the FP10 number, which drugs had been issued and being signed by a doctor and a nurse.
- Patients could access the on-site pharmacy Monday to Friday from 9am to 5pm. There was no evening or weekend access on-site. Outside these hours nursing staff had access to on-call support from Watford General Hospital if they required medication advice or information. Medicines that could not be dispensed in the unit out of hours were prescribed using an FP10 prescription. These were stored securely and a record kept of the person that had used them and the medicine prescribed.

## Records

- Patients' individual care records were written and managed in a way that kept them safe. We reviewed eight records and found that they were all accurate, complete, legible and up to date. There was evidence of appropriate risk assessments, such as patient mobility and communication issues.
- Records were paper-based with some diagnostic requests and results stored electronically. The trust's outpatient strategy was to be 'paper-lite' by 2020 and paperless in 2022. By 2020, their aim was to have introduced electronic recording and document management systems so that all patient records, requests and clinic forms were accessed electronically. At the time of our inspection, plans had been delayed due to a recent cyber-attack. To minimise risk, the trust had temporarily suspended introduction of new IT systems and had shut down certain systems until the threat was reduced.
- Paper medical records were stored securely in lockable trolleys to maintain patient confidentiality. The trolleys had keypad codes so that only authorised professionals had

access. All trolleys were locked when unattended during our inspection.

- During our previous inspection in September 2016, it was highlighted that the availability of patient notes was causing an issue in clinics. At the inspection in August 2017, we found that notes were not always available in time for patient appointments, but rates had improved. From August 2016 to June 2017, on average 97% of patients' notes were available for their outpatient appointment. All staff we spoke said that the availability of records no longer caused problems for the running of clinics.
- If notes were not available in time for clinics, the trust mitigated this by preparing the patient's referral letter, patient labels and clinical note paper for new appointments, where appropriate. If the clinician deemed that this was not appropriate, the appointment would be rescheduled. Follow-up appointments could still take place as many specialties held a record of previous test results and clinic letters on their record systems.
- The trust reported that no appointments were cancelled as a result of notes not arriving to the outpatient department in time. Staff we spoke with on inspection confirmed this.
- The outpatient department quality improvement plan included implementing a system to track patient notes to improve the availability for clinics. This was in place at the inspection in August 2017.
- Radiology records were held securely on the radiology information system (RIS) and patient archiving communication system (PACS). Staff had access to PACS across the trust and the systems were password protected. Staff received training on these systems as part of the departmental induction.
- Imaging requests were made electronically by doctors and other trained staff across the trust and the local GP community. Paper request forms were still in use for external referrers outside of the trust.

## Safeguarding

- There were policies in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. However, staff in the outpatient departments were not aware of some policies and compliance with safeguarding training was not in line with national guidance.
- During our previous inspection, we found that not all staff working in clinics that saw children had the appropriate level of safeguarding training. This was still the case at the inspection in August 2017. Not all nursing or radiology staff who had direct contact with children had received level 3 safeguarding children training, which was not in line with national guidance. The Royal College of Paediatrics and Child Health 2014 intercollegiate document for safeguarding children and young people states that all healthcare professionals directly involved in assessing and treating children should be trained to level 3 in safeguarding children. At the time of inspection, only consultants, the senior sister and matron were trained to this level. All other nurses and radiology staff were trained to level 2. We raised the issue with senior staff who told us the trust's safeguarding team had advised that level 3 was not required for all staff working in clinics that see children. This was not in line with national guidance.
- Compliance rates for outpatients staff who were required to have safeguarding children levels 1 and 2 were 95% and 100% respectively, at the time of inspection. This met the trust target of 90%. Compliance for required radiology staff was 100% for levels 1 and 2.
- Compliance with adult safeguarding training across outpatients and radiology was 100% safeguarding adults level 1 and 2, compared to the trust target of 90%.
- All staff we spoke with, including senior managers were unaware of the trust policy on identifying and assessing the risk of female genital mutilation (FGM). It is a legal requirement for healthcare professionals to report cases of FGM to the police. The Department of Health issued national guidance to all healthcare services outlining the

requirement for appropriate policies and risk assessments to be communicated and used by all registered clinicians. The trust had a policy for identifying and assessing the risk of FGM, but no staff members we spoke with knew what it included. We raised this to senior staff at the time of inspection and were advised that they had also been unaware of this responsibility. We therefore could not be assured that the service was fulfilling the mandatory reporting duty. Managers advised that the importance of this policy would be communicated to all staff.

- Other than the FGM policy, staff were aware of their responsibilities to report safeguarding concerns and knew who to contact for advice. There was a safeguarding link nurse to provide advice and guidance to the team, where needed. The safeguarding link nurse described contacting the trust safeguarding lead for advice on handling safeguarding concerns. We saw evidence that safeguarding was discussed in departmental monthly meetings.
- Safeguarding concerns were shared with patients' GPs via written letters or a shared electronic system. GPs included safeguarding concerns in their referrals to the outpatient and diagnostic imaging departments.
- Information on safeguarding from abuse was displayed in waiting areas so patients and visitors could see. The information included advice and support for child sexual exploitation.
- Staff in diagnostic imaging followed safeguarding procedures such as 'Paused and Checked'. The 'Paused and Checked' process was developed by the Society and College of Radiographers and involves checking the justification of the exam, the pregnancy status of the patient, their examination history in case of duplication, the anatomical area to be examined and that radiation safety measures for staff and/or carers have been undertaken. Information was displayed in all imaging areas we visited and staff could describe the process.
- The World Health Organisation (WHO) surgical safety checklist was in use in the diagnostic imaging department. The WHO checklist was designed to prevent incidents due to wrong procedures, sites or patients. We saw evidence of WHO checklists completed appropriately.

### **Mandatory training**

- The trust's mandatory training included adult basic life support, conflict resolution, equality and diversity, fire and evacuation, hand hygiene, health and safety, infection control, information governance, moving and handling and safeguarding.
- Training was completed as e-learning modules with some face-to-face sessions, such as manual handling and basic life support. Staff completed basic life support training annually.
- Senior nurses monitored staff compliance with mandatory training on a monthly basis. Email reminders were sent to staff whose training was due the following month.
- Compliance with mandatory training was 98% for medical and nursing staff in the outpatient departments. This was better than the trust target of 90%. The department achieved the target for compliance in all twelve modules.
- The trust radiology department also achieved the trust target for overall compliance with mandatory training. Compliance was 100% in nine out of eleven modules; however compliance with fire safety training was worse than the trust target of 90%. Overall staff compliance was 76%. Nursing staff compliance was 40% for clinical staff and 80% for non-clinical staff.

### **Assessing and responding to patient risk**

- All clinical areas had processes in place to assess and monitor patient risks. We saw robust risk assessments for patients attending the outpatient departments. This included

use of a 'generic assessment of patients' tool for moving and handling. This was used for patients with mobility issues. Staff had attended study days for the use of this risk assessment tool. There were also violence and aggression, falls and sharps risk assessments in place.

- The World Health Organisation (WHO) five steps to safer surgery was completed for patients undergoing minor procedures in the outpatient department, for example in dermatology. Patient records we reviewed showed the WHO checklist had been completed, where appropriate. Pregnancy checks were also undertaken before a patient had a minor procedure in dermatology.
- If a patient became clinically unwell in an outpatient area, staff would monitor them and check their vital signs then call the direct number for emergency assistance if needed. The direct number for emergency assistance sent a message to bleep devices which were held by an on-call team of senior nurses across the Hemel Hempstead General Hospital site. Bleep devices were tested daily to ensure they were working correctly.
- If a patient had a cardiac arrest, the process was to call the on-site emergency team and 999. They then managed the patient using life support training until an ambulance arrived. In the diagnostic imaging department, the tables where patients sat or lay for their examinations could be detached from the scanner to allow staff to access them to perform basic life support. Staff we spoke with were aware of the process and what action they would take if a patient deteriorated. Competency folders in the diagnostic imaging showed all staff had read and signed the trust cardiac arrest policy.
- There was an appointed resuscitation officer who attended the outpatient departments to run scenario training every six months. We saw evidence of de-briefing sessions held with staff to discuss areas for improvement from the most recent scenario training in February 2017. The service had also appointed a local resuscitation lead to provide advice and support to staff on-site.
- Anaphylaxis trays were stored in the outpatient and diagnostic imaging departments to respond to patients who had an allergic reaction. Anaphylaxis is a severe and potentially life-threatening reaction to a trigger, such as an allergy. Trays were stored in medicines cupboards and were portable so that they could be taken to patients. Risk assessments for patients who were having minor operations or injections, such as in dermatology included known allergies.
- Phlebotomy staff demonstrated how they would manage a vasovagal syncope. Vasovagal syncope is the term for a person fainting due to certain triggers, such as low blood pressure or the sight of blood. It is therefore more common in phlebotomy. Staff responded to vasovagal syncope by reclining the patient's chair and getting them a drink of water to help their blood pressure return to normal. If the patient did not seem to recover as expected, phlebotomists called an outpatients nurse to check vital signs and could transport patients to the on-site urgent care centre. Patients with low blood sugar were given glucose-drinks or biscuits to stabilise their sugar levels. Emergency procedures were displayed in the clinical area.
- There were emergency grab bags for patients with diabetes who may have a hypoglycaemic episode (low blood sugar) while attending an outpatient appointment. This contained glucose-drinks and emergency insulin products to be administered, where appropriate. Weekly checks of the grab bags contents were recorded and everything was in date at the time of inspection. Staff we spoke with could describe how they would use the kits to treat a patient who had dangerously low blood sugars.
- Waiting lists for outpatient appointments were reviewed weekly. Risk assessments and individual treatment plans were completed for patients who waited 30 weeks or more. Treatment plans included identifying risk of further delays, for example if a patient had previously failed to engage with the service or capacity issues within the department. Operational managers worked with clinicians and schedulers from each specialty to monitor waiting times on an ongoing basis. At the time of our inspection, no clinical harm

had occurred to patients because of waiting over 30 weeks.

