

## West Hertfordshire Hospitals NHS Trust

### St Albans City Hospital

RWG03

### Quality report

Waverley Road  
St Albans  
Hertfordshire  
AL3 5PN

Tel: 01727 866122

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 ●

Minor Injuries Unit

Requires improvement ●

Surgery

Good ●

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. In September 2015 the trust was rated as inadequate overall and went into special measures. A further inspection took place in September 2016 and was rated requires improvement overall, as was St Albans City Hospital. The trust remained in special measures

Part of the inspection was announced taking place from 30 August 2017 to 1 September 2017 during which time Watford Hospital, St Alban's Hospital and Hemel Hempstead Hospital were all inspected. We carried out the unannounced inspection on the 12 September 2017.

At St Albans City Hospital we inspected and rated the core services of:

- Minor injuries unit
- Surgery
- Outpatients and diagnostic imaging.

We rated St Albans City Hospital as requires improvement overall.

We rated the Minor Injuries Unit (MIU) as requires improvement. We rated surgery 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 requiring improvement. Caring, and responsive were rated as good overall.

- During our last inspection, we found there was no initial clinical assessment of adult patients. This had not improved since our last inspection and meant that patients' condition was at risk of deteriorating while they waited for treatment.
- Although children were assessed quickly during our inspection, the trust could not provide assurance that this took place consistently.
- Staff did not use an early warning scoring system in order to identify deteriorating patients.
- There remained a lack of monitoring of patient outcomes, performance measures and compliance with evidence-based protocols.
- X-ray services were not always available when patients needed them.
- There was no job description for the lead nurse role meaning that their responsibilities were unclear. The matron of the unit also managed a neighbouring emergency department and an urgent care centre that was several miles away. This left little time for direct clinical leadership of the MIU.
- There was a lack of understanding of the risks that could affect the delivery of good quality care. We raised this with the trust at our last inspection. There had been some improvements but not all risks had been added to the risk register.
- The vanguard theatre did not allow for waste and dirty linen to be removed without travelling outside or through a clean area.
- Imaging, diagnostics and dietetics and speech and language therapy services were available Monday to Friday from 9am to 5pm. If support was required outside of these hours it would be at the Watford Hospital site. If a patient required diagnostic imaging, for example an x-ray or scan, outside of these hours they would have to be transferred to the Watford site via non-emergency ambulance transport.
- Pharmacy support was available on site Monday-Friday with support provided out of hours from Watford General Hospital site.
- Those who had surgery cancelled were not always treated within the following 28 days in line with guidance.

However:

- During this inspection, we found nurse 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.
- Children were clinically assessed on arrival and pain relief administered if necessary.
- We observed staff taking trouble to maintain patient's privacy, dignity and confidentiality. They demonstrated empathy towards people who were in pain or distress and were skilled in providing reassurance and comfort.

- Almost all patients (99.9%) were treated, discharged or transferred within four hours.
- 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.
- There were clear processes in place for reporting incidents and providing feedback. Learning from incidents was shared across all areas.
- 'Test your care' nursing care indicators were consistently high and meeting trust targets.
- Written records were consistent across areas, clearly maintained with risk assessments and nursing/medical records easy to locate. Records were stored securely throughout our inspection.
- Improvements had been made in relation to standardisation of World Health Organisation safer surgery checklists and compliance with these met the trust target.
- Infection control practices had improved since the previous CQC inspection and audits demonstrated good levels of compliance.
- There was a dedicated orthopaedic ward and a dedicated general surgical ward to manage patient's specific needs.
- Policies were up to date in line with guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations.
- Care bundles were embedded in patient care to improve patient outcomes.
- Significant work was being carried out in relation to enhanced recovery. Enhanced recovery pathways were used to improve outcomes for patients in general surgery, breast, urology, orthopaedics and ear nose and throat (ENT). Outcomes for enhanced recovery were collected and monitored within the service.
- The average length of stay for patients was better (shorter stay) than the England average.
- The re-admission rate for elective patients were slightly better than the England average overall. However, the re-admission rate for elective orthopaedic patients was slightly worse than the England average.
- The service continuously reviewed and improved patient outcomes through participation in national audits including the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry and surgical site infection audits.
- Staff told us they had opportunities for personal development and to enhance their skills. Practice development support was available to all staff.
- All staff provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.
- Staff provided emotional support to patients and staff directed patients to clinical nurse specialists for support where required.
- Patients' and relative feedback was sought on the care they received to ensure they were happy with the care provided.
- Changes in senior leadership had led to positive operational and cultural changes within surgical service.
- Senior managers had a clear understanding of risks to the service and how these were being mitigated and monitored.
- All staff spoke positively about working within the service and felt local and senior managers were approachable.

- Staff understood the trust's vision and values and portrayed these in their day to day role.
- Cross site working occurred to improve risk and quality management within the service.
- The service demonstrated a drive to improve clinical services and supported innovations.
- Since our previous inspection in September 2016, an outpatient quality improvement plan (QIP) had been implemented for issues raised. Performance data had improved and the service was performing in line with their planned trajectory.
- Referral to treatment times had improved since our last inspection and were similar to the England average.
- Radiation protection in the diagnostic imaging department was robust. Medical physics experts and radiation protection supervisors actively worked with staff to provide advice and ensure compliance with safety standards.
- Waiting lists for outpatient appointments were reviewed weekly and risk assessments were completed for patients who waited 30 weeks or more. At the time of our inspection, no clinical harm to a patient had happened because of waiting over 30 weeks.

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

Importantly, the trust must:

- To ensure that there are effective triage/ streaming systems in place in the unit and all staff have had appropriate training to carry out this process.
- Ensure that systems and processes are in place to monitor and review all key aspects of performance to identify areas for improvement.
- Develop a clinical audit process in the MIU to monitor compliance with clinical guidelines and protocols 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:

- Undertake a safety review of the medicines cupboard located in the reception area.
- Consider a process to avoid waste and dirty linen to be removed from the vanguard theatres without travelling outside or through a clean area.
- Patients who have had surgery cancelled should be treated within 28 days of the cancellation.
- Improve the availability of patient records during pre-operative assessment clinics.
- 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.

- Risk assess the multiple uses of the treatment room in the main outpatient department at that is used for the treatment of leg ulcers and consider using a separate room.
- Ensure damaged chairs in the main outpatient department are replaced.
- Consider providing outpatient services during evenings and weekends.
- Ensure staff are up to date with Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DOLS) training.
- Ensure patients in radiology have their privacy and dignity maintained at all times.
- 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.
- Improve communication between divisions within outpatient services.

**Professor Edward Baker**  
Chief Inspector of Hospitals

## Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Minor Injuries Unit	Requires improvement	<p>● Overall, we rated the Minor Injuries Unit (MIU) as requires improvement because;</p> <ul style="list-style-type: none"> <li>• There was no initial clinical assessment of adult patients. This had not improved since our last inspection and meant that patients' condition was at risk of deteriorating while they waited for treatment.</li> <li>• Although children were assessed quickly during our inspection, the trust could not provide assurance that this took place consistently.</li> <li>• Staff did not use an early warning scoring system in order to identify deteriorating patients.</li> <li>• There remained a lack of monitoring of patient outcomes, performance measures and compliance with evidence-based protocols.</li> <li>• X-ray services were not always available when patients needed them.</li> <li>• There was no job description for the lead nurse role meaning that their responsibilities were unclear. The matron of the unit also managed a neighbouring emergency department and an urgent care centre that was several miles away. This left little time for direct clinical leadership of the MIU.</li> <li>• There was a lack of understanding of the risks that could affect the delivery of good</li> </ul>

quality care. We raised this with the trust at our last inspection. There had been some improvements but not all risks had been added to the risk register.

However, we also found:

- Nurse 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.
- Children were clinically assessed on arrival and pain relief administered if necessary.
- We observed staff taking trouble to maintain patient's privacy, dignity and confidentiality. They demonstrated empathy towards people who were in pain or distress and were skilled in providing reassurance and comfort.
- Almost all patients (99.9%) were treated, discharged or transferred within four hours.
- 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.

Surgery

Good



We rated this service as good because:

- There were clear processes in place for reporting incidents and providing feedback. Learning from incidents was shared across all areas.
- 'Test your care' nursing care indicators were consistently high and meeting trust targets.
- Written records were consistent across areas, clearly maintained with risk assessments and nursing/medical records easy to locate. Records were stored securely throughout our inspection.
- Improvements had been made in relation to standardisation of World Health Organisation safer surgery checklists and compliance with these met the trust target.
- Infection control practices had improved since the previous CQC inspection and

audits demonstrated good levels of compliance.

- There was a dedicated orthopaedic ward and a dedicated general surgical ward to manage patients' specific needs.
- Policies were up to date in line with guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations.
- Care bundles were embedded in patient care to improve patient outcomes.
- Significant work was being carried out in relation to enhanced recovery. Enhanced recovery pathways were used to improve outcomes for patients in general surgery, breast, urology, orthopaedics and ear nose and throat (ENT). Outcomes for enhanced recovery were collected and monitored within the service.
- The average length of stay for patients was better than the England average.
- The re-admission rate for elective patients were slightly better than the England average overall. However, the re-admission rate for elective orthopaedic patients was slightly worse than the England average.
- The service continuously reviewed and improved patient outcomes through participation in national audits including the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry and surgical site infection audits.
- Staff told us they had opportunities for personal development and to enhance their skills. Practice development support was available to all staff.
- All staff provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.
- Staff provided emotional support to patients and staff directed patients to clinical nurse specialists for support where required.

- Patients' and relative feedback was sought on the care they received to ensure they were happy with the care provided.
- Changes in senior leadership had led to positive operational and cultural changes within surgical service.
- Senior managers had a clear understanding of risks to the service and how these were being mitigated and monitored.
- All staff spoke positively about working within the service and felt local and senior managers were approachable.
- Staff understood the trust's vision and values and portrayed these in their day to day role.
- There was cross site working in place to improve risk and quality management within the service.
- The service demonstrated a drive to improve clinical services and supported innovations.