- Areas where radiation took place were clearly signposted and there were lights outside each room to indicate when imaging occurred. This was to highlight to patients, staff and visitors that imaging was taking place and there was a risk of exposure to radiation.
- Staff in the diagnostic imaging department were trained to cannulate patients and administer intravenous contrast media for computed tomography (CT) scans. CT safety questionnaires were sent to patients prior to their appointment so that risks could be assessed before an examination took place.
- The service audited the percentage of patients who had their pregnancy status recorded to monitor compliance with IR(ME)R guidance. In 2017, 98% of patients had their pregnancy status recorded in their notes. There were signs in waiting areas and x-ray rooms reminding patients to inform staff if they may be pregnant. Staff we spoke with were aware of the importance of checking the pregnancy status of female patients.
- The trust held annual radiation incident summits where teams challenged each other on why each radiation incident had occurred and the lessons learned. These meetings were introduced in 2014 and three had been held at the time of our inspection.
- The diagnostic imaging department monitored requests for examinations, in line with IR(ME)R recommendations. Request forms from all three sites were included. Results show that 92% of forms were appropriately filled in, signed and had patient identity checked against the electronic system. This was an improvement since 2016 when compliance was 88%. Audits were also conducted to ensure referrals were made by approved healthcare professionals only. The trust was 100% compliant with this measure.

## **Nursing staffing**

- Nursing establishments for the outpatient department were planned and reviewed to ensure safe care for patients based on clinic volumes and capacity. The trust did not use an acuity tool to determine staffing for outpatient services. Staffing levels and skill mix across all of the trust's three sites were discussed during monthly senior nurse meetings.
- During our previous inspection in September 2016, we were told a business plan had been submitted to increase the trained nursing establishment for all outpatients' services across the trust's three sites. At the inspection in August 2017, we found that this had been approved and recruitment was in progress. A review of nursing skill mix had identified the need for three additional healthcare assistants on each of the trust's three sites. This had been approved at Hemel Hempstead General Hospital and vacancies were out to advert at the time of inspection.
- Staffing levels were appropriate for the services provided at the time of inspection. The actual number of nurses and healthcare assistants on duty was in line with the planned level. Nursing and healthcare assistant staffing levels were displayed in waiting areas. Rotas for the previous five months showed staffing levels generally met service demand.
- The outpatients department at Hemel Hempstead General Hospital had a nursing establishment of 14.96 whole time equivalent (WTE) staff. Other than the three additional healthcare assistant posts that were being recruited, there were no vacancies at the time of our inspection.
- The outpatients departments across the trust were meeting the target for managing nursing sickness rate. There was an average of 2.9% nursing sickness, compared to the trust target of 3.5%.
- Bank staff were used to cover sickness and shifts that were short-staffed. There was an induction programme for all bank staff to complete before working in the department. Most bank staff worked regularly in the department so were familiar with policies and procedures. The service did not use agency staff to cover shifts.
- Student nurses undertook clinical placements in the outpatients and diagnostic imaging department.

## **Radiology staffing**

- Radiologist workload was allocated according to a staffing tool. This was based on individual radiologist job plans, reporting parameters and the department's radiologists' rota.
- The radiology department was open for outpatients to access diagnostic imaging from 8am to 8pm, Monday to Friday.
- Each area within the imaging department had superintendents. This was a senior practitioner who worked with the team to monitor staff competence and ensure compliance with training.
- Radiography assistants had been recruited to assist radiographers and undertake clerical duties. They were trained to carry out tasks such as monitoring the storage of drugs and contrast media to ensure they were safe.
- A new staff rostering system had been introduced to improve radiology staff availability. Staff were allocated into teams who worked on rotations of three twelve-hour shifts and then one week off. All staff were spoke positively about the new way of working and felt it had improved service delivery.
- In July 2017, there was a medical vacancy rate of 23.4% across the trust's diagnostic imaging services. The turnover rate was 5%. Locum staff were used to fill shifts. In May 2017, there was a 9% locum usage.
- The induction for new radiologists and radiographers included reading and signing local rules and employee procedures. All staff we spoke with had undergone appropriate induction.
- Final year medical students and undergraduate radiography students undertook clinical placements at the trust. Students worked with and were supervised by superintendent radiographers. There were plans to also have postgraduate radiology trainees and registrars to join the department. The timescale for this was 2017 to 2018.

## **Medical staffing**

- The individual specialities arranged medical cover for their clinics. Clinicians and divisional managers agreed the structure of clinics and patient numbers.
- Clinic medical staffing was arranged by the individual specialities such as cardiology, gastroenterology and dermatology in line with the activity and demands of the service. Medical staff worked across the range of sites within the trust to facilitate outpatient clinics.
- Consultants were supported by junior colleagues in clinics where this was appropriate. For example, we saw some urology clinics were staffed by junior doctors as part of their training rotation.
- In May 2017, the overall vacancy rate for medical staff across the outpatient specialties was 2%, which was better than the trust target of 9%. The overall medical staff sickness rate for this period was 1%, which was better than the trust target of 3.5%.
- From June 2016 to May 2017, the overall turnover rate for medical staff was 21%, which was worse than the trust target of 12%. Locum staff were used to ensure staffing levels met demand. From August 2016 to May 2017, the average locum usage was 12% across the trust's outpatient specialties.

## **Major incident awareness and training**

- Fire safety assessments were completed for the outpatient areas every two years. The appointed fire safety officers completed assessments in line with the trust policy. Fire safety officers made recommendations and action plans were managed by departmental fire marshals. However, the 2017 assessment showed that there were not enough staff members trained as fire marshals to cover all clinics. On inspection, we found that this had

been resolved. Fire marshals names were displayed throughout the outpatient department and there were marshals appointed in phlebotomy and pathology. Other action points included out of date extinguishers. We found that this had also been resolved.

- In the event of a power cut, there was a trust policy for getting patients out of diagnostic imaging scanners. Staff we spoke with on inspection could describe this process and we saw evidence of their competency signed by senior staff.
- The IT systems were recognised as a risk to service delivery and were included on the divisional risk register. The service continuity plan was to store clinic information, such as lists, investigation forms and results in hard copy so that appointments could still take place. Paper forms were processed once the IT systems were running. Consultants we spoke with told us that if IT systems went down they relied on patients' paper records. The trust had recently replaced all computers in the outpatient department, but staff reported that issues still frequently occurred as the systems that fed into the computers had not yet been replaced. The issue was recognised by the trust and plans were being developed to replace all IT systems that were not fit for purpose.
- Service continuity plans for IT system failure were also in place in the pathology department. They had hard copies of telephone numbers for local labs they could access to run basic tests in emergencies, so that patients could still receive prompt diagnostic services.

Are outpatients & diagnostic imaging services effective?

Inspected but not rated ●

We inspected, but did not rate the service for effectiveness. We found:

- Care and treatment was delivered in line with evidence-based guidance, standards and best practice. Pathways were in place for the management and treatment of specific medical conditions that followed national guidance.
- There was a local audit programme in the outpatient department that included monitoring compliance with best practice.
- The diagnostic imaging department was working towards the Imaging Services Accreditation Scheme (ISAS).
- There was a comprehensive clinical audit programme in the radiology department to monitor compliance with trust policy and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- Clinics were run by specialists in their field and staff were supported to develop based on their professional and clinical interests. Multidisciplinary meetings were held to assess, plan and deliver co-ordinated patient care.
- The service communicated regularly with patients' GPs and worked with the trust's GP liaison manager to share information.
- Staff understood their responsibilities for obtaining consent and making decisions in line with legislation, including the Mental Capacity Act (MCA) 2005.

However:

- There were no seven-day outpatient services provided at the time of inspection. Some ad-hoc Saturday clinics had been provided, but this had not taken place since March 2017. There were no plans to introduce evening or weekend clinics.
- Staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training was below the trust target.

## Evidence-based care and treatment

- Care and treatment was delivered in line with evidence-based guidance, standards and best practice. Trust policies were up to date and assessed to ensure they did not discriminate on the basis of race, nationality, gender, religion or belief, sexual orientation or age.
- Pathways were in place for the management and treatment of specific medical conditions that followed national guidance. For example, the National Institute for Health and Care Excellence (NICE) clinical guidance CG169, 'Acute kidney injury: prevention, detection and management' was followed in the pathology department. Staff we spoke with could describe how they complied with this guidance when analysing blood samples.
- The service followed the trust's post-fall protocol if a patient fell in the outpatient department. Guidance was displayed at nursing stations and included using the National Early Warning Score (NEWS). NEWS uses physiological measurements to assess the severity of a person's condition.
- The pain service followed guidance from the British Pain Society (BPS) and consultants were working towards gaining accreditation as a BPS-recognised pain centre. This included using activity management techniques, pharmacological and non-pharmacological pain relief and providing therapies such as cognitive behavioural therapy (CBT). CBT is a form of talking therapy that is used to re-address how people think to promote health and wellbeing.
- There was a comprehensive clinical audit programme in the radiology department to monitor compliance with trust policy and best practice, including Adult General Radiography Written Examination protocols, Radiology Reporting protocols and Local Rules. Local Rules are sets of working instructions staff should follow to minimise radiation exposure. Results for 2017 showed 96% of examinations reviewed were compliant with Adult General Radiography Written Examination protocols and 98% of attendances reviewed were reported in line with Radiology Reporting protocols. This was an improvement since the previous year. The percentage of staff members who had read and signed the local rules had also improved since 2016; however, compliance was 63%, which was worse than the trust target of 100%. Actions to improve this result included sending email reminders and displaying posters with the importance of reading local rules. We observed these posters throughout the department during our inspection in August 2017.
- Dose reference levels (DRLs) were used in the radiology department. DRLs are used to optimise medical exposure, which means using a level of radiation that produces high quality images but has minimal effect on the patient. DRLs were displayed in all imaging areas we visited.
- The radiation dose administered to a patient was recorded in their notes, in line with IR(ME)R recommendations. Audits were conducted to monitor compliance. Results for 2017 showed 94% of patients had their doses recorded in line with guidance. The trust target was 100%. Audits and actions to improve were discussed at monthly meetings.
- The diagnostic imaging service also monitored its compliance with best practice relating to patients receiving chest radiography. Guidance from the Royal College of Radiologists (RCR) states that it is best practice to undertake chest radiographs on patients in the postero-anterior (PA) upright position, apart from when this is not appropriate due to immobility or ill-health. PA position is where the patient is stood up facing the scanner. The RCR set targets of 95% of outpatient chest radiographs should be undertaken in PA position as it improves image quality. In an audit in June 2017, the service achieved the outpatient target. A re-audit was scheduled to monitor ongoing compliance. Staff we spoke with were aware of the audits and told us that all patients who were assessed as being suitable for PA positioning, were scanned in that manner.

## **Nutrition and hydration**

- Nutrition and hydration was not routinely assessed as part of the outpatient services. The hospital café was directly next to the main outpatient area so patients and visitors could buy food and drinks.
- There were water coolers available in waiting areas and staff offered hot drinks and refreshments to patients who waited long periods of time, or if the café was closed. The trust had recently changed their patient transport service provider which had caused delays in people arriving and leaving the department. Staff offered these patients hot drinks, sandwiches and biscuits while they waited.
- Glucose preparations, drinks and biscuits were available in the outpatient department for patients with diabetes if their blood sugars were found to be low. The manufacturer of the glucose drinks had recently changed its sugar content. This information was displayed in staff areas so that staff were aware.

## **Pain relief**

- Pain relief could be prescribed within the outpatient department and subsequently dispensed by the pharmacy as required.
- Staff had access to simple analgesia in areas where patients were undergoing minor procedures. In ear, nose and throat (ENT) clinics, pain relief sprays were used prior to inserting a scope.
- Phlebotomy staff used cold sprays to reduce pain when taking blood. Children who attended phlebotomy arrived with local anaesthetic cream prescribed by their GP, where appropriate.
- There was a chronic pain service run by four consultants who specialised in pain management, in line with the Royal College of Anaesthetists recommendations. The consultant we spoke with had undergone advanced pain training as part of their professional development.
- Multidisciplinary clinics were held for patients attending the pain service. This included clinical psychology staff, in line with the Faculty of Pain Medicine's Core Standards for Pain Management (2015). However, at the time of inspection the service did not have physiotherapy or pharmacy input as recommended. The consultant we spoke with had identified that this was an area for improvement and had submitted a business case for physiotherapy input into the service. Previous business cases had not been successful, but they were in the process of developing a new case.

## **Patient outcomes**

- During our previous inspection in September 2016, the trust stated that they planned to begin submitting data to national audits, such as the national diabetic foot audit 2016/17. At the time of this inspection in August 2017, the diabetes service had made a submission but results were not yet published. The trust had also reported that they planned to begin submitting data to other national audits to monitor outpatient outcomes; however we found that this had not yet been introduced.
- The pain service submitted patient outcome data to the National Pain Audit to benchmark against other similar services. This involved collecting Patient Reported Outcome Measures (PROMS). The PROMS were questionnaires for patients to fill in at their first visit to the clinic, six months afterwards and 12 months after their initial appointment. This was used to calculate each patient's pain severity. Results for the trust show they performed in line with national average. Staff also collected patients' pain outcomes locally by monitoring their pain scores at each visit and after treatments, such as injections.
- There was a local audit programme in the outpatient department. This included the 'Test Your Care' audit which monitored compliance with best practice, such as the percentage of

patients offered smoking cessation advice in line with NICE guidance. The audit also monitored the percentage of patients who were offered alcohol consumption advice, had their height and weight recorded and had observations appropriately recorded. The outpatient departments had received an award for achieving over 90% on 11 consecutive months. The latest results for July 2017 were displayed in the patient waiting area and showed 100% compliance. The service had appointed a healthcare assistant as a 'Test Your Care' champion to monitor compliance throughout the month.

- From February 2016 to January 2017, the follow-up to new rate for Hemel Hempstead General Hospital was similar to the England average. Follow-up to new ratios calculate the proportion of outpatient appointments that are patients' first attendance and the proportion that are follow-up appointments. There are no national standards for this measure; it is used to determine how much time is taken up with follow-up appointments as may reduce capacity to see new patients.
- The diagnostic imaging department was working towards the Imaging Services Accreditation Scheme (ISAS). This was a development since our last inspection when ISAS was not being considered. ISAS is a patient-focussed assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. The lead superintendent radiographer had recently become a qualified ISAS assessor which meant they were aware of best practice and how to achieve this. The timescale for this work to be completed was April 2018.
- The outpatients department did not participate in the Improving Quality in Physiological Services (IQIPS) accreditation scheme. IQIPS is a professionally-led assessment and accreditation programme that is designed to help healthcare organisations ensure that patients receive consistently high quality services, tests, examinations and procedures delivered by competent staff working in safe environments. There were no plans in place to gain this accreditation.

### **Competent staff**

- During our previous inspection, the service was found to be in breach of Regulation 18 of the Health and Social Care Act Regulations 2014: Staffing due to low appraisal rates. At the inspection, we found that appraisal rates had improved to meet the trust target of 90%. Data for July 2017 showed 94% of staff within outpatients had received an appraisal. The radiology department was also in line with the trust target for appraisal rates. In August 2017, 91% of staff had received their annual appraisal. However, this was the highest it had been in the six months prior to our inspection when rates were from 71% to 90%.
- Senior staff reviewed competency folders to identify areas for development, which were then discussed at appraisal meetings. Staff also described being able to discuss additional training they were interested in with their managers on an ad-hoc basis. Senior nurses had records of bank staff competencies so they could plan a skill mix that was appropriate for the clinics provided when using bank staff.
- Study days were held for areas such as leg ulcer management and brief interventions for smoking and alcohol.
- During one-to-one meetings with their managers, nurses and healthcare assistants who worked in gastroenterology clinics had shown an interest in following the patient pathway after they attended for an outpatient appointment. This had been supported and three members of staff we spoke to had been given the opportunity to observe an endoscopy procedure. Other nursing and care staff had asked if they could observe x-ray procedures as patients often expressed anxiety around what would happen. All staff we spoke with said this had reinforced their clinical knowledge and allowed them to provide patients with further information during their outpatient visits.
- There were processes for monitoring and managing staff performance in the radiology and phlebotomy departments. For example, in radiology, audits were conducted to monitor staff

compliance with best practice for cannulating patients and administering intravenous contrast media for computed tomography (CT) scans, in line with recommendations from the Royal College of Radiologists. Individual staff members' audit results were discussed at one-to-one meetings with their lead superintendent radiographer.

- In phlebotomy there was a process for identifying and managing variable staff performance relating to the quality of blood samples taken. The pathology lab was in the same department as the phlebotomy unit at Hemel Hempstead General Hospital. Blood samples were taken directly to the pathology lab for testing. The lab rejected samples if they did not meet the necessary standards to produce reliable diagnostic results. Reasons for rejection included insufficient volumes of blood taken and clotted samples, both of which could be prevented through appropriate clinical practice. If a sample was rejected by the pathology lab, phlebotomy staff were notified and could identify who had taken the sample from records. The incident would be discussed with the individual so that training and supervision could be arranged. The error rate reported was low.
- Staff in diagnostic imaging were given opportunities to develop. For example, radiographers had expressed an interest in becoming trained in barium swallow examinations (an X-ray imaging test used to visualise the structures of the oesophagus). This had been supported and a member of staff had commenced training.
- There was a clinical supervision policy in the radiology department. The policy stated all professional practitioners that had direct contact with patients should receive one-to-one supervision every eight weeks. Appointed supervisors were given training to ensure they were competent in their role. Staff we spoke with had received regular clinical supervision in line with the trust policy.
- The lead superintendent radiographer was receiving external training to become an Imaging Services Accreditation Scheme (ISAS) assessor. This meant they had been trained in radiology best practice so that they could assess departments that were applying for accreditation. The lead superintendent had shared learning with the team.
- Clinicians who were specialists in their field ran outpatient clinics. For example, a team of consultant urologists, urology nurse specialists and a cancer nurse specialist ran the outpatient urology service. Specialist paediatric consultants and nurses ran clinics that saw children in dermatology.
- A consultant in the chronic pain service was the neuropathic representative for the British Pain Society and used this knowledge to plan and deliver services. They were part of a national specialist interest group for neuropathic pain that discussed understanding, education and research in the identification, prevention and management of neuropathic pain.
- There were education leads at the trust to support registered clinicians through revalidation. Continuous professional development sessions were held and staff were provided with certificates to support their revalidation. Copies of certificates from training courses and study days were also kept on-site so managers could monitor staff competency across the department.
- Senior nurses we spoke with had been supported to undertake leadership courses provided by the trust. One nurse was on a leadership masters course at the time of inspection.
- Bank and newly recruited staff received an induction that included trust policies and departmental procedures. Staff who had recently completed this induction told us it supported them to start their role. Nurses spent two weeks supernumerary and were only included in the nursing staffing levels once they were assessed as competent and felt confident in their roles. Newly recruited radiology staff were supervised by a mentor and rotated through the clinical areas to gain experience.

## **Multidisciplinary working**

- Outpatient and diagnostic teams worked together to plan and deliver care and treatment. Staff worked together to assess, plan and deliver co-ordinated care.
- Multidisciplinary team (MDT) meetings included clinicians from different specialties to provide effective assessment and treatment. For example, the chronic pain service worked with clinicians from musculoskeletal and spinal care to provide co-ordinated assessments and pain management.
- One-stop clinics were provided in urology, respiratory, dermatology and ear, nose and throat (ENT) clinics. A one-stop clinic involves a multidisciplinary team providing consultation, diagnostic testing, results and treatment options in one visit. For example, haematuria clinics allowed patients to access computed tomography (CT), ultrasound and cystoscopy and receive results on the same day. This facilitated prompt diagnosis and treatment planning.
- Specialist nurses completed clinics either independently or in conjunction with the consultant/ medical team. This included respiratory, dermatology and urology clinics. Nurse-led urology clinics included prostate assessment and flow-rate clinics (to assess bladder function).
- The trust assessed diagnostic imaging requests to ensure the examination was appropriate and prevent risk of unnecessary radiation exposure to patients. Radiology staff reviewed each patient's previous examinations, including those undertaken by external providers, to determine if the request was justified. This was in line with IR(ME)R guidance, which states all non-emergency, in-hours examination requests should be vetted prior to the appointment being made.