However:

- The vanguard theatre did not allow for waste and dirty linen to be removed without travelling outside or through a clean area.
- Imaging, diagnostics and dietetics and speech and language therapy services were available Monday to Friday from 9am to 5pm. If support was required outside of these hours it would be undertaken at the Watford Hospital site. If a patient required diagnostic imaging, for example an x-ray or scan, outside of these hours they would have to be transferred to the Watford site via non-emergency ambulance transport.
- Pharmacy support was available on site Monday-Friday with out of hours and weekend support from Watford General Hospital site.
- The trust was failing to meet referral to treatment targets for all specialties. The trust performance was also worse than the England average.
- Those who had surgery cancelled were not always treated within the following 28

days in line with guidance.

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 for issues raised. Performance data had improved and the service was performing in line with their planned trajectory.
- There was a positive incident reporting and learning culture across the services provided. Duty of candour was evident in incident investigations we reviewed.
- Radiation protection in the diagnostic imaging department was robust. Medical physics experts and radiation protection supervisors actively worked with staff to provide advice and ensure compliance with safety standards.
- 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.
- The main outpatient department was due to have a full nursing establishment by the end of 2017.
- Waiting lists for outpatient appointments were reviewed weekly and risk assessments were completed for patients who waited 30 weeks or more. At the time of our inspection, no clinical harm had occurred 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.
- A local audit programme included monitoring compliance with best practice. The outpatient department regularly achieved the trust target.
- 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). Results showed consistent compliance and actions taken to improve.

- 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 this inspection in August/September 2017, we found that appraisal rates had improved to meet the trust target of 90%.
- 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 care.
- The service communicated regularly with patients' GPs and had worked with the trust's GP liaison manager to share information with local doctors.
- 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.
- 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.
- Chaperones were available throughout the outpatient and diagnostic imaging services. All patients we spoke with had been offered a chaperone or to have a friend or relative accompany them.
- 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.
- Patients we spoke with described being offered emotional and social support.
- Outpatient and diagnostic imaging services were planned and delivered to meet people's needs.
- The facilities at were generally suitable for the services provided.
- 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 hearing loops and written information in languages other than English.
- The departments tailored care to meet the needs of patients with a learning disability and the main outpatient department was working towards gaining a Purple Star accreditation for this.
- 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.
- All staff we spoke with felt respected and valued. The culture across outpatient and diagnostic imaging services encouraged openness, candour and honesty.
- Patients, relatives and visitors were actively engaged and involved when planning services. Clinical leads led an outpatient user group to gather information on patient experience.
- Leadership of the diagnostic imaging department was focused on driving improvement and delivering high quality care to patients. Radiology governance and risk management processes were robust and effective.

However:

- We saw evidence that learning within the

clinical divisions was shared across Watford General, Hemel Hempstead General and St Albans City Hospitals. However, this was not always communicated to the outpatient services in other divisions.

- 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.
- There was an infection control concern regarding the use of one treatment room in the main outpatient department. The room was used for leg ulcer care in the morning and by the ear nose and throat team to suction patients' ears in the afternoon. This posed an infection control risk as leg ulcers are open wounds that could have been infected by bacteria.
- Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.
- Some clinic rooms did not have non-slip finish flooring to minimise falls and infection control risk, which was not in line with Department of Health guidance. This had been recognised as an issue and floors were scheduled to be replaced by October 2017.
- Although naso-endoscopes were cleaned manually, the service did not follow best practice guidelines for scope decontamination.
- 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.
- 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.

- Changing facilities for patients in the ultrasound department were not in a discreet location to maintain privacy and dignity.
- 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.
- In the main outpatient department, we could not be assured that there was robust local risk assessment or management, as staff could not provide us with evidence.
- At the time of inspection, there was only one risk on the department risk register. However, during our inspection we identified other risks that should have been recognised.

# St Albans City Hospital

Requires improvement



## Detailed findings

### Services we looked at

Minor Injuries Unit; Surgery; Outpatients & Diagnostic Imaging

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### Summary of this inspection

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## Background to St Albans City 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 600 inpatient beds throughout the trust and over 4300 staff are employed. In addition, there are 350 volunteers. The majority of acute services are delivered at Watford Hospital.

St Albans City Hospital has a minor injury unit which is open from 9am to 8pm, seven days a week, two surgical wards with a total of 40 beds and an outpatients department and diagnostic and imaging services.

We carried out an announced comprehensive inspection of the trust, which included St Albans City Hospital from 30 August to 1 September 2017. We undertook unannounced inspections throughout the trust, including St Albans City Hospital, on 12 September 2017.

This was the third comprehensive inspection of the trust, the first taking place in April and May 2015. 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, although overall was rated requires improvement, 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, specialist surgical nurses, a consultant surgeon, 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 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.

Some people shared their experience by email, telephone or completing comment cards.

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, MIU and outpatients departments.

## Facts and data about St Albans City Hospital

St Albans City Hospital is part of West Hertfordshire Hospitals NHS Trust. It has 40 beds.

St Albans has a population of over 130,000. It is ranked 320 out of 326 in the English Indices of Deprivation Rankings so is one of the least deprived areas in the country. However about 8.2% (2,400) children live in poverty. Overall life expectancy for both men and women is higher than the England average but in the most deprived areas of St Albans the life expectancy is 6.9 years lower for men and 5.8 years lower for women than in the least deprived areas.

## Overview of ratings

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor Injuries Unit	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Requires improvement	Inspected but not rated <sup>1</sup>	Good	Good	Good	Good
Overall	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.

# Minor Injuries Unit

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

## Information about the service

The Minor Injuries Unit (MIU) at St Albans City hospital is open every day (except Christmas Day) from 9am to 8pm. It provides a service for adults and children, aged two years and over, who have sustained minor injuries such as cuts, sprains, minor fractures, burns and minor head injuries.

The unit is staffed by emergency nurse practitioners (ENPs) and administrative support staff. It has five treatment rooms, a resuscitation room, and access to on-site x-ray facilities from Monday to Friday (9am to 5pm).

For the year ending August 2017, 18,000 patients attended the MIU, of which nearly 5,000 (28%) were children aged 2 to 17 years old.

The MIU forms a part of the trust's unscheduled care division, which includes the emergency department at Watford General Hospital and the Urgent Care Centre at Hemel Hempstead Hospital. All three services are 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 inspection reports.

We carried out an announced inspection of the MIU on 31 August 2017. During our inspection, we spoke with five members of staff and six patients. We looked at 16 sets of patients' records.

## Summary of findings

Overall, we rated the Minor Injuries Unit (MIU) as requires improvement because:

- There was no initial clinical assessment of adult patients. This had not improved since our last inspection and meant that patient was at risk of deteriorating while they waited for treatment.
- Although children were assessed quickly during our inspection, the trust could not provide assurance that this took place consistently as it was not recorded.
- Staff did not use an early warning scoring system for both adults and children, in order to identify deteriorating patients.
- There remained a lack of monitoring of patient outcomes, performance measures and compliance with evidence-based protocols.
- X-ray services were not always available when patients needed them.
- There was no job description for the lead nurse role meaning that their responsibilities

were unclear. The matron of the unit also managed a neighbouring emergency department and an urgent care centre that was several miles away. This left little time for direct clinical leadership of the MIU.

- There was a lack of understanding of the risks that could affect the delivery of good quality care. We raised this with the trust at our last inspection. There had been some improvements but not all risks had been added to the risk register.

However, we also found;

- Nurse 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.
- Children were clinically assessed on arrival and pain relief administered if necessary.
- We observed staff taking trouble to maintain patient's privacy, dignity and confidentiality. They demonstrated empathy towards people who were in pain or distress and were skilled in providing reassurance and comfort.
- Almost all patients (99.9%) were treated, discharged or transferred within four hours.
- 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?**

Requires improvement 

Overall, we rated the MIU as requires improvement for safe because:

- During the last inspection, we found that there was no clear streaming or triage process in place. Although children were clinically assessed (triaged) within 20 minutes adults could wait for over an hour. This meant that they were at risk of deteriorating while they waited.
- Although all children were clinically assessed within five minutes during our inspection, there were no records for the months leading up to our inspection. Therefore, we could not be assured that all children were assessed in a timely manner.
- Staff did not use an early warning scoring system in order to identify deteriorating children or adults.
- No risk assessment had been carried out for medicines storage in the reception area.
- There were no hand hygiene audits undertaken.

However, we also found:

- The MIU met the 'Standards for Children and Young People in Emergency Care Settings, 2012' and Intercollegiate standards for staffing and safeguarding. (2014.) There was a process in place for all children to be seen by a clinician within 20 minutes.
- Clinical staff had undertaken further training in the assessment and treatment of sick and injured children.
- Staff were aware of the major incident policy and their required actions if a major incident was declared.

### **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 harm 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. 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.
- For year ending June 2017 there had been no serious incidents reported to the Strategic Executive Information System (STEIS) for the MIU.
- There had been 23 incidents reported in the year ending June 2017, two had been assessed as low harm and the remainder had caused no harm. The vast majority of reports regarded transfer of patients to other hospitals. The unit 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. Discussions were also held at monthly clinical governance meetings. For example, silver nitrate application sticks had been moved and were 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 having anticoagulant treatment (a type of medicine that reduces the blood's ability to clot) 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. During our inspection, we observed a patient with a similar condition arriving at the reception desk of the MIU. The receptionist knew to call a nurse practitioner immediately. Treatment proceeded according to the flowchart and the patient was rapidly transferred to Watford General Hospital for a CT scan
- Providers are 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. Staff had a good understanding of these regulations and spoke confidently about when they should be applied. There had been no incidents that met the threshold of the duty of candour regulation (moderate or severe harm).

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

- We saw that 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 81% which did not meet the trust standard of 95%. The weaknesses concerned storage of equipment and cleaning materials. However, during the inspection, we checked these areas and found that storage complied with trust policy.
- 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 MIU. Staff told us that it was difficult to conduct these audits as care and treatment took place in enclosed environments and it would be difficult to measure the

practice.

- 'Arms bare below the elbow' policies were adhered to and staff wore minimal jewellery in line with the trust's infection control policy. In addition, personal protective equipment such as gloves and disposable aprons were used in accordance with the same trust policy.

### **Environment and equipment**

- There was adequate space and seating in the waiting area of the MIU 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 MIUs 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 MIU, there was limited space to have a separate waiting area for children.
- The unit was well equipped and the equipment was checked daily to ensure that it was ready for use. We saw records showing a regular programme of planned maintenance and servicing and had maintenance that 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 sharps bins were sealed securely and were not overfilled.

### **Medicines**

- Medicines were stored in line with the trust's 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 of controlled drugs, which include strong pain relief medicines and sedatives. These were stored correctly, carefully monitored and we found that the stock balance was correct.
- Since our last inspection, five of the Emergency Nurse Practitioners (ENPs) had qualified as non-medical prescribers. Those that were not prescribers administered selected medicines under guidance, known as patient group directions (PGDs). We looked at five PGD's and found them to be within date and appropriately completed. Records showed that staff had been trained and were competent to use them.
- A new medicines cupboard had been placed in the reception area so that painkillers could be rapidly administered to newly arrived children. This was in full view of the general public in the waiting room which could have compromised the security of the medicines. No risk assessment had been carried out for the placement of this cupboard.
- Pharmacy services were available at St Albans Hospital from Monday to Friday, 9am to 5pm. Outside of these hours; nursing staff had access to on-call support if they required medicines 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, 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 sixteen sets of records and found that information regarding the patient's care and treatment was methodically documented. There was appropriate information to understand the treatment delivered.
- Paper records were stored behind a locked door in secured cabinets in the reception area when they were no longer required.

### **Safeguarding**

- There was a clear system and process in place for identifying and managing both children and adults at risk of abuse. Nursing and administrative staff we spoke with were able to explain the safeguarding process and provided us with specific examples of when they would refer a vulnerable person to the appropriate authority. Records showed that all clinical staff had received children's level 3 and adult safeguarding training in the last year.
- 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 through the unit's electronic system. This 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 the records of all children aged five years or less and review any safeguarding referrals.
- The MIU 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 whom to contact if they had any safeguarding questions.

### **Mandatory training**

- 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 95% of MIU staff had completed this training in the last year. This had improved since our last inspection.
- Records showed that all clinical staff had successfully completed immediate life support training and paediatric immediate life support training in the last year. It was unclear whether any staff were advanced life support providers. Additional training about sepsis had also been provided to relevant staff.

### **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 in 2015 and 2016, we found delays of up to two hours before patients were assessed. At this inspection, some improvements had been made. These 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. This was in line with the RCEM: Triage position statement (2011.) Guidance for non-clinical staff. Reception staff that we spoke with were familiar with this guidance. We observed clinical staff being rapidly alerted when a patient arrived with a red flag condition.

- In addition, all receptionists were undergoing basic life support training so that they could respond appropriately if someone collapsed in the waiting room.
- During our inspection children were assessed immediately by appropriately trained clinical staff and pain relief was offered if necessary. We looked at the records of six children who had attended in the previous three days and found that all had been assessed within 10 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 patient's paper record document, it was not possible to record it on the computer system. This meant that the trust did not collect the information and could not assure us that all children were assessed in a timely manner.
- Adult patients were not clinically assessed as soon as they arrived and they sometimes waited for extended periods of time to be seen by a nurse practitioner. We looked at 16 patient records from the previous 10 days. We found that a patient who had been involved in a road traffic collision had waited an hour and ten minutes to be assessed, and someone with chest pain waited 35 minutes. A patient that we spoke with said that, a few months previously, he had suffered a head injury and had waited over an hour to be seen by a nurse practitioner. We did not further evidence this by checking the patient's record. NICE 176 (2014) states that all patients with head injuries should be assessed within 15 minutes.
- Data supplied to us from the department's paper records showed that, from August 2016 to July 2017, the average (median) time patients waited to see a nurse practitioner varied from 27 minutes to 39 minutes. This meant that many patients waited longer than these times and there was a risk that their condition could deteriorate.
- Nursing staff briefly viewed the waiting room when they collected their next patient but they did not have line of sight of all waiting patients when they did this.
- We saw that from August 2016 to July 2017 during the same time-period, the percentage of people who left the MIU before being seen was 2%, which was better than the England average of 3%.
- The MIU was designed to treat patients of two years and older. Staff told us that if a child under the age of two years old presented at the MIU, they would be assessed by an ENP and then directed to an appropriate urgent care facility, 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, as there was no paediatric team based at the St Albans Hospital site.
- Staff had 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 meant that they were at risk of deteriorating. However, these systems were not routinely used. We reviewed a sample of records of nine patients who had attended in the three days prior to our inspection and who should have had an early warning score calculated. None of them contained evidence that an early warning score had been calculated or recorded.
- 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 patients with sepsis who had recently attended and the emergency transfers to an emergency department that had resulted.

### **Nursing staffing**

- We reviewed that staffing rota for the month prior to our inspection. This demonstrated that there were always two emergency nurse practitioners (ENP) on duty. A third ENP worked on Mondays as this was the day that most patients attended. 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 MIU with the full range of competencies to assess children's needs. Since then, four of the eight ENPs had undertaken further training in the assessment and initial treatment of children. The rota was arranged so that there was always one on duty. The remaining four ENPs were due to complete their training by the end of 2017.
- Staff had access, by telephone, at all times to specialist children's nurses at the emergency department at Watford General Hospital.
- There was minimal use of bank (temporary) staff in the MIU and no agency staff used. Bank staff were provided through a dedicated specialist service. 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 MIU.

### 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 the 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.
- There were plans in place to deal with possible disruptions to services such as computer failure, power cuts and flood.

## Are urgent & emergency services effective?

Requires improvement



Overall, we rated the Minor Injuries Unit (MIU) as requires improvement for effectiveness because:

- There remained a lack of monitoring of patient outcomes and compliance with evidence-based protocols, outstanding since the last inspection.
- Pain assessment scores were not recorded.
- The unit had an unplanned re-attendance rate of 8.4% compared to a national average for urgent and emergency care of 6%. There had been no analysis of these sub-optimal results and the staff could not fully explain them.

However, we also found:

- 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 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. Children's pain was assessed as soon as they arrived and pain relief given if necessary.
- There was good multi-disciplinary working and the unit met 17 of the 19 standards set out in the Royal College of Medicine (RCM) report on "Unscheduled care facilities" 2009.

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

- Staff in the MIU 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 them and could speak confidently about any actions that needed to be taken.
- During our last two inspections we found there was no local clinical audit programme to check that treatment given to patients followed best practice. Although some audits had been planned for 2017, none had taken place.
- During our inspection, we found that the MIU met 17 of the 19 principles set out by the RCEM document 'Unscheduled care facilities' 2009. The principles that they did not meet was regular clinical audits and a lead doctor in post.
- All x-rays were reviewed by a radiologist (specialist x-ray 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 MIU. However, the level of pain was not recorded using a pain score and was not reassessed to check if pain relief had been effective.
- 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 be reassessed every hour. This had not occurred during our previous inspections. However, a change in practice had occurred during the last year. Children were assessed as soon as they arrived and pain relief was given if necessary.

## **Nutrition and hydration**

- The majority of patients (95%) spent less than three hours in the unit and so meals were not provided.
- Staff spoke confidently about the recognition of signs of malnutrition and dehydration.

## **Patient outcomes**

- At our last inspection we found that there was no formal monitoring of patient outcomes. During this inspection we found no improvement had taken place.
- MIU patients were not included in relevant national audits that were being conducted in the unscheduled care division such as treatment of feverish children.
- A low rate of unplanned re-attendances is often used as an indicator of good patient outcomes. During the year ending July 2017 the MIU had a rate of 8.4% 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**

- Staff who were new to the department took part in a structured orientation programme. Staff that we spoke with told us that they found it informative and effective.
- The orientation programme for nurse 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.

- The trust sent us data showing that by June 2017 88% of nursing staff and 75% 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 undergone an appraisal in the last year. This was an improvement. At our last inspection in September 2016, very few of the staff had received a recent appraisal and so specific learning needs had not been identified.
- All nurse practitioners were currently undertaking an on-line paediatric assessment course organised by Health Education England. In addition, they rotated to a neighbouring children's emergency department 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 MIU 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.
- Reception staff, at the time of our inspection, were undergoing training in basic life support.

### **Multidisciplinary working**

- There were good working relationships with community services, the emergency department at Watford General Hospital and with the urgent care centre at Hemel Hempstead Hospital.
- Practitioners could discuss complicated injuries or X-rays with a senior doctor at the nearby emergency department at Watford.
- Direct referrals were made to physiotherapists for conditions such as soft tissue injuries or ligament strains. There were therapy departments based at the hospital, this enabled treatment to continue in one place.
- 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 MIU was open seven days a week (except for Christmas Day) from 9am to 8pm.
- X-ray facilities were only available at St Albans City Hospital Monday to Friday 9am to 5pm. During the evening, at weekends and bank holidays, patients who required-rays had to travel to Hemel Hempstead or Watford. If further treatment was required, for example if a fracture had been identified on X-ray, the patients sometimes had to return to St. Albans for the treatment to be carried out.
- There was an on-site pharmacy available at St Albans 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, for example pain relief and antibiotics, 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 all stored on the hospital's intranet and we observed staff referring to them when necessary.
- Previous X-rays and their results were available electronically, via the imaging archiving system.
- Patients who were discharged from the unit, were given written information to share with their GPs.

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

- Patients had their consent obtained in line with national guidance.
- We observed that consent, both written and verbal, was obtained for any procedures undertaken by the staff.
- 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 the unit's matron or local psychiatric crisis teams if this was necessary
- Further written guidance on consent, and assessing mental capacity was available via the trust's intranet.

### Are urgent & emergency services caring?

Good ●

Overall, we rated the Minor injuries Unit (MIU) as good for caring because:

- Feedback from patients and those close to them confirmed that staff were caring and kind.
- We observed staff taking trouble to maintain people's privacy, dignity and confidentiality.
- Staff demonstrated empathy towards people who were in pain or distressed and were skilled in providing reassurance and comfort.
- People 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

- 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. We observed a nurse putting their arm around a patient's shoulders when they became upset about being transferred to another hospital.
- Confidentiality was maintained at the reception desk by means of signs asking people to

stand back from the desk, when someone was being registered.