## **Seven-day services**

- During our previous inspection in September 2016, managers were discussing plans to introduce six-day services. This was not in place at the time of inspection in August 2017. There had been some ad-hoc clinics held on Saturday mornings, but that had not occurred since March 2017. Saturday clinics had been suspended due to issues with staffing and resource capacity at weekends.
- Outpatient and diagnostic imaging services were provided at Hemel Hempstead General Hospital from 9am to 5pm, Monday to Friday. There were no plans in place to implement weekend clinics.

## **Access to information**

- The information needed to deliver effective care and treatment was available to relevant staff; however this was sometimes delayed by the functionality of the IT systems. Medical records were paper-based; however referrals and test results were also stored electronically. Staff told us that sometimes the IT systems were slow and could impact administration staff ability to fulfil their roles in a timely way. Medical, nursing and administration staff we spoke with reported issues with the IT system and stated that they regularly caused delays in accessing information. The issue had been recognised by the trust and plans were in place to monitor progress. Computers in the outpatient department had been replaced; however, the systems they used were still causing delays. The trust was planning to replace all systems.
- Each clinic room had a computer so that staff could access the trust intranet to obtain information relating to trust policies, procedures, NICE guidance and e-learning. Staff could demonstrate how they accessed information. When a policy was introduced or reviewed, there was a document for staff to sign to indicate that they had read and understood the contents. We saw evidence of this during our inspection.
- Communication with GPs was via an electronic system and the trust's GP Liaison

Manager. The GP liaison manager role was to promote communication between the three trust sites and local GPs. In May 2017, the GP liaison manager had attended the outpatient senior nurses meeting with staff from all three outpatient sites. As a result, the June 2017 newsletter that was sent to GPs included a feature on the outpatient departments. This focused on the use of purple folders to improve continuity of care for patients with a learning disability or living with dementia. Patients carried purple folders to share information between health and social care providers. The GP liaison manager also discussed the availability of results and inappropriate consultant requests.

- Requests for imaging were received via electronic and paper-based systems from GPs and other healthcare providers. The radiology department monitored the quality of information they received. IR(ME)R guidance states that referral forms must include all patient demographics, such as their title, name, date of birth, address, NHS number and GP address. Audit results for 2017 showed external providers did not always comply with IR(ME)R guidance when submitting request forms. The trust responded to this by communicating with referrers to remind them of the importance of sharing all relevant information with the receiving radiology department.
- GPs could access the electronic system used by the diagnostic imaging department to store examination results. This included patients' reports for plain film x-rays, ultrasound examinations, nuclear medicine investigations and some CT scans.
- The outpatient and diagnostic imaging departments participated in the National Cancer Patient Experience Survey 2017. Scores were in line with the England average for doctors having the right notes and other documentation available.

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

- Staff understood their responsibilities for obtaining consent and making decisions in line with legislation, including the Mental Capacity Act (MCA) 2005. Patient records we reviewed contained evidence of appropriate consent, where required. Consent was obtained on the day by consultants who were carrying out the procedure, in line with legislation.
- The service used different consent forms, depending on the patients' capacity to make the decision. This was in line with Department of Health guidance. They used four nationally recognised consent forms: one for adults with the capacity to consent to treatment, one for obtaining parental consent for treatment of a child or young person, one for treatment where consciousness is impaired and another for adults who have been assessed as lacking the capacity to consent to treatment.
- Staff received training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). Compliance was worse than the trust target for staff in the outpatient departments. Data for July 2017 showed 78% compliance, compared to a trust target of 90%. However, all staff we spoke with during our inspection could describe the appropriate actions to take if it was suspected that a patient may lack capacity.
- Staff could access information on the mental capacity act in a folder in the senior nurses' office. This included the trust's MCA and DOLS policies, guidance on completing MCA assessments in line with legislation and copies of MCA assessment forms. We also saw evidence of MCA assessment forms appropriately completed in clinics.
- We observed implied consent being obtained in the phlebotomy department. Implied consent can be expressed by a person's actions, rather than a verbal or written agreement. For example, we observed a phlebotomist explaining the procedure of taking blood from a patient; the patient then held out their arm to allow this to happen. Staff we spoke with were aware of the legislation and that implied consent was appropriate in such cases.
- All patients we spoke with felt that their care and treatment was fully explained. They described being given options for treatment with pros and cons of each explained so that

they were informed to make their own decisions.

## Are outpatients & diagnostic imaging services caring?

Good 

We rated caring as good because:

- Patients were treated with kindness, dignity, respect and compassion. Staff were considerate of people's personal, cultural, and religious needs.
- Chaperones were available throughout the outpatient and diagnostic imaging services.
- Staff communicated with people so that they understood their care, treatment and condition. Patients we spoke with felt well-informed about their treatment and could explain what would happen next.
- Staff recognised when people needed additional support to help them understand and took action to meet their needs.
- Patients we spoke with described being offered emotional and social support.

However:

- However, Friends and Family Test scores for outpatient services across the trust were worse than the England average from January to June 2017, although this had improved in July 2017.

### Compassionate care

- Patients were treated with kindness, dignity, respect and compassion. Staff understood people's personal, cultural and religious needs and provided care in a considerate manner. We observed caring interactions throughout our inspection and staff introducing themselves to patients and visitors.
- All patient feedback we received on inspection was positive about the treatment staff provided. Patients were actively encouraged to provide feedback and we saw most patients filling in Friends and Family Test (FFT) forms in clinics we attended. There were thank you cards and letters displayed in staff areas.
- Friends and Family Test (FFT) data for July 2017 showed 94% of outpatients would recommend the service, which was in line with the England average. However, from January to June 2017 the average score was 92%, which was below the England average of 94%. Scores were generated using the FFT feedback tool that supports people who use NHS services to provide feedback on their experience. It asks people if they would recommend the services they have used. Their average response rate for the trust was 4%, compared to an England average of 7%.
- During our inspection, we found that senior nurses collected their FFT for each hospital site, as well as the nationally reported statistic. For July 2017, Hemel Hempstead General Hospital outpatient department scored 96%, which was better than the England average.
- Chaperones were available throughout the outpatient and diagnostic imaging services. Information on the chaperone policy was displayed in clinical rooms and waiting areas. All patients we spoke with said they had been offered a chaperone or to have a friend or relative accompany them.
- Reception had a queuing area set up with signs advising patients to wait before being called to the desk. This meant patients could speak to receptionists without being overheard.
- Boards that were used to inform patients of waiting times included the consultant name only, not the specialty or service provided. Staff advised that this was to maintain patient

privacy and dignity as some specialties could be of a sensitive nature. Lockable notes trolleys were also marked with consultant name, rather than specialty.

- Staff took action to improve the environment to maintain patients' privacy and dignity. For example, because space was limited in the phlebotomy department and patients had their bloods taken in the same area, staff placed chairs facing outwards and asked patients if they would like the curtain drawn to maintain their privacy. In the diagnostic imaging department, privacy screens were used when patients were being positioned for their examinations.

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

- Staff communicated with patients so that they understood their care, treatment and condition. Patients we spoke with felt well-informed about their treatment and could explain what would happen next.
- Staff recognised when patients needed additional support to help them understand and took action to meet their needs. For example, staff booked interpreters in advance for patients whose first language was not English.
- Patients were encouraged to be involved in their care and were given advice on how to promote their wellbeing. For example, patients we spoke with had been offered advice on stopping smoking and maintaining a healthy weight. We also saw evidence of this in patient notes and audits.
- We observed staff taking time to answer patients' questions during our inspection. This was reflected in the trust's results for the National Cancer Patient Experience Survey 2017. The outpatients department scored in line with the England average for 'Patient was able to discuss worries or fears with staff during visit', 'Patient given understandable information about whether radiotherapy was working' and 'Patient given understandable information about whether chemotherapy was working'. The department also scored in line with the England average for patients receiving all information they needed before starting radiotherapy and chemotherapy treatment.
- The diagnostic imaging department scored in line with the England average for patients 'given complete explanation of test results in an understandable way' and patients receiving all information they needed before their diagnostic test in the National Cancer Patient Experience Survey 2017.
- Patients we spoke with described staff as 'cheerful', 'polite' and 'friendly'. Patients who had attended the department before spoke positively about the care and treatment they received at each appointment.

### **Emotional support**

- Staff understood the emotional and social impact that care and treatment could have on patients and those close to them. Patients we spoke with had been offered support to deal with their condition.
- Phlebotomists understood the emotional needs of children attending the clinic and used distraction techniques to minimise distress. They also used pictures of animals to distract children when having their blood taken.
- Patients we spoke with had been made aware of support groups for their medical conditions. For example, staff had signposted patients to skin cancer and cardiac support groups, to contact if they wished.
- There were 'dementia cafes' held every fortnight. Dementia cafes were social events for patients with dementia and their carers or loved ones.
- Specialist nurses ran education and support clinics in urology. This included patient

education on medical conditions and support with procedures such as self-catheterisation. A nurse in the urology department was a Macmillan cancer care nurse. This meant they could provide specialist emotional support for patients.

- The department used volunteers as 'meet and greeters' to support patients, carers and relatives. Volunteers were present at the time of our inspection and we observed them taking the time to sit and chat with patients. Staff spoke highly of the 'meet and greeters' and felt it improved patient experience.