- The MIU had examination and treatment rooms with doors to ensure privacy when patients were being seen and examined. We saw that staff knocked and waited to be called in before entering.
- We observed staff introducing themselves and explaining what was about to happen before examining patients.
- Practitioners took time to distract and comfort children during examinations and wound dressings. Parents were involved in the assessment and treatment of their children and clear explanations were given.
- We spoke with six patients and their families. They all reported a positive experience. One said, "The staff here are great. I trust them completely".
- 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 to their friends or family.

### **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.
- 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 observed staff interacting with patients and family members. Staff talked to all in a way that patients could understand and described what they were going to do.
- Staff also checked that people had understood what they had 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.
- One small child was reluctant to have an x-ray. The practitioner looking after the child gently explained the importance of the x-ray and successfully dispelled the child's fears.
- 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 Minor Injuries Unit (MIU) good for responsive because:

- Services were planned to meet the needs of patients, including those who were vulnerable or who had complex needs.
- The units were easy to access and there was sufficient space for the number of people using them.
- The average time to treatment was 27 minutes and 99.9% of patients were treated, discharged or transferred within four hours.
- 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. People with dementia or a learning disability received care and treatment that was sympathetic and knowledgeable.

- Improvements were made to the quality of care because of complaints and concerns.

However, we also found:

- X-ray services were not always available when patients needed them. The x-ray department was closed during the evening and at weekends which meant that people had to travel to Hemel Hempstead or Watford if they needed an x-ray.

### **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 been proposed or finalised at the time of the inspection.
- The premises were appropriate for the service that was being delivered.
- X-ray facilities were not always available. The X-ray department closed at 5pm during the week and was not open at weekends or bank holidays. This meant that some patients had to travel nine miles to Hemel Hempstead Hospital, or further to Watford, for an X-ray.
- Patients told us that they appreciated having a local minor injuries unit, which meant that they did not have to travel to a larger emergency department.

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

- The unit was well signposted from the entrance to the hospital site. Patients told us that it was easy to find. There was drop-off point immediately outside and wheelchairs were available just inside the entrance. This meant the people with leg injuries or limited mobility could access the unit easily.
- 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 people 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 a learning disability or dementia who had recently attended the department. They recognised that the hospital environment could be confusing and distressing to this group of patients. Therefore they were seen promptly in order that their visit to the unit was as short as possible.
- The computer system featured a flagging system for people with a learning disability so that staff could be alerted to their special needs.
- Staff had compiled 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.
- 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.
- We observed that staff adapted their practice and communication styles to meet the needs of individuals who attended the unit.
- Staff gave information leaflets given 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 MIU was on a single level and there was sufficient space for wheelchair users or those who had limited mobility, to move around easily. There were designated disabled parking bays outside the unit and we saw that 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 MIUs. Annual performance for the year ending July 2017 was 99.9%.
- While waiting no more than four hours from arrival to departure is a key measure of MIU performance, there are other important indicators, such as how long patients wait for their treatment to begin. A short wait reduces patient risk and discomfort. The national target is a wait of below 60 minutes. The trust consistently achieved this target. The average time from arrival to treatment in the first six months of 2017 was 27 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 1.2% of patients left without being seen during year ending July 2017. This compared favourably 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. 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
- Nursing staff told us that the main reason that people complained was due to the lack of x-ray facilities during the evening and at weekends. This had not changed since our last inspection.
- In the year ending August 2017, there were three complaints recorded for the MIU. We saw that complaints were investigated in a timely manner, opportunities for learning identified and action taken when required. For example, there had been a large display panel at the front door informing people of the opening times of the unit and describing their options for treatment and advice when the unit was closed.

## Are urgent & emergency services well-led?

Requires improvement ●

Overall, we rated the Minor Injuries Unit (MIU) 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 MIU the matron was able to spend very little time at the unit.
- There was no active medical oversight of the unit.
- On-site leadership was by means of rotational post between different emergency nurse

practitioners (ENP). There was no job description for this post and so the responsibilities of the lead nurse was unclear.

- There continued to be a lack of understanding of the risks that could affect the delivery of good quality care. In addition, there was little monitoring of performance measures.
- Although the MIU 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 MIU was a part of the unscheduled care division, which also included the emergency department (ED) at the Watford General hospital and the urgent care centre (UCC) at Hemel Hempstead. The overall management of the division included a divisional director, divisional general manager, and divisional lead nurse.
- Direct management of the MIU was the responsibility of the ED matron based at Watford General Hospital. Trust documents stated that the clinical director of the emergency department at Watford General Hospital had clinical and managerial responsibility for the minor injuries unit. However, staff told us that due to the shortage of consultants in the emergency department, the clinical director was not able to visit the unit 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 start.
- Due to the shortage of consultants at the emergency department, there was no specific medical oversight of the MIU. It was planned that a new consultant would commence employment in October 2017.
- The matron told us that she tried to visit the MIU twice a week. However, the pressures of the Watford General Hospital emergency department meant that this was normally reduced to once a week for one to two hours at a time. This provided little time for direct clinical leadership.
- It had been anticipated that each of the emergency nurse practitioners (ENP) would rotate into an on-site management role for six months at a time. However, in practice, most of the ENPs were reluctant to leave their clinical roles and so the current lead nurse had been in post for over a year.
- 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, 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 our last inspection.

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

- There was a trust vision and values in place, of which staff were aware.

- There was a trust strategy in place, which directly affected the MIU at St Albans City Hospital. This was described in, 'Your care, your future' (2015). Staff were aware of this strategy and that the trust were in favour of keeping, and potentially expanding, urgent care and minor injury services keeping them as close as possible to local population hubs including St. Albans.
- There was no other specific documented plan or policy for further development of the MIU. 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 MIU in this document was that clinical pathways would be reviewed. No timeline was given for the reviews.

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

- There was a governance framework in place to support the delivery of good quality care.
- It was clear that here had been some improvements in clinical governance since our last inspection. Aspects of clinical safety were 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. We were shown the results of the last two audits, which showed the unit had scored 100%.
- Monthly clinical governance meetings were held jointly with the urgent care centre at Hemel Hempstead. Minutes from meetings in May and June 2017 showed that complaints, incidents and new working processes were discussed and acted upon. Although risks, such as the attendance of aggressive or violent patients, were discussed, they were not added to the divisional risk register.
- There was 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. This was an improvement since our last inspection.
- There continues to be a lack of understanding of the risks that could affect the delivery of good quality care, despite the fact that we had raised this during our last two inspections.
- The MIU did not have its own risk register. We asked the trust to send us risks associated with urgent and emergency care that had been entered onto the divisional risk register. None were related to the MIU. Risks that we found on previous inspections had not been identified and added to the risk register. For example, the lack of effective monitoring of the time from arrival to initial clinical assessments.
- The unit was required to measure the four hour admission to discharge target. However, there was no formal process in place to monitor other elements of performance, such as compliance to protocols or time to initial assessment. This meant that the unit was not consistently identifying areas for improvement or best practice and staff were not aware of how they were performing in some other areas.
- There was no formal programme for clinical audits to measure patient outcomes and performance.

### **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 any 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 there was a good sense of teamwork.
- It was apparent that the culture within the MIU was centred on the needs and experience of people who used the service.
- The safety and wellbeing of staff was considered important. For example, a member of staff had recently had period of long-term illness. Support had been given during the illness

and there had been a graduated return to work once recovery had taken place.

- 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**

- People who used the service and those close to them, were asked their opinion so that they were actively engaged and involved in decision-making.
- There were questionnaires available in the waiting and reception area of the unit asking patients to provide feedback about their experience at the MIU. Any comments were considered and acted upon by the senior staff.
- 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 MIU through their 'Your Care, Your Future' plans.

### **Staff engagement**

- Staff told us they felt involved and their views were considered when there were changes planned in the delivery of services.
- Engagement with staff had improved since our last inspection. Regular staff meetings, were held and their 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 MIU. We saw the minutes of the last two meetings, which had been 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.
- There had been a staff survey undertaken since our last inspection, however, the trust were unable to provide separate results for the MIU.

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

- Staff recognised that patients who had to be sent to Hemel Hempstead hospital for an urgent x-ray did not always want to return to St. Albans for the results. Therefore, arrangements were made to view the x-ray remotely at St Albans and the results telephoned to the patient. This meant if there was no fracture, or a minor injury, the patient did not have to make an extra journey to the MIU for the results.
- Since our last inspection, there had been improvements in facilities for, and treatment of, children; staff engagement and training and some aspects of clinical governance. In addition, escalation processes when there were long waits for treatment had improved. Staff also had an increased awareness of their role should there be a major incident.

# Surgery

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

## Information about the service

Surgical services provided by West Hertfordshire Hospitals NHS Trust are located on two hospital sites, Watford General Hospital and St Albans City Hospital. Services at Watford General Hospital are reported on separately.

St Albans City Hospital provides a wide range of surgical, diagnostic and outpatient facilities to approximately 500,000 people living in West Hertfordshire and the surrounding areas.

The surgical service provision at St Albans is for low risk, elective procedures. This includes orthopaedics, ophthalmology, vascular, ear nose and throat (ENT), urology, endocrine and breast surgery.

The hospital performance summaries from February 2016 to January 2017 showed there were 11,469 spells at St Albans. The trust identified that 80% of surgical patients were day cases and 20% were elective (planned) during this period. Surgical services at St Albans City Hospital are located within the surgery, anaesthetics and cancer division. There are six theatres and 40 elective surgery beds on two wards De La Mere and Beckett. De La Mere ward was mainly used for elective orthopaedic patients and Beckett ward was used for general surgical patients. Along with the surgical wards there was also a pre-assessment unit and day case surgery department.

We previously inspected this service in September 2016 and found it to require improvement. Areas we told the service it must improve were:

- To ensure medicines are stored at correct temperatures in all areas and ensure appropriate action is taken if temperatures are outside the recommended range in surgery.
- To ensure the surgery service is compliant with recommendations for the safe management of controlled drugs.
- Plans must be put into place to ensure referral to treatment (RTT) and cancer treatment times to continue to improve so that they are similar to or better than the England average.
- To ensure all resident medical officers (RMOs) staff receive a trust induction.
- To ensure all staff received feedback after reporting incidents.
- To ensure all staff in surgery report any issues, concerns and incidents using the trust's electronic incident reporting mechanism.
- Actions on fire risk assessments in surgery are should be completed urgently and areas are regularly monitored for future compliance.