## Are outpatients & diagnostic imaging services responsive?

Good 

We rated responsive as good because:

- During our last inspection in September 2016, we were not assured that patients had timely access to outpatient treatment. The service was found to be in breach of Regulation 12 of the Health and Social Care Act Regulations 2014: Safe care and treatment, due to being worse than national standards for waiting times. During this inspection, we found that most waiting times had improved to meet national standards.
- The trust had improved its performance for cancer waiting times and was meeting the national standard in four out of five measures.
- Patients had timely access to diagnostic imaging services and the percentage of patients waiting more than six weeks was lower than the England average.
- Services were planned and delivered to take into account different people's needs. This had improved since our previous inspection with the introduction of written information in languages other than English.
- The main outpatient department was working towards gaining a Purple Star accreditation for the care and treatment they provided to patients with a learning disability.
- The phlebotomy service engaged with people in vulnerable circumstances and took actions to overcome barriers when people found it difficult to access services.

However:

- Five out of 16 specialties were not meeting the England overall performance for patients being seen within 18 weeks of referral.
- During the previous inspection, it was raised that hearing loops were not in use to aid people with a hearing impairment. This was still the case at the most recent inspection.
- Staff were not always informed in advance if a new patient had mobility issues, a learning disability or dementia. This meant adjustments could not be made prior to their attendance to facilitate their journey through the department.

## Service planning and delivery to meet the needs of local people

- Information from local people was used in service planning and delivery. This was facilitated by the department's quality improvement plan. For example, during the last inspection of outpatient services across the trust, it was identified that clinic letters did not provide patients with enough information about what to expect. We saw patient's letters at Hemel Hempstead General Hospital now included contact details, date and time of appointment, consultant name, information on any tests, samples or fasting required and car parking.
- Most outpatient specialties provided clinics across all of the trust's three sites so that patients had a choice of where they attended. Nuclear medicine investigations were provided at Hemel Hempstead General Hospital only.

- Facilities were suitable for the services provided; however, patients told us they found the outpatient departments difficult to find. During our inspection, we observed people in corridors asking volunteers and staff for directions. There were signposts to the departments but patients told us they were not always easy to follow. The signs were in black text on a yellow background, which was in line with national guidance for healthcare environments where people may be visually impaired.
- The pharmacy was not located in close proximity to the outpatient areas so people had to walk a distance to collect their medicines. Porters were available to take patients in wheelchairs, where required.
- Patient feedback highlighted that car parking fees were unclear. During our inspection, we saw that signs were displayed at reception areas to inform patients on car parking, including the policy to prevent further fees if appointments ran late. All patients we spoke with who had driven to the hospital said they had found a space easily and understood the car parking fees.
- Waiting areas were comfortable with adequate seating. This included seating to accommodate bariatric patients. Television screens displayed relevant information for patients and visitors, for example, in the radiology department they showed information about bone health and knee replacement surgery. Free Wi-Fi was also available. Toys and books were available for children. Toilets and baby changing areas were accessible in all areas we visited.
- There were two electronic booking-in stands in the main outpatient area where patients could enter their name, date of birth and consultant they were attending, rather than saying it aloud to a receptionist. Due to the design of the screen, details were only visible to the person who was using the machine, therefore maintained confidentiality. Boards that were used to inform patients of waiting times included the consultant name only, not the specialty or service provided. Staff advised that this was to maintain patient privacy and dignity as some specialties could be of a sensitive nature. Lockable notes trolleys were also marked with consultant name, rather than specialty.
- The diagnostic imaging department had three ultrasound machines, two x-ray rooms and one digital screening room. Changing cubicles led directly into x-ray rooms so that patients did not have to walk through public areas in their hospital gowns. There was also a radiology suite in the urgent care centre and a separate nuclear medicine department.
- The radiology department had adapted how they deliver services to increase scanning and reporting capacity. This included introducing a new rota for radiologists and radiographers to improve the department's ability to provide emergency cover. Staff spoke positively about this change.
- The phlebotomy department operated a walk-in service where patients who were referred by services at the trust or their GPs could attend. Patients entered the department and took a numbered ticket. Staff then called in patients by number. Appointments could be made for children to reduce their waiting times and minimise distress.
- At the time of inspection, there were no evening or weekend clinics offered to accommodate people outside of regular working hours. The chronic pain service offered telephone advice to reduce the need for patients to attend the department in person.

### **Access and flow**

- During our last inspection, we were not assured that patients had timely access to outpatient treatment. The service was found to be in breach of Regulation 12 of the Health and Social Care Act Regulations 2014: Safe care and treatment, due to being worse than national standards for waiting times. This included waiting times for accessing first appointments and consultations for patients with cancer. At this inspection, we found that the trust had worked ahead of its trajectory for improving referral to treatment times (RTT) and was meeting four out of five national standards for cancer waiting times.
- From April 2017, the trust's RTT for non-admitted pathways met the England overall

performance for the percentage of patients receiving an outpatient appointment within 18 weeks of referral. This was an improvement since our previous inspection when they were performing consistently worse than the England average (from May 2016 to March 2017). The latest figures for July 2017 showed 90% of patients were treated within 18 weeks, which was in line with the England average.

- In July 2017, ten out of 16 outpatient specialties were in line with or better than the England average for non-admitted RTT. They were:
  - Ophthalmology
  - Oral surgery
  - General medicine
  - Gastroenterology
  - Dermatology
  - Thoracic medicine
  - Rheumatology
  - Geriatric medicine
  - Gynaecology
  - Other.
- In July 2017, the following specialties were worse than the England average for non-admitted RTT:
  - General surgery
  - Urology
  - Trauma and orthopaedics
  - ENT
  - Cardiology
  - Neurology.
- The trust met the England overall performance for RTT for incomplete pathways since February 2017. This was an improvement since our previous inspection when they were performing consistently worse than the England average (from May 2016 to March 2017). The latest figures for July 2017 showed 90% of patients were treated within 18 weeks, which was in line with the England average.
- In July 2017, the 12 out of 16 specialties were in line with or better than the England average for RTT incomplete pathways:
  - General surgery
  - Oral surgery
  - General medicine
  - Gastroenterology
  - Cardiology
  - Dermatology
  - Thoracic medicine
  - Neurology
  - Rheumatology
  - Geriatric medicine
  - Gynaecology
  - Other.
- In July 2017, the following specialties were worse than the England average for RTT incomplete pathways:
  - Urology
  - Trauma and orthopaedics
  - ENT
  - Ophthalmology.
- From April 2017, the trust performed in line with the 93% operational standard for patients being seen within two weeks of an urgent GP referral for cancer. This was an improvement since our previous inspection when they were not meeting the operational standard. In July 2017, 95% of patients were seen within two weeks of urgent GP referral.

- Since our previous inspection, the trust consistently achieved the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis of cancer (decision to treat). In June 2017, the service achieved 100% and the latest data for July 2017 showed 98% of patients received treatment within 31 days of diagnosis.
- Since our previous inspection, the trust consistently achieved the 98% operational standard for patients receiving outpatient anti-cancer drug treatments within 31 days of diagnosis. From April to July 2017, performance was 100%.
- Since our previous inspection, the trust performed better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The latest data for July 2017 was 90%.
- The trust was not meeting the 93% operational standard for patients with breast symptoms being seen within two weeks of urgent GP referral. This had not improved since our previous inspection. The latest data for July 2017 showed 88% of these patients were seen within two weeks. The trust had agreed a joint action plan with the clinical commissioning group to improve waiting times for patients with breast symptoms by increasing outpatient capacity.
- In July 2017, 17 patients waited over 40 weeks for an outpatient appointment. The longest wait reported at the time of inspection was one patient in ENT who waited 51 weeks for their appointment. The reason for some of the longest waits was the patient's own choice to wait for an appointment with a specific consultant, rather than the next available date. Patients who waited over 30 weeks were reviewed and prioritised for appointments. Waiting times were not included on the departmental risk register.
- At the end of August 2017, there was a total of 15,222 patients waiting for first outpatient appointments. This was less than at the previous inspection in September 2016, when there were 24,270 patients on the waiting list.
- The specialties with the most patients on their waiting lists at the time of our inspection were dermatology, ophthalmology and oral surgery.
- Booking co-ordinators were based at St Albans City Hospital. If a patient breached 18 weeks waiting time, booking co-ordinators flagged this to divisional and service level managers who aimed to prioritise these patients.
- The trust improved their performance by analysing the reasons for breaches and had an action plan based on the results. The analysis showed the main reason for breaching the two-week wait was patient cancellation. The trust aimed to improve performance by increasing their capacity to offer appointments within seven days of referral, so that patient cancellations may be rescheduled within the two-week period. Prior to this, dates of first appointments were typically offered within ten to 14 days of referral. Operational plans included reviewing clinic capacity and staffing resources; creating additional appointments where possible and recruiting consultant posts to dermatology. Administration staff who managed two-week waiting lists told us they were now managing to book most patients within five days of referral.
- From February 2016 to January 2017, the 'did not attend' rate for Hemel Hempstead General Hospital was similar to the England average. The latest figures for March 2017 show that the percentage of appointments where patients did not attend was 7.6%, which was in line with the national average of 7.4%.
- Patients who did not attend an appointment were contacted and offered another appointment. If they did not attend the second appointment, their records were reviewed by medical staff and they were referred back to their GP, if clinically appropriate. If not, the medical staff could request another appointment be arranged by booking co-ordinators. If a child or young person did not attend an appointment, staff would attempt to contact their family and reschedule an appointment. If this happened a second time, a further appointment would be made and their GP would be informed as there may be safeguarding concerns.