- The five steps to safer surgery checklists should be incorporated into all services and the three step checklist should be removed from use.

Areas we told the service it should improve were:

- All patients should have a venous thrombus embolism (VTE) assessment within 24 hours of admission and follow the National Institute of Health and Clinical Excellence (NICE) guidelines on VTE assessment and treatment.
- Action should be taken reduce the number of cancelled surgery operations and benchmarking should be undertaken against other similar hospitals.
- Pre-assessment documentation should include an assessment for patients living with dementia or a learning disability.
- All patients transferred, because of complications; from St Albans hospital should be fully reviewed. This should include an audit of any delay in this transfer.
- To review delays for patients receiving take home medicines and a plan put into place to minimise these delays.
- All complaints should be responded to within the agreed timescales.
- To review ways in which all staff are made aware of the trust's mission, vision, and strategic objectives.

During our announced inspection on 30 and 31 August 2017, we visited all surgical services, spoke with 14 patients, observed patient care and treatment and looked at 18 patient care records. We spoke with 26 staff including nurses, healthcare assistants, clinical nurse specialists, doctors, consultants, theatre staff, ward managers and matrons. We received comments from our focus group listening events and from people who contacted us to tell us about their experiences at the hospital.

## Summary of findings

We rated this service as good because:

- There were clear processes in place for reporting incidents and providing feedback. Learning from incidents was shared across all areas.
- 'Test your care' nursing care indicators were consistently high and meeting trust targets.
- Written records were consistent across areas, clearly maintained with risk assessments and nursing/medical records easy to locate. Records were stored securely throughout our inspection.
- Improvements had been made in relation to standardisation of World Health Organisation safer surgery checklists and compliance with these met the trust target.
- Infection control practices had improved since the previous CQC inspection and audits demonstrated good levels of compliance.
- There was a dedicated orthopaedic ward and a dedicated general surgical ward to manage patient's specific needs.
- Policies were up to date in line with guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations.
- Care bundles were embedded in patient care to improve patient outcomes.
- Significant work was being carried out in relation to enhanced recovery. Enhanced

recovery pathways were used to improve outcomes for patients in general surgery, breast, urology, orthopaedics and ear nose and throat (ENT). Outcomes for enhanced recovery were collected and monitored within the service.

- The average length of stay for patients was better (shorter) than the England average.
- The re-admission rate for elective patients were slightly better than the England average overall. However, the re-admission rate for elective orthopaedic patients was slightly worse than the England average.
- The service continuously reviewed and improved patient outcomes through participation in national audits including the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry and surgical site infection audits.
- Staff told us they had opportunities for personal development and to enhance their skills. Practice development support was available to all staff.
- All staff provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.
- Staff provided emotional support to patients and staff directed patients to clinical nurse specialists for support where required.
- Patients' and relative feedback was sought on the care they received to ensure they were satisfied with the care provided.
- Changes in senior leadership had led to positive operational and cultural changes within surgical service.
- Senior managers had a clear understanding of risks to the service and how these were being mitigated and monitored.
- All staff spoke positively about working within the service and felt local and senior managers were approachable.
- Staff understood the trust's vision and values and portrayed these in their day to day role.
- Cross site working occurred to improve risk and quality management within the service.
- The service demonstrated a drive to improve clinical services and supported innovations.

However:

- The vanguard theatre did not allow for waste and dirty linen to be removed without travelling outside or through a clean area.
- Imaging, diagnostics and dietetics and speech and language therapy services were available Monday to Friday from 9am to 5pm. If support was required outside of these hours it would be at the Watford hospital site. If a patient required diagnostic imaging, for example an x-ray or scan, outside of these hours they would have to be transferred to the Watford site via non-emergency ambulance transport.
- Pharmacy support was available on site Monday-Friday with out of hours and weekend support from Watford General Hospital site.
- Those who had surgery cancelled were not always treated within the following 28 days in line with guidance.

## Are surgery services safe?

Good ●

We rated safe as good because:

- There were clear processes in place for reporting incidents and providing feedback. Learning from incidents was shared across all areas.
- 'Test your care' nursing care indicators were consistently high and meeting trust targets.
- Equipment was well maintained and appropriately stored throughout all surgical areas. Staff knew how to report faulty equipment and how to source replacement items.
- Medicines, including controlled drugs, were managed appropriately to keep patients safe and storage of medicines was in line with the trust policy.
- Records were consistent across areas, with risk assessments and nursing/medical records easy to locate. Records were stored securely throughout our inspection.
- Improvements had been made in relation to standardisation of World Health Organisation safer surgery checklists and compliance with these met the trust target.
- Infection control practices had improved since the previous CQC inspection and audits demonstrated good levels of compliance.
- Safety thermometer data collected by the trust was better than the England average for falls, pressure ulcers and catheter associated urinary tract infections (CAUTI).
- A resident medical officer (RMO) was available across both surgical wards 24 hours a day, seven days per week. RMO's could access more senior medical advice from consultants at the Watford hospital site as required.
- There was a dedicated orthopaedic ward and a dedicated general surgical ward to manage patient's specific needs.

However:

- The vanguard theatre did not allow for waste and dirty linen to be removed without travelling outside or through a clean area.

### Incidents

- 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. From June 2016 to June 2017, there had been no reported never events within the surgery division at the St Albans site.
- From June 2016 to June 2017, there had been no serious incidents reported in relation to surgery services at the St Albans site.
- There was an electronic reporting system in place to allow staff to report incidents. All staff we spoke with knew how to access this system and their responsibilities to report incidents. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas via staff meetings, huddles, emails and notices.
- Ward managers and matrons felt there was a good incident reporting culture across surgery services at St Albans and that this had improved since being identified as an area of concern during the previous CQC inspection in 2016.

- From September 2016 to August 2017, 764 incidents were reported within St Albans surgical services. Incidents were given a harm rating, ranging from 'no harm' to 'catastrophic/death'. Of the reported 764 incidents, 89.6% were no harm, 8.6% were low harm, 1.3% were moderate harm and the remaining 0.5% were severe or catastrophic harm.
- Each incident was also categorised, the main categories reported were relating to procedures (63 incidents), patient monitoring (36 incidents), access and admissions (35 incidents) and infrastructure (28 incidents).
- All incidents were overseen at a trust wide level by the risk manager and at department level by the relevant area manager. We observed that incidents were investigated in a timely way and had outcomes and learning points recorded as necessary. Staff we spoke with could describe a never event that had occurred in the trust's outpatient division and could explain what learning points had come from this including the checking of patient identification prior to procedures.
- From November 2014, all 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. Staff were aware of the duty of candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident resulting in moderate or severe harm. Staff could give us examples of where they had used this in practice or instances where they would use it. However, we did not check any incident records to see if this had been applied.
- Mortality review meetings were carried out within the trust, and monthly at divisional level. We reviewed the previous three meetings minutes and found them to contain information relating to performance data relating to mortality, including the Hospital Standardised Mortality Ratio (HSMR), clinical coding and patient safety indicators. Consultants reported that the meetings were well attended. Information and case studies were shared in presentations to look at what was done well and what needed to be improved.

### **Safety thermometer**

- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harms including new pressure ulcers, catheter urinary tract infections and falls. The information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly. Information relating to these areas was displayed throughout surgical wards for staff, patients and visitors to see.
- NHS Safety Thermometer Data was provided at trust level for surgical services as a whole and not split into site data for St Albans and Watford. Data from the Safety Thermometer showed that the trust reported four new pressure ulcers, one fall with harm and two new urinary tract infections in patients with a catheter between June 2016 and June 2017 across the surgical division.
- The surgical division also used a monthly performance dashboard to monitor quality of care. Standards were measured, using a collection of nursing care indicators, called 'Test Your Care'. Indicators of care included missed medication doses, nutritional assessments, and pressure ulcers. These indicators were measured by senior nursing staff and inputted onto a database for frequent monitoring.
- We observed that 'Test Your Care' data was visible on entering ward areas to staff,

patients and visitors. Compliance with standards had been above 95% since March 2017 within the surgical division at St Albans.

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

- At the time of our inspection, good standards of cleanliness were maintained cross the department, with reliable systems in place to prevent healthcare-associated infections. Whilst some areas of surgical services at St Albans were dated, the environment and equipment were visibly clean and all areas were tidy and well organised.
- Staff had received training about infection, prevention and control (IPC) during their initial induction and annual mandatory training. We saw that 97% of surgical nursing staff and 90% of medical staff across both sites had completed their IPC training. This was in line with the trust target of 90%. Staff also received hand hygiene training as part of their annual update. The trust's training record for 2017 showed that 87% of nursing staff had completed this training. This was below the trust target of 90%. The trust did not provide data for medical staff.
- Audits were carried out monthly in relation to hand hygiene, commode cleanliness and ward cleaning.
- We observed that from within the surgical wards, compliance with hand hygiene met the trust target of 95% for all months and all staff groups from December 2016 to May 2017 with the exception of doctors in April 2017. Hand hygiene in theatres met the trust target of 95% for all months and all staff levels from December 2016 to May 2017.
- Commode cleanliness was consistently about 96% within surgical wards from December 2016 to May 2017. Ward cleanliness consistently scored better than the trust target of 95% for all areas from December 2016 to May 2017.
- Where compliance did not meet trust targets, or areas of consistent non-compliance were identified, action plans were put in place.
- There were specific environmental cleaning schedules in place throughout the surgical division. Domestic staff understood their responsibilities for keeping all areas clean and how to record what tasks had been undertaken. We saw that all schedules were up to date and had been signed by domestic staff at the necessary points of cleaning.
- Hand hygiene gel was available at the entrance to the wards, in bays and side rooms and at the end of patient beds. Hand-wash basins were also available in bays and side rooms. We observed staff washing their hands before and after patient contact during our inspection.
- Each item of equipment was cleaned after patient use. We saw clean equipment was labelled with 'I am clean' stickers so staff knew the items were clean and ready for use.
- All empty beds on surgical ward had completed cleaning checklists indicating they were ready for patient use. These checklists were placed into patient nursing records once a patient was using the bed to demonstrate it was clean on their arrival. Appropriate cleaning products were available and safely stored in a locked room.
- During the previous CQC inspection in 2016, concerns had been identified relating to the storage of dirty and clean linen and equipment. During this inspection, we observed that there had been an introduction of clearly defined areas for storing clean and dirty equipment, and the introduction of a designated linen room. This was an improvement in practice.
- We observed that staff followed the trust's policy regarding infection prevention and control. This included staff being 'arms bare below the elbow', adhering to uniform guidelines and hand washing between patient contact and clinical tasks.
- We observed personal protective equipment (PPE) such as gloves and aprons being used appropriately and were available in sufficient quantities.
- Both surgical wards had side rooms where patients with infectious conditions could be isolated to prevent the spread of infection.