- The service had systems in place to reduce the number of DNAs. There was a text message reminder service where patients who gave their mobile phone number were sent a message a week ahead of their appointment to remind them. Patients we spoke with had received reminder text messages. The service also displayed the cost to the NHS every time a patient did not turn up for their appointment, to remind people of the importance of attending.
- From May 2016 to April 2017 the percentage of patients waiting more than six weeks to see a clinician was lower than the England average.
- In the National Cancer Patient Experience Survey 2017, the diagnostic imaging department scored in line with the England average for 'The length of time waiting for test to be done was about right'.
- The overall cancellation rate for outpatient clinics from February to May 2017 was 13%. This had remained approximately the same since 2016. However, they were performing better than their target for short notice cancellations. The average percentage of clinics that were cancelled at short notice (within 6 weeks) was 4%, which complied with the trust target of 5%. The main reasons for short notice cancellations were medical staff sickness, test results not being available, consultants' decision that appointments were no longer required and changes to clinic templates.
- Clinics that were cancelled over six weeks prior to the clinic date were re-scheduled and letters with new appointment details were sent to patients. If clinics were cancelled at short notice, administration staff attempted to contact patients by phone. Staff and patients told us that there were occasions where contact had been unsuccessful and people had turned up to the department unaware that their appointment had been cancelled. This was reported as an incident on the electronic reporting system.
- The service was aiming to minimise unnecessary short notice cancellations. Cancellation requests within six weeks of the scheduled clinic date were flagged by the clinic scheduling team to divisional management who could reject inappropriate requests. Clinic schedulers gave examples of where this had happened as a consultant had requested annual leave within six weeks of a busy clinic. The request was rejected and the clinic went ahead.
- Outpatient services generally ran on time and patients were not kept waiting for long periods. A development since our last inspection was the introduction of an electronic dashboard system to capture data on the timeliness of clinics. From December 2016 to August 2017, doctors arrived to clinics on average three minutes after the scheduled start time. Clinics finished on average nine minutes after the scheduled end time over this period. The trust recorded a clinic as starting or finishing late if the time between scheduled and actual time was over 15 minutes. The most recent data for August 2017 shows clinics started on average two minutes late and finished on average three minutes late.
- The electronic dashboard also monitored how many patients were overbooked for appointments. From December 2016 to August 2017, on average 5% of patients were overbooked in clinics. This was identified as a risk on the departmental risk register. Templates were used when booking appointments but slots could often be allocated to more than one patient so that the clinic was over capacity. Booking co-ordinators advised that this was done at the request of the consultant. Reasons for consultants overbooking clinics included the availability of a Medical Registrar at the clinic to see patients, where appropriate, and if they felt patients were likely to not attend. The data provided did not show a correlation between clinic overbooking and timeliness of clinics; however, staff we spoke with told us that there were occasions where all patients turned up to overbooked clinics and therefore experienced delays.
- The time patients spent waiting in the outpatients department was not monitored. Waiting times were displayed on boards in each clinic which were updated every 30 minutes. We also observed staff verbally informing patients of expected delays. At the time of our inspection, the longest wait was 25 minutes.
- The diagnostic imaging service monitored how long patients waited for examinations once

they arrived in the departments across the trust. From December 2016 to April 2017, patients waited an average of 36 minutes before being seen. This met the trust target of 40 minutes.

- There had been a review of reasons for patients waiting over 40 minutes for radiology appointments. Findings showed that one of the main reasons was patients arriving early for their appointment and being marked as attended on the IT system. Another reason was that some patients were required to attend the department early to undergo preparation prior to their examination. For example, some patients were required to drink water 20 minutes prior to a CT scan so were asked to attend early to ensure compliance. The longest waits were in nuclear medicine and the main reason for this was patients were booked for bone scans which involved injection of radio-isotope in the morning, with images in the afternoon.
- The service audited how long outpatients had to wait in the department for medicines from the pharmacy department. From June 2016 to June 2017, patients waited on average 23 minutes for their medicines.
- The trust had introduced urology virtual clinics to reduce the need for patients to attend the hospital and minimise waiting times. This had resulted in a significant reduction in new to follow up ratios for urology.
- There were rapid access chest pain clinics where patients received consultant review and any required outpatient diagnostics in a single visit. This promoted timely diagnosis and access to treatment.
- Patients were referred to the department via GP referral or the NHS 'e-Referral system'. The e-Referral is an electronic service that allows patients to request preferred place, date and time for their first outpatient appointment. Most patients we spoke with during our inspection had been offered a choice of location.
- Part of the outpatient quality improvement plan was to introduce clinic management tools to maximise utilisation of the environment across all three outpatient sites. During our inspection, senior staff demonstrated how this tool was used to facilitate ad-hoc clinics as they could easily see where rooms were available. There were three ad-hoc clinics taking place during our inspection. Clinic scheduling staff also used this tool when managing requests and cancellations.
- There were also plans being discussed to introduce 'fire-break' clinics to minimise delays for patients. The fire-break system involved keeping the resources and capacity for one or two clinics free, every six to eight weeks. This would then be used to re-schedule any cancelled clinics within a short space of time, therefore reducing waiting times for patients. Staff in the clinic scheduling team were aware of these plans and felt they would improve service delivery.

### **Meeting people's individual needs**

- Services were planned and delivered to take into account different patient's needs, including those who required additional support. During our previous inspection in September 2016, the outpatient and diagnostic imaging services did not provide information for patients in languages other than English. This had improved at the inspection. There was information in languages other than English in the waiting areas we visited, for example leaflets with advice for stopping smoking were displayed in Urdu. Staff we spoke with knew how to access information in further languages electronically to print for patients.
- Translation services were available and the electronic booking-in stands had over fifteen languages to choose from. The need for an interpreter was flagged at referral so that booking co-ordinators could arrange this in advance.
- Information was available in accessible formats; for example, the electronic booking-in stands had an option to enlarge the text for those with visual impairment. However, the

service did not have hearing loops in place for those with hearing impairment. This was raised as an issue during our previous inspection.

- There was a display in phlebotomy with visual aids to show patients and visitors what to expect when they arrived in the department. Photographs were used to show the blood-taking procedure and what happens with the blood samples. Visual aids can be used to communicate with people who have cognitive impairment.
- Facilities had been adapted to accommodate wheelchair users, such as low-access reception desks. There were assisted changing rooms in the diagnostic imaging department.
- Additional equipment was available to meet specific needs. For example, there was a specific pat slide to accommodate bariatric patients in radiology. Pat slides are used to safely transfer patients in reclining or lying positions. Bariatric couches were also available in the outpatient department.
- Care for patients who had cognitive impairment was tailored to meet their individual needs. The outpatient services were working towards achieving a 'Purple Star' accreditation. Purple stars are awarded by the local authority to healthcare services when they are recognised as achieving best practice for care of patients with cognitive impairment, such as a learning disability or dementia. Plans included ensuring seating, signage and documentation met people's needs.
- Purple folders were in use across outpatient and diagnostic imaging services, as part of their work towards purple star accreditation. Purple folders were filled in by patients and carers of patients with cognitive impairment. They contained information on their health needs, communication issues and how best to support the patient. The folders also contained information from other health and social care providers. Staff in the outpatient and imaging departments used purple folders to ensure they were providing care and communicating in ways patients could understand. During appointments, health action plans were filled in by clinicians for patients to keep in their purple folders. If patients with cognitive impairments arrived to the department without a purple folder, staff could fill in referrals to the local authority.
- There was a fast-track system for patients who were known to have a learning disability or were living with dementia, to minimise distress during their visit. This policy was displayed in waiting areas throughout the department.
- Children were also given priority when they arrived to clinics.
- When diagnostic imaging staff were aware that an examination had been booked for a patient with a learning disability, they invited the patient and their carer to attend the department prior to their appointment so that they could familiarise themselves with the staff and the environment. Staff described examples where this had taken place and reduced distress for the patient during their examination.
- The diagnostic imaging service used 'twiddle muffs' for patients with dementia. Twiddle muffs were specially designed gloves for patients that had buttons and other sensory objects attached to the inside. Patients wore these to provide a sensory distraction during examinations. Sensory distractions are a recognised way to minimise distress for patients with dementia, which can be particularly beneficial in environments such as x-ray rooms.
- An outpatient nurse and healthcare assistant had been appointed as dementia champions for the department. This meant they received up to date information on dementia care to communicate to their teams. Some staff within the radiology department had attended additional training to become 'dementia friends'. This meant they had additional knowledge to support the needs of patients with dementia.
- New patients were allocated longer appointment times so that they had additional time to ask questions. The time allocated to appointments varied depending on specialty. For example, new patients in colorectal clinics were allocated 15 minutes and follow-up appointments were ten minutes. However, new appointments in the chronic pain service were allocated 30 minutes and follow-ups were allocated 15 minutes. This took into

account the complex nature of chronic pain.

- The phlebotomy service engaged with patients in vulnerable circumstances and took actions to overcome barriers when patients found it difficult to access services. For example, phlebotomists carried out home visits for housebound patients who were on anti-coagulant medicines. Patients who are on blood-thinning medicines must be assessed regularly to monitor their condition and assess dosage of the drug. Phlebotomists conducted finger-prick tests in housebound patients' homes to facilitate their access to treatment. This also reduced the need for these patients to have blood tests, which is beneficial if the patients are elderly as taking blood can be difficult and distressing.
- The trust had a transport service for patients with mobility issues; however, the provider of this service had recently changed and patients were experiencing delays. The trust and departmental managers had recognised this issue and were taking action to mitigate impact on clinics. For example, patients who arrived late due to patient transport issues were prioritised to minimise further waits. This policy was displayed in waiting areas to inform other patients. All staff we spoke with were aware of the issue and reported each delay as an incident on the electronic reporting system. There were examples of patients who had been picked up early for their morning appointments but were then kept waiting in the department for their return transport until after lunch. Staff offered these patients food and drinks while they waited and made regular phone calls to the transport service to keep patients informed of expected waiting times. Staff tried to prevent delays by making requests for return transport as early as possible as they could.
- Staff were not always informed in advance if a new patient had mobility issues, a learning disability or was living with dementia. The electronic patient tracking system had the capability to flag this information; however this was not being used at the time of inspection. Staff would only be made aware in advance if the referrer included it as an additional comment, but this regularly did not happen. This meant that staff could not make arrangements beforehand to facilitate the patient's journey through the department, for example by putting them first on the list. Staff did not report these occasions as incidents and there were no plans in place to address the issue at the time of inspection. Information on additional needs was recorded at their first appointment so that adjustments could be made in advance if follow-up appointments were needed.