- We observed that waste disposal was a risk within the vanguard theatre as staff had to either go outside or through a clean area to dispose of linen and clinical waste. We observed that a risk assessment was in place to support this as a temporary measure whilst the upgrade work was being carried out. Staff tried to ensure waste was as covered as possible and bagged appropriately to avoid contamination of other areas. A health and safety risk assessment had been carried out relating to this practice.
- During the previous CQC inspection in 2016, there had been concerns identified that toiletries were being shared in some areas. At the time of our inspection in August 2017, there had been an introduction of individual toiletry packs to rectify this.
- Waste was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps bins. Waste bins were emptied regularly and were not overfilled.
- An infection control notice board was visible on both surgical wards. This provided staff with up to date guidance and any new policies relating to infection control.
- MRSA screening was carried out on all elective patients prior to their surgery. If a patient had a positive result they were provided with nasal cream and body wash to use. Patients would then be re-swabbed three times at 48 hour intervals. If all three results returned as negative then surgery could continue at the St Albans site. If a patient received a positive result after treatment they would be referred to Watford for surgery to allow appropriate management.
- From September 2016 to August 2017, surgical services at St Albans reported no cases of MRSA or hospital acquired *Clostridium difficile* (*C.difficile*). *C. difficile* is a potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patients who have been exposed to antibiotic therapy.
- Most recent published data relating to surgical site infections ranged from January 2017 to March 2017. For this period St Albans reported 0% of surgical site infection for patients receiving total hip or knee replacements. From January 2016 to December 2016 rates of surgical site infections were 0.5% for total hip replacements and 1.2% for total knee replacements.

### **Environment and equipment**

- All operating theatres were undergoing a ventilation system upgrade. This meant that some theatres were closed and a vanguard theatre was being utilised as an interim measure.
- There were three theatres with laminar flow air systems suitable for orthopaedic surgery. Staff told us the airflow systems were serviced and revalidated every six months by an external organisation and met standards set out in the national guidance, HTM03-01: Specialised Ventilation for Healthcare Premises.
- Air changes were carried out in line with requirements across theatres.
- The trust had told staff that due to the airflow upgrade being completed some prep rooms could not be used, resulting in staff needing to lay up equipment in the theatre area.
- All theatres were deep cleaned every three months on a rolling programme by a contracted cleaning company. If a patient had a suspected communicable disease, theatres were cleaned immediately after surgery.
- There were eight bed spaces within the recovery area, with one of these being 'latex free' to care for any patients with a latex allergy.

- There were resuscitation trolleys available on all wards and theatre areas. Other areas including pre-operative assessment unit had cardiac arrest grab bags as opposed to full trolleys. We observed that these were accessible and had received the necessary daily and weekly checks from March 2017 to August 2017.
- All equipment stored within resuscitation trolleys and grab bags was within expiration dates and in sealed packaging ready for use.
- Automatic external defibrillators within resuscitation trolleys and grab bags had received suitable device testing to confirm its safety for use.
- A difficult airway trolley was available in theatres which contained the necessary equipment. This trolley was visually checked daily, and a full equipment review carried out weekly in line with trust policy.
- Specimens were stored in line with trust policy and a specimen collection record was completed by porters.
- The trust outsourced all equipment decontamination to an external provider. A handbook was in place for both theatre and external decontamination staff which described areas such as collection/delivery times, turnaround times, decontamination certificates, tracking items and how to report any concerns with the decontamination processes
- There were several equipment store rooms across wards and theatre areas. All portable equipment stored for use had received appropriate device testing to ensure its safety and suitability for use. We observed some equipment stored in De La Mere ward had not received device testing within the previous 12 months but all of these items were clearly marked as unsuitable for use and a poster was clearly displayed to advise staff not to use this equipment.
- Staff told us they could access bariatric equipment when required, for example larger patient beds and wheelchairs.
- Staff knew how to report faulty equipment and how to source a replacement for any essential items.
- Waiting areas in the pre-operative assessment unit and the day surgery unit were spacious and contained sufficient seats for patients and their relatives.
- During the previous CQC inspection in 2016, there had been concerns identified in relation to fire evacuation processes. During this inspection, we observed a complete fire safety assessment had been completed to ensure the correct equipment was in place to allow the safe evacuation of patients.
- We observed that fire exits signs were clear throughout surgical areas, and that evacuation slides were accessible where necessary.

### **Medicines**

- Medicines, including controlled drugs, were managed appropriately to keep patients safe. Storerooms were well-organised and only allowed authorised people to have access through key codes and manual keys.
- During the previous CQC inspection in 2016, concerns had been identified in relation to the safe storage of medicines. We observed the trust had implemented a more robust system for checking temperature storage of medicines and introduced guidance for staff relating to this.
- Medicines were stored securely with access limited to nursing staff. Controlled drugs which require special storage and recording were stored in line with national guidance, including

daily checks by two nurses on quantities and records.

- Safe systems were in place for the disposal of controlled drugs and staff knew their responsibilities in relation to this. Staff could explain and demonstrate how to manage controlled drugs and how this was required to be checked and documented in line with hospital policy and national guidance. Denaturing pots were available throughout all areas and were stored appropriately in line with guidance once used.
- Fridge and ambient room temperatures were recorded in all areas where medicines were stored. We observed that these had been completed each day from March 2017 to August 2017. Within recording sheets it was documented what the maximum and minimum temperatures of rooms and fridges should be.
- Laminated sheets were displayed in all areas medicines were stored to advise staff what to do if a temperature was below or above the temperature limits suggested. This included contacting the pharmacy department and also adjusting expiry dates depending on how long the temperature limit had been breached.
- We observed that it had been identified the week before our inspection that ambient room temperatures had exceeded the maximum limit and after consultation with pharmacy staff all medicines had shortened expiration dates added to them.
- We noted that one medicines storage room on De La Mere ward regularly exceeded the maximum ambient room temperature (70 days from March 2017 to August 2017). The fridge temperature limit was also exceeded for 26 days during this time period. Senior staff told us that this was a problem due to lack of air circulation, and whilst a fan had been purchased, the ward was on a schedule for an air-conditioning unit to counteract the high temperature. There was no date specific for when this would be installed. Medicines had their expiration dates reduced in line with trust policy when temperatures had exceeded the recommended temperatures.
- We observed that staff notified the ward sister each time the temperatures were exceeded but did not always see evidence this was escalated to pharmacy within the medicine records log. We also observed that not all instances of temperatures exceeding maximum or minimum temperatures were reported as incidents. Senior nursing staff had identified that processes had not always been well followed prior to them commencing their roles a number of weeks prior to our inspection. We found that since these senior nursing staff had been in their roles, reporting and discussing with pharmacy had improved.
- During our inspection a key for a medicine store broke, meaning that a new lock needed to be fitted to the storage cabinet. We observed that a member of staff remained in the store room whilst estates staff carried out this work. This meant there was a staff member who was authorised to access the medicines in the room at all times.
- We reviewed medicine charts of 18 patients and found that they accurately reflected the prescribed and administered medications for that patient. Medicine charts and patient records also clearly documented any patient allergies.
- Any medicine related incidents had been reported appropriately within the service.
- Pharmacy support was available on surgical wards Monday to Friday within the ward areas. There was an out of hours and weekend service operating from Watford General Hospital where support could be accessed as required. Medication required for weekend discharges at St Albans were dispensed on Friday and provided to the site to facilitate discharges.
- A pharmacist was also available as part of the pre-operative assessments process to

ensure patients received the correct medicines once they were admitted to hospital and to ensure they stopped other medicines, as necessary, before their surgery. In addition, the pharmacist answered any other questions patients had about their medicines, including pain relief.

- There were processes and procedures in place to complete weekly checks and reconciliation of medicines as well as monthly audits to check stock and utilisation by pharmacy.

### **Records**

- Patients' individual care records were written and managed in a way that keeps them safe.
- Medical notes were in good order and information was easy to access. All records were consistent, with risk assessments and nursing proformas being stored in the same place throughout patient records.
- We reviewed 18 sets of nursing and medical records which were fully completed, legible with entries timed, dated and signed for.
- We observed patients' medical notes were in locked notes trolleys to ensure patients' details were kept confidentiality. End of bed folders were used to store daily assessment records and medicine charts. These were easily accessible and enabled staff to record ongoing care in a timely manner.

### **Safeguarding**

- Appropriate arrangements were in place to ensure patients were kept safe. The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff.
- The nursing and medical staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- All staff within surgical areas were required to complete up to and including level two safeguarding adult and children training. 90% of nursing staff had completed this safeguarding training which met the trust target of 90%. We were not provided with surgery medical staff safeguarding training compliance by site, across both sites the compliance for safeguarding adult training was 88%, which was below the trust target of 90%.
- We observed that some patients aged 16-18 were seen for pre-operative assessments at St Albans. Nine nursing staff were trained in level three safeguarding training within pre-operative assessment to cover this.

### **Mandatory training**

- Mandatory training was provided for staff and covered key topics, such as basic life support, fire and patient moving and handling. Staff received some of their mandatory training through face-to-face sessions and the rest through online courses. Staff told us they completed their mandatory training during quiet periods in their clinical area. Theatre staff also told us they completed training during their clinical governance days.
- St Albans City Hospital had an 89% mandatory training completion rate, slightly below the trust target of 90%. The trust target was not reached for five of the 11 modules. Fire and evacuation had the lowest completion rate of 81% while non-patient moving and handling had a 100% completion rate.
- The dedicated practice development facilitator told us they kept records of staff mandatory training and sent email reminders to staff who had of any outstanding training.