### **Learning from complaints and concerns**

- There were 112 complaints related to outpatient and diagnostic imaging services across the trust from July 2016 to July 2017. Themes included delayed or cancelled appointments (52), communication with patients (25) and attitude of staff (20).
- The trust's policy was to complete investigations into complaints from 25 to 35 working days after they were received, depending on the nature of the complaint. In the outpatient and diagnostic imaging department, 80% of complaints were managed within this timescale. The longest delays were due to complex investigations involving different teams from across the trust.
- If patients or visitors complained directly to outpatient and diagnostic imaging staff, they aimed to resolve the issues locally to prevent a formal complaint, where possible. This was in line with trust policy. If the complaint could not be resolved directly, patients were advised of the complaint procedure and given written information on how to follow this. Patients were also directed to the Patient Advice Liaison Service (PALS).
- Patient could access advice on how to complain throughout the department. Staff demonstrated how they accessed PALS information in languages other than English. There were leaflets and contact details for PALS displayed in all areas we visited. Recent complaints and actions to improve were also displayed in waiting areas.
- A complaints management team dealt with formal complaints across the trust. Complaints that could not be resolved at local resolution meetings were passed to the relevant divisional lead to arrange an investigation. We saw examples of divisional and nursing

leads contacting patients to offer apologies and inform complainants of the investigation progress.

- Complaints were discussed in outpatient and diagnostic team meetings. Staff we spoke with could describe common complaints within their service.

## Are outpatients & diagnostic imaging services well-led?

Good ●

We rated well-led as good because:

- Since our previous inspection in September 2016, an outpatient quality improvement plan (QIP) had been implemented. This included issues raised during the previous inspection and 14 out of 15 had been completed in August 2017. Progress against the QIP was regularly monitored and used in service planning.
- Leaders and staff across outpatient and diagnostic imaging services were continuously striving for improvement. In addition to the QIP, local leaders had further plans to improve services.
- The culture in across outpatient and diagnostic imaging services encouraged openness, candour and honesty. All staff we spoke with felt supported, respected and valued.
- Patients, relatives and visitors were actively engaged and involved when planning services. People were encouraged to provide feedback and we saw their comments used to improve.
- Leadership of the diagnostic imaging department was focused on driving improvement and delivering high quality care to patients.

However:

- At the time of inspection, there was only one risk on the outpatient department risk register. This was related to clinics being overbooked. However, during our inspection we identified other risks that should have been recognised.

## Leadership of service

- The outpatient departments were led by clinical leads, divisional and directorate managers. The main outpatient department was managed by the medical division and phlebotomy was managed by clinical support services. The diagnostic imaging department was also part of the trust's clinical support services.
- A matron and service manager were responsible for staff working in the main outpatient department. The cardiology service was run by senior staff who were based at Watford General Hospital. Phlebotomy and diagnostic imaging were led by service managers who reported to the divisional lead of clinical support services. Each specialty also had a clinical lead so staff had access to clinical expertise.
- Staff reported feeling supported by their managers. This included senior staff support from lead superintendents, matrons, clinical leads and divisional managers. All staff we spoke with had regular one-to-one meetings and could contact their manager for advice.
- The matron for main outpatient services had worked in the department as a qualified nurse so understood the challenges of providing high quality outpatient care and took appropriate actions to address them.
- During our inspection, senior leaders and divisional managers were visible throughout the departments. However, staff we spoke with in the cardiology service told us that they did not regularly see their managers as they were based at another site.
- All staff we spoke with felt that the trust's chief executive and director of nursing were approachable and had visited the department. There were examples of staff raising

concerns and being listened to by the chief executive and chief nurse. For example, senior nurses had raised the issue with the heating and ventilation system in the main outpatient department with the chief nurse during a previous visit. The chief nurse had responded by including the issue in a review of medicines storage across the trust. This project was due for completion in August 2017 so the outcome was not available at the time of inspection. Senior nurses had also raised the issue with delayed transport services directly with the chief executive.

- We observed positive, friendly and caring interactions between senior managers, matrons and local staff. Managers had developed supportive, appreciative relationships with staff across the service, which was evident on our inspection.

### **Vision and strategy for this service**

- The trust values were commitment, care and quality. Both medical and nursing staff could describe the trust's values and directed us to posters across the service. Staff said they could contribute ideas on how to improve the service and felt involved in plans for the future.
- There was an outpatient strategy for 2017 to 2027 that was in line with the trust's vision and values. The strategic aims for 2018 were:
  - To consistently achieve the two-week cancer waits and referral to treatment times
  - To engage clinicians in technological advances and embed changes
  - To reduce the number of complaints regarding outpatients
  - To implement changes from the Patient Panel
  - To deliver a service that continually has the capacity to meet demand
  - To explore opportunities of integrated care.
- By 2027, the service aimed to be a 'model outpatients department' using innovative patient pathways that integrate primary and secondary healthcare.
- The department aimed to be 'paperlite' by 2020 and paperless by 2022. The strategy included introducing electronic patient record systems and contacting patients by email where they prefer.
- Staff we spoke with were aware of the service aims and strategy. For example, they could describe work with the patient panel and plans to use electronic medical records, rather than paper.
- Progress against the outpatient strategy was monitored through monthly performance reports. Minutes from meetings were well-structured and showed discussion of progress against key performance indicators.

### **Governance, risk management and quality measurement**

- Managers and representatives from the outpatient and diagnostic imaging departments attended monthly meetings and committees as part of the trust's clinical governance framework. For example, a supervisor in phlebotomy was a member of the trust's health and safety committee. Divisional governance meetings fed into the trust-wide groups for escalation to board level.
- There was a task group to monitor the use of local safety standards for invasive procedures (LocSSIPs). A programme was in place that focused on ensuring current LocSSIPs were in line with national safety standards (NatSSIPs). At the time of inspection, the task group were focusing on implementing LocSSIPs across the specialties. LocSSIPs were in place for steroid injections and arthrograms (x-rays to investigate the inner structures of a joint). The next phase of the programme was to develop a team of LocSSIP champions to conduct audits of compliance. The LocSSIP task group reported to the trust's medical director.
- Information on clinical governance was communicated with staff at departmental meetings. Matrons and senior nurses met on a monthly basis and there were separate monthly meetings within each department. We saw information was shared across locations;

however, communication between divisions did not always take place. For example, main outpatients had implemented a hand hygiene audit programme in response to concerns raised in our previous inspection, but this had not been shared with phlebotomy.

- The trust had implemented a quality improvement plan (QIP) for the outpatients and diagnostic service since the last inspection. There were actions in place for key issues highlighted in the previous inspection and progress against these targets was monitored. At the time of inspection, 14 out of 15 actions were completed or on track to be completed by the recommended date. The outstanding action was to use the electronic booking-in stands to monitor how long patients waited in the department; however, had been delayed due to IT systems being temporarily shut down in response to a cyber-attack. The QIP included action plans to improve referral to treatment time (RTT) performance and cancer wait times. Data showed that performance had improved since the quality improvement plan was implemented.
- Local leaders led on individual projects that formed the overall outpatient QIP. There was also an outpatient user group led by divisional and nursing leads to monitor progress against the QIP and how this was impacting patient experience and service delivery. This group reported to the trust-wide strategy and delivery board.
- As part of the QIP to improve RTTs, leaders planned to create a comprehensive capacity and demand model to review how efficiently services were delivered. At the time of inspection, templates were still being developed. Leaders were focusing on maximising clinic utilisation before progressing.
- Clinic utilisation had been improved by the introduction of room planners for all three trust sites. Nursing and administration staff demonstrated how they accessed this information and used it to plan ad-hoc clinics or re-schedule clinics that had been cancelled.
- There were effective arrangements in place to monitor waiting lists. Clinical leads, medical staff and divisional managers met on a weekly basis to review all patients who were waiting for an appointment. They worked to the trust's patient access policy to ensure patients were prioritised based on clinical need.
- Quality improvement was a key focus in the diagnostic imaging department. There were monthly radiology clinical governance and discrepancy learning meetings. Performance data and diagnostic waiting times were monitored and we saw meeting minutes discussing plans to improve.
- During our previous inspection, it was highlighted that the outpatient service did not use a dashboard to capture and monitor performance data. At the inspection in August 2017, this had improved and a dashboard was in use. Senior staff demonstrated how they submitted data to be included in the dashboard and how they accessed their monthly performance scores. The dashboard allowed them to monitor information such as activity levels, clinic overbooking, patient notes availability, timeliness of clinics and the percentage of patients who did not attend their appointment. Meeting minutes showed that the dashboard was used to monitor performance and identify areas for improvement.
- Risk assessments were conducted locally and reviewed by the clinical governance manager at quarterly meetings. Risks were added to a departmental risk register if they were deemed as high risk. In phlebotomy and radiology, risks were assessed and managed by service managers or radiology superintendents.
- There was evidence of risk management at a local level; however, the departmental risk register did not contain all risks to outpatient services. At the time of inspection, the outpatient department risk register contained one risk: clinic overbooking. This did not incorporate all risks to outpatient services; for example, patients waiting over 18 weeks for treatment. Some risks were recorded on separate registers; for example, issues with IT systems were recorded on a divisional risk register and the issue with the heating system was recorded on the estates risk register. This meant that risk management could be disjointed. However, all senior staff we spoke on inspection with were aware of the separate risk registers and mitigating actions.

- Risk assessments were in place throughout the outpatient and diagnostic imaging services. This included use of generic assessments of inanimate objects (GAIL) for moving and handling, ligature risk assessments of the environment and lone working policies. Meeting minutes showed risk assessments were discussed and there were completed sheets for staff to sign when they had read the policies.
- Risk management in the phlebotomy department was overseen by the phlebotomy supervisor who was a member of the trust's health and safety committee and had completed a course with the Institution of Occupational Safety and Health (IOSH).
- Staff were encouraged to lead improvement projects and we saw evidence of this on our inspection. For example, a radiology paediatric group had developed a quality improvement project to ensure the department met the needs of children. This included prioritising children when they attended for x-ray and having distraction toys. We saw that this was in place during our inspection.
- There were robust arrangements in place to monitor risks to staff, patients and service delivery in the diagnostic imaging department. For example, staff wore whole body dosimeters to monitor the occupational radiation exposure. This was reviewed on a quarterly basis. No unusual results had been noted at the time of inspection.
- There was a pro-active attitude to improving performance in the diagnostic imaging service. This included implementing good practice and learning from other NHS trusts. For example, leaders in radiology had identified that other trusts had received enforcement actions due to lack of adequate staff induction for radiographers. As a result, they had taken action to improve their own induction processes. The new rota system they used had also been introduced as a result of networking to share good practice with other trusts.
- The diagnostic imaging department had recently introduced annual radiation incident summits where teams challenged each other on why each radiation incident had occurred and the lessons learned. These meetings began in 2017 only; one had been held at the time of our inspection.
- A computerised tomography (CT) optimisation team had been established with the aim of reducing risk to patients by standardising terminology in written protocols and guidance. In radiology, terminology can differ depending on the type of equipment and operating system used. This was an area of risk as radiographers used a range of scanners in their roles, which could lead to confusion. On inspection we found written protocols had been updated and communicated to staff.

### **Culture within the service**

- The culture across the outpatient and diagnostic imaging services encouraged openness, candour and honesty. There were posters displaying details of the trust's Freedom to Speak Up Guardian and policy. Freedom to Speak Up Guardians work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers. All staff we spoke with were aware of this role and where they could access information. Staff we spoke with were aware of this policy and said they felt comfortable raising concerns.
- Duty of Candour was followed throughout the services and meeting minutes showed the importance of being open and honest was communicated to staff.
- The service promoted a culture where staff could challenge inappropriate behaviour, regardless of seniority. For example, managers supported nurses to challenge medical staff over starting and finishing clinics late.
- Staff we spoke with said they felt proud to work in the department and felt valued in their role. In the diagnostic imaging department, long standing staff were offered incentives to remain in the department.
- Patient experience was at the centre of the services provided. For example, staff had been supported to attend customer service style training that focused on ensuring attitudes and

behaviours promoted patient satisfaction.

- Staff morale was positive in all areas we visited and teams were inclusive of staff across varying roles. For example, there were photographs and 'Hello my name is...' posters displaying the member of staff who was responsible for ordering stock in the outpatient department.

### **Public engagement**

- Patients who used outpatient services were actively engaged and involved when planning services. Patients and relatives were encouraged to provide feedback and we saw their comments used to improve. It was clear that the department recognised the value of public engagement.
- Managers and senior nurses in the outpatients department worked with members of the trust's 'patient panel'. The patient panel was a group of people from the local community who use or have previously used the hospital services. Members of the panel were involved in various projects in the outpatient department and provided feedback across the trust's three sites.
- The patient panel had conducted a '15 Steps Challenge' in the outpatient department. A 15 steps challenge is a nationally recognised tool for gathering information on patient experience in healthcare environments. Feedback from the patient panel was being reviewed at the time of inspection to identify areas for improvement.
- An outpatient experience group had been recently established to gain insight into patient views on services provided. The group was made up of staff and volunteers from the patient panel. The group conducted visits to each of the three trust sites to gather feedback using questionnaires that looked at the timeliness of appointments, quality of information received and open questions where patients could make suggestions. The visit for Hemel Hempstead General Hospital was scheduled for September 2017.
- The outpatient department had also included members of the patient panel in a trial of introducing a 'front of house' member of staff. An idea was put forward that patient experience could be improved by having a member of staff as a 'host' at the front door of outpatient departments across the trust. This staff member would act as a first point of contact to assist with queries and improve flow through the department. To determine the value of this role, managers invited volunteers from the patient panel to act as hosts. Patient feedback was then gathered. The result of this trial was patient experience was improved and a business case was being developed to add this as a permanent role.

### **Staff engagement**

- Staff were considered and involved in service planning and delivery. There were systems in place for staff to express raise concerns and make suggestions for improvement. For example, the clinical supervision policy in the diagnostic imaging department had been developed by the lead superintendent with input from radiology staff. Feedback for the new policy was positive across the service.
- In the diagnostic imaging department, the chief executive had attended a meeting with staff to include them in decisions around the future of the department. The chief executive had also communicated information on training opportunities for radiology staff at this meeting.
- The trust newsletter was distributed throughout the hospital to update staff on current issues and future plans. Staff we spoke with knew what had been included in recent newsletters.
- Quality champions had been appointed in outpatient and diagnostic imaging department. Their role was to pass on suggestions on service improvement from local staff to the executive leadership team. Champions attend forums where they could relay ideas to be escalated to the board. We did not see evidence of any suggestions made by the outpatient teams at the time of our inspection.

- There were also champions for particular areas of interest, such as dementia, health and safety, infection prevention and control, Control of Substances Hazardous to Health (COSHH) and manual handling. Champions were nurses or healthcare assistants who received up to date communication in their respective area of interest to share with the team.
- Medical staff we spoke with took active roles in clinical governance committees. They described how they had made suggestions to improve quality of care for patients.
- Instant messaging services were used in the diagnostic imaging department to communicate information to staff across the service. This was information such as shift changes and did not include any confidential information.

### **Innovation, improvement and sustainability**

- Leaders and staff across outpatient and diagnostic imaging services were continuously striving for improvement. This was evident throughout our inspection and from information we reviewed.
- At this inspection, there had been the following improvements noted since our inspection in September 2016:
  - The availability of patient records in outpatient clinics had improved.
  - Eleven out of sixteen specialties were meeting the England overall performance for patients being seen within 18 weeks of referral. Referral to treatment time (RTT) performance was on an upward trajectory, whereas it was on a downward trajectory in September 2016.
  - Four out of five national cancer waiting time standards were being met.
  - The service was meeting the trust target for annual appraisals.
  - Clinic room utilisation tools were in use to improve outpatient capacity.
  - Written information was available in languages other than English.
- The services had also made additional improvements outside of those that were raised. Improvement programmes were ongoing and further plans were in development.
- There were areas where there had not been any changes since our inspection in September 2016. These included:
  - Staff in clinics that saw children did not all have safeguarding children level three training in line with national guidance.
  - Nasal endoscopes were not fully decontaminated in an endoscope washer-disinfector at the end of each clinic.
  - There were no plans to introduce seven-day services.
  - Hearing loop systems were not in use to aid people with hearing impairment.

## Outstanding practice

- The phlebotomy service engaged with people in vulnerable circumstances and took actions to overcome barriers when people found it difficult to access services. For example, phlebotomists carried out home visits for housebound patients who were on blood-thinning medicines. Patients who are on blood-thinning medicines must be assessed regularly to monitor their condition and assess dosage of the drug. Phlebotomists conducted finger-prick tests in housebound patients' homes to facilitate their access to treatment. This also reduced the need for these patients to have blood tests, which is beneficial if the patients are elderly as taking blood can be difficult and distressing.

## Areas for improvement

### Action the hospital **MUST** take to improve

- Ensure that systems and processes are in place to monitor and review key aspects of performance (for example patient waiting times) to identify areas for improvement.
- Ensure there are processes in place to monitor arrival time to initial clinical assessment for all patients
- Develop an audit process in the UCC to monitor compliance to protocols/pathways in line with other areas of the unscheduled care division.
- Implement arrangements for identifying, recording and managing risks, issues and mitigating actions.
- Ensure that all staff caring for patients under 18 years of age complete safeguarding children level 3 training.
- Ensure staff in outpatient services are aware of the trust policy and fulfil the mandatory reporting duty for cases of female genital mutilation.
- Monitor compliance with hand hygiene and environmental infection control in the phlebotomy department.
- Ensure clinical staff within the radiology department are up-to-date on fire and evacuation training.
- Ensure that all risks relating to outpatient services are identified, recorded and managed on the departmental risk register.

### Action the hospital **SHOULD** take to improve

- The matron was also responsible for a neighbouring emergency department and a minor injuries unit that was several miles away. This left little time for active clinical leadership in the UCC. The trust should consider how effective clinical leadership is in these circumstances.
- The trust should consider the roles and responsibilities of the rotational leadership role in UCC with regards to defined responsibilities and consider devising a job description.
- The trust should consider risks that lack of monitoring of performance measures could impact on the delivery of good quality.
- Although the UCC was part of the unscheduled care division it did not feature in their current strategy document.
- Consider decontaminating reusable naso-endoscopes in a washer-disinfector at the end of each clinic, to meet Department of Health Technical Memorandum (HTM) 01-06 best practice.
- Consider providing outpatient services at evenings and weekends.

- Ensure staff are up to date with Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DOLS) training.
- Ensure patients across all specialties are seen within 18 weeks of referral.
- Consider using electronic systems to flag patients with mobility issues, dementia or a learning disability so that arrangements can be made in advance to meet their needs.
- Consider using hearing loop systems across the department.
- Improve communication between divisions within outpatient services.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Regulated activity	Regulation
<p>Treatment of disease, disorder and injury Diagnostic and screening Surgical procedures</p>	<p>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 (2) (a) (b) Good Governance.</p> <p><u>How the regulation was not being met:</u></p> <p>There were no robust systems, for example, audits in place to assess, improve and monitor performance and quality of services.</p> <p>There was no monitoring of waiting times to initial assessment of patients.</p> <p>There was a lack of understanding of the risks that could impact on the delivery of good quality care. Risks that we had identified at previous inspections (For example, lack of paediatric competent nurses and lack of monitoring of waiting times) had not been placed on the risk register.</p> <p>Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.</p> <p>Not all risks to outpatient services had been identified, recognised and managed on the departmental risk register.</p>
Regulated activity	Regulation
<p>Treatment of disease, disorder and injury Diagnostic and screening procedures</p>	<p>Regulation 18: (1) (2) (a) Staffing</p> <p><u>How the regulation was not being met:</u></p> <p>Not all nursing staff who had direct contact with children in outpatient clinics had received level</p>

3 safeguarding children training, which was not in line with national guidance.

We could not be assured that the service was fulfilling its mandatory duty to report cases of female genital mutilation (FGM) as all staff we spoke with were unaware of the trust policy on identifying and assessing the risk of FGM.

Compliance with fire safety training in the radiology department was worse than the trust target of 90%. Overall staff compliance was 76%. Nursing staff compliance was 40% for clinical staff and 80% for non-clinical staff.