- There was a structured induction and mandatory training programme for new staff and this included any required local training.

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

- During the previous CQC inspection in 2016, concerns had been identified in relation to utilisation of the World Health Organisation (WHO) 'five steps to safer surgery' checklist. This checklist is used to reduce errors and enhance patient safety during surgery. Following the inspection the trust standardised this checklist to ensure it met the five steps as required (some areas were previously carrying out three steps). We observed checklists in all 18 patient records we reviewed with all steps completed. We also observed staff physically completing the checklist during our observation in theatres.
- Audits were completed in relation to the completion of the WHO checklist. We observed that in April, May and June 2017, St Albans had over 97% compliance with checklist completion which met the trust target of 90%.
- We saw that surgical patients attended a preoperative assessment clinic prior to any planned surgery, where risk assessments for complications were undertaken. This clinic was nurse led with the support of an anaesthetist. In addition, there was support from healthcare assistants, pharmacists and reception staff. The clinic was open Monday to Friday, from 9am to 6pm.
- Pre-operative investigations were carried out in line with NICE guidance: Preoperative tests for elective surgery, Clinical Guideline CG3 (2003). Nursing staff had undergone training in pre-operative assessments and could explain when they would refer a patient. We observed that where the nurse had concerns about a patient's co-morbidities or current clinical conditions; they would document this and ask the anaesthetist to review the patient and approve them for surgery.
- Nursing staff within pre-operative assessment were aware of how long an assessment was valid for before the patient would need to be re-assessed. This was three months for general and orthopaedic surgery patients, and four weeks for a patient being treated for cancer.
- Admissions teams reviewed hospital admissions records and if a patient had an acute admission between their pre-operative assessment and surgery date they would be recalled to ensure they were still clinically suitable for surgery.
- Advice regarding smoking and alcohol cessation prior to surgery was provided during pre-operative assessments.
- Within the surgical wards, risk assessments were carried out on patients, which included malnutrition screening, falls risks and pressure ulcer risks. We observed that all 18 patient records contained risk assessments and where any high risks had been identified the appropriate actions had been taken.
- The trust assessed the appropriateness of patients for surgery using the American Society of Anaesthesiologists scale (ASA) physical status classification. Within this classification system, ASA1 meant the patient was healthy and ASA2 for mild systemic disease. Only patients with a status of ASA1 or ASA2 were initially considered safe for surgery at St Albans City Hospital. However, we were informed that ASA3 (severe systemic disease) category patients were accepted for surgery but this was on a case by case basis to ensure patient safety. ASA3 patients were more likely to experience post-operative complications and require a critical care bed. Critical care beds were unavailable at St Albans and therefore a patient would require transfer to Watford if complications arose.

From August 2016 to August 2017, 118 ASA3 patients were operated on at St Albans, with the majority (75) being orthopaedic patients.

- All unplanned transfers of patients were recorded and discussed at monthly transfer meetings. Each transfer had a root cause analysis completed to ensure that any lessons or areas for improvement were identified. Data had not been collected and it was not in meeting minutes whether the patients who required transfer, were those who had been graded as ASA3.
- The trust had a transfer policy in place which detailed procedures for staff to follow. Staff knew how to access this policy and could describe how it worked in practice and when it had been previously followed.
- From September 2016 to August 2017 there were 32 unplanned transfers from St Albans.
- Monthly transfer meetings were carried out. In these meetings each unplanned patient transfer was reviewed with senior management to establish the cause and any action points. We observed these meetings were clearly minuted and detailed. No themes had been identified in transfers from February 2017 to August 2017.
- There was a policy regarding deteriorating patients and procedures that should be following if this occurred.
- A system of having a 'starred' anaesthetist had been introduced within theatres. This meant that anaesthetic cover was doubled up to allow one to be free for any cardiac arrest calls or medical emergencies. During our inspection the anaesthetist in this role knew their responsibilities.
- Consultants did not leave the hospital until all patients had left recovery to ensure they were available for any medical emergencies following surgeries.
- Critical care outreach was available from the Watford hospital site; this team provided clinical support to staff caring for deteriorating patients. Out of hours the critical care outreach team calls were triaged by the hospital at night team, who were based at Watford.
- We observed that the national early warning score (NEWS) system was used within the trust and at St Albans. NEWS allows clinicians to monitor the stability of a patient and recognised early any deterioration in their condition. Staff we spoke with understood when to escalate to senior staff and how to document NEWS within patient records. We observed that if a patients' NEWS score deteriorate, this was escalated appropriately in line with trust policy.
- We observed that all patients during our inspection had received a venous thromboembolism (VTE) risk assessment on their admission, which was then repeated at 24 hour intervals if they were an inpatient.
- A sepsis-screening tool was incorporated into the risk assessment documentation within the patients' notes. This gave clear, best practice guidance on the assessment and treatment for sepsis. There was a trust policy for management of sepsis (blood infection) and a sepsis bundle, which could have been implemented if sepsis was suspected.
- All patients had bed rail assessments completed in records we reviewed. We found that three patients had 'yes' ticked for requiring bed rails despite not meeting the criteria for bed rails to be placed up, with no narrative to explain why. The assessment form stated that if bed rails are required then a further risk assessments needed to be completed, which were not completed for these three patients. We escalated this to ward sisters who immediately took steps to re-assess patients and establish whether bed rails were needed. It was found that the patients had bed rails up either at their request or because they were being transported to/from theatres. The need for a narrative and clear documentation as to why a

patient had bed rails up was discussed with all staff at the following morning handover.

- There was a dedicated orthopaedic ward and a dedicated general surgical ward to manage patients' specific needs. The only occasions where general surgery patients would be nursed on De La Mere ward if staffing levels were affecting patient safety and Beckett ward had to be closed. However, all general surgery patients would be nursed in a side room where possible with separate nursing staff as mitigation. We observed that Beckett ward had closed for 11 nights and three days from June 2017 to September 2017 due to staffing shortages.

### **Nursing staffing**

- The trust utilised a national safer nursing tool to assess, identify and plan staffing levels. We observed that nursing staff figures were displayed throughout all areas, and met planned levels during our inspection. The areas that we visited displayed the required and actual staffing numbers. We reviewed historic nursing staff rotas and found staffing levels mostly met the necessary planned levels. Where lower numbers of nurses had been on duty, staff told us this was because there were fewer patients on the ward. Staff rotas showed levels were maintained out of hours and at weekends. There were 83.3 whole time equivalent (WTE) nursing staff working across all surgical areas at St Albans, out of 102.2 established posts. This meant that St Albans surgical services had 18% (18.82) less WTE staff in place than what was established by the trust to provide safe and effective care. De La Mere ward had this highest level of vacancies with 20% (10.77) less staff than required. Theatres at St Albans also had a high vacancy rate with 17% (8.05) less WTE staff in post than what was established by the trust.
- Pre-operative assessment nursing staff worked across both St Albans and Watford site. There were two vacant nursing sister posts at the time of our inspection, however both of these had been filled with staff due to start in October 2017.
- The trust used agency staff and their own bank staff to ensure staffing levels remained safe during staff sickness or other absence. We observed that if a temporary member of staff was working within surgical areas they had completed an induction and were supported by senior nursing staff if unfamiliar with the area. Senior nursing staff told us it was sometimes difficult to fill vacant shifts with temporary staff and they relied heavily on permanent staff to cover shifts when vacant. St Albans surgical services reported a bank and agency staff usage rate of 15.4% from July 2016 to June 2017, this was below the trust average of 25%.
- From June 2016 to May 2017, there was a reported staff turnover rate of 17% within surgical services at St Albans. The trust target turnover rate was 12%; therefore St Albans was higher than the trust target. De La Mere Ward had the highest turnover rate within surgical service at St Albans, with a rate of 32.7%.
- Staffing levels and difficulties in recruitment was identified within the divisional risk register. All managers we spoke with understood this risk and were considering initiatives to improve recruitment.
- We observed nursing safety huddles and handovers and found them to be detailed and areas including clinical conditions, physiotherapy needs and discharge planning were discussed.
- The nurse in charge of each area was identified by a yellow badge 'sister in charge' badge. This meant they were easily identifiable to staff, visitors and patients. We found that the

sister in charge had a good knowledge of their area and the current status of patients and staff.

- We observed that student nurses worked within surgical wards, each student had a mentor and we observed them working well together during shifts.

### **Surgical staffing**

- Medical cover was provided by a resident medical officer (RMO) this was available across both surgical wards 24 hours a day, seven days per week. RMO's could access more senior medical advice from consultants at the Watford site as required.
- We observed that RMOs worked a shift pattern of seven days or nights on duty (12 hour shifts), then seven days off. This meant there were four RMOs working on the rota. Handovers occurred every 12 hours with the patients' condition, any concerns and changes to their clinical needs or care pathway discussed.
- Doctors ward rounds included the RMO, a doctor from the consultant's team/speciality, nurses and therapy staff. We were not able to observe a doctors round on our visit.
- RMOs were provided by an agency and most had anaesthetic backgrounds. RMOs we spoke with had been working within the trust for a number of years and were familiar with policies and procedures. RMOs were trained in advanced life support and their responsibilities included providing emergency assistance for medical emergencies out of hours.
- During the previous CQC inspection in 2016, concerns were raised that RMOs had not undergone trust inductions. We found during this inspection that RMOs we spoke with had undergone a trust induction.
- Staffing levels for the surgical teams in theatres were in accordance with the Association of Perioperative Practice (AfPP) guidelines. Staff worked across St Albans and Watford sites and were familiar with processes at each site. This meant that staff could be moved across sites where there were shortages which would affect patient safety. Staff told us they were given notice of this and senior staff tried not to ask staff to move at short notice.
- Bank and agency staff working in theatres received an induction and also had to sign off to say they were competent at using the equipment within the area.
- Any new staff to theatres were allowed a supernumerary period to shadow and observe areas such as the WHO checklist being completed.

### **Major incident awareness and training**

- Potential risks to the service were anticipated and planned for in advance.
- There was a major incident policy in place relating to all services within the hospital including surgical services. Staff were aware of the policy and how to access this. Managers of the service understood actions that would be taken should a major incident occur.
- Scenarios had been carried out to ensure staff were familiar with procedures and the role they would take if a major incident was to occur.

## Are surgery services effective?

Good ●

We rated effective as good because:

- Policies were up to date in line with guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations.
- Care bundles were embedded in patient care to improve patient outcomes.
- Significant work was being carried out in relation to enhanced recovery. Enhanced recovery pathways were used to improve outcomes for patients in general surgery, breast, urology, orthopaedics and ear nose and throat (ENT). Outcomes for enhanced recovery were collected and monitored within the service.
- The average length of stay for patients was better than the England average.
- The re-admission rate for elective patients were slightly better than the England average overall. However, the re-admission rate for elective orthopaedic patients was slightly worse than the England average.
- The service continuously reviewed and improved patient outcomes through participation in national audits including the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry and surgical site infection audits.
- Staff told us they had opportunities for personal development and to enhance their skills. Practice development support was available to all staff.
- Multidisciplinary work was effective within the service.

However:

- Imaging, diagnostics and dietetics and speech and language therapy services were available Monday to Friday from 9am to 5pm. If support was required outside of these hours it would be at the Watford site. If a patient required diagnostic imaging, for example an x-ray or scan, outside of these hours they would have to be transferred to the Watford site via non-emergency ambulance transport.
- Pharmacy support was available on site Monday to Friday with out of hours and weekend support available from Watford General hospital site.
- Patient records were not always available during pre-operative assessment clinics.

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

- Policies were up to date, in line with guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations, such as the Association for Perioperative Practice (AfPP).
- The hospital had systems in place to provide care in line with NICE CG50 Acutely ill patients: Recognition of and response to acute illness in adults in hospital. Local policies, such as falls prevention and infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- The service had a clinical audit plan that included monitoring practice against guidelines to ensure compliance. Audits included the monitoring of guidelines from NICE and the Royal College of Surgeons, surgical site infection, and environmental cleanliness.
- Care bundles were used to improve the quality of care. A care bundle is a set of

interventions that, when used together, significantly improve patient outcomes. They involve multidisciplinary teams working to deliver care supported by evidence-based research and practices, with the ultimate outcome of improving patient care. For example, the service used the peripheral intravenous cannula care bundle and urinary catheter care bundle.

- The trust recorded medical device implants on the National Joint Registry to ensure outcomes for patients undergoing joint replacement surgery were monitored.
- Pre-operative assessment clinics assessed patients in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. For example, MRSA screening and blood tests were included.
- We reviewed the enhanced recovery pathways and found they also followed current best practice guidance.

### **Pain relief**

- Pain relief was well managed throughout the surgical departments. Patient records we reviewed showed that pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. Pain management for individual patients was discussed at handovers as required.
- Staff had access to the hospital pain control team when required and stated they were accessible.
- All patients we spoke with felt their pain was well managed and that staff acted upon their requests for further analgesia when required.

### **Nutrition and hydration**

- The trust used the Malnutrition Universal Screening Tool (MUST) as a way of screening patients who may be underweight or at risk of malnutrition. We reviewed 18 patients' records and found that MUST assessments had been completed appropriately in all records. Patients who required bariatric or complex bowel surgery had this carried out at Watford General, and referral to dietetic services were operated on at Watford site.
- Where applicable, patients' nutrition and hydration intake had been recorded. Staff used fluid balance charts to monitor patients' intake. We saw that patients had jugs of water on their bedside tables, within reach, to promote hydration.
- There were processes in place to identify and support patients that needed assistance with eating and drinking. For example, wards used the red tray system where food was served on red trays for patients who may require assistance with their meals.
- Pre-operative fasting guidelines used for adults were aligned with the recommendations of the Royal College of Anaesthetists (RCOA) which states that patients can have an intake of water up to two hours before induction of anaesthesia and a minimum pre-operative fasting time of six hours for food solids, milk and milk-containing drinks. However, some patients were provided fasting advice based on the start time of the theatre list as opposed to the start of their surgery. This meant that depending on where patients were on the theatre lists, some patients could have been fasting for long periods. Staff advised us they would seek advice from the anaesthetist in such cases and patients offered fluid and light diet if appropriate.

## Patient outcomes

- Enhanced recovery pathways were used to improve outcomes for patients in general surgery, breast, urology, orthopaedics and ear nose and throat (ENT) specialities. These pathways focused on thorough pre-assessment, less invasive surgical techniques, pain relief, and the facilitation of early discharge.
- An enhanced recovery lead was in place to support the process and worked closely with other colleagues in the surgical division. Outcomes were measured and accessible within a database.
- The outcome database showed that the average length of stay from January 2017 to June 2017 for patients on the joint enhanced recovery pathway was three days. For those on a spinal enhanced recovery pathway the average length of stay was one day. If a patient's discharge was delayed this was clearly documented with a reason on the database to help improve any areas that could be amended. The main reasons documented for delayed discharge for patients on enhanced recovery pathways were reduced mobilisation and wound issues.
- Overall, the average length of stay for patients at St Albans was better than the England average from June 2016 to May 2017. From April 2016 to March 2017 the average length of stay for surgical elective patients at St Albans City Hospital was 2.1 days, compared to 3.2 days for the England average. Elective admissions for general surgery had the shortest length of stay; 1.1 days compared to 3.3 days nationally. Trauma and orthopaedics had the longest length of stay of 2.8 days though length of stay was still below the England average of 3.4 days.
- From March 2016 to February 2017, surgical patients had a lower than expected risk of readmission for non-elective admissions compared to the England average. Elective admission for trauma and orthopaedics at trust level were higher than expected compared to the England average.
- At St Albans the re-admission rate for elective patients was slightly better than the England average overall, although trauma and orthopaedics and urology had a worse than average re-admission rate for elective admissions compared to the England average.
- The service continuously reviewed and improved patient outcomes through participation in national audits including the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry and surgical site infection audits.
- PROM audits measure health gain in NHS patients in England. Patients having hip or knee replacements, varicose vein surgery or groin hernia surgery were invited to complete PROMs questionnaires regarding their health and quality of life before and after they had surgery. The results enabled the NHS to measure and improve the quality of care.
- The patient related outcome measures for the hospital for groin hernia were positive at 56% compared to the England average of 51%. The outcomes for hip replacement were positive at 100% compared to the England average of 97%. Although, varicose veins showed a worse measurement at 62% compared to the England average of 39%.
- We spoke with several patients who had received multiple joint replacements at St Albans and they felt pleased with their outcomes and that they exceeded their expectations.
- The surgical service used a nursing performance dashboard that included clinical quality indicators such as compliance with falls assessments, documentation audits, complaints and patient experience scores. Results were reported by ward so that performance could be monitored and reviewed at a local level. Areas of variable or poor performance were

discussed at ward meetings and actions were taken to improve.

### **Competent staff**

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- A practice education nurse was in post within the surgical division. We observed they had an oversight of medical device training records, mandatory training, professional development records and care setting improvement tools.
- We saw there was an extensive training programme in place for student operating department practitioners and nurses to enable them to progress in their role.
- Pre-operative assessment staff told us that they had protected time every three months to attend afternoon team meetings which often involved a training aspect. Clinics were not booked for these afternoons to allow all staff to attend.
- We saw that staff were encouraged to rotate through specialities and surgical areas, including scrub, anaesthetics and recovery. The division had started to look at the possibility of rotating staff through other acute areas including A&E and intensive care at the Watford site.
- Medical and nursing staff told us that they had sufficient support relating to revalidation. Revalidation is a process by which doctors and nurses can demonstrate they practice safely.
- Staff told us they had opportunities for personal development and to enhance their skills. If they wished to attend a clinical course or external event this was supported by the management team. Funding could also be sourced from the trust.
- Staff received yearly appraisals to allow them to discuss their progress with managers and raise any developmental areas. We saw that 94% of staff across surgical services within the trust had received an appraisal. Staff told us they found appraisals to be meaningful and were clear of how they intended to progress for the following year.

### **Multidisciplinary working**

- Multidisciplinary working was effective throughout surgical services.
- Physiotherapy staff attended daily handovers and ward rounds to ensure they knew which patients required their input, and could also feedback patient progress to nursing and medical staff.
- Staff described the multidisciplinary team as being supportive of each other. Healthcare professionals told us they felt supported and that their contribution to overall patient care was valued. Physiotherapy staff described effective working relationships with nursing and medical staff on the wards and communicated well with them.
- Discharge planning commenced at pre-assessment and was communicated to ward staff and therapists. Patient records showed that pre-assessment included questions on any walking or mobility aids used, the patient's living arrangements and whether they were already receiving care. This meant staff were informed as to what arrangements would need to be in place for discharge.
- RMOs told us that senior medical staff were approachable and accessible at both St Albans and Watford sites.
- Electronic discharge summaries were sent to each patient's GP following their surgery. However, the trust was not currently meeting its target of 95% for completion across the

surgical division, with year to date figures as of May 2017 showing that these summaries were only sent for 63% of patients. We observed that this was being monitored with an action plan in place to improve performance.

### **Seven-day services**

- A dedicated physiotherapy team worked within surgical wards at St Albans. This meant physiotherapy support was available to patients seven days a week from 9am to 5pm.
- Imaging, diagnostics and dietetics and speech and language therapy services were available Monday to Friday from 9am to 5pm. If support was required outside of these hours it would be at the Watford site. If a patient required diagnostic imaging, for example an x-ray or scan, outside of these hours they would have to be transferred to the Watford site via non-emergency ambulance transport, although staff told us this did not happen very often.
- Pharmacy support was available on site Monday-Friday but there was no support at weekends. During weekends staff would have to contact the pharmacist at Watford for advice. Where possible discharges were planned ahead so that patients medicine to take away were prepared in advance. Staff felt that the lack of pharmacy at weekends sometimes delayed discharges, if this happened it was reported as an incident by ward staff.
- Out-of-hours medical cover was provided by the RMO. Senior medical advice out of hours was available from Watford General Hospital. Medical staff we spoke with told us they could easily access this advice.

### **Access to information**

- There were arrangements to ensure staff had all the necessary information to deliver patient care. All risk assessments, clinical notes and other relevant information was contained in patient records. All staff, including agency and locum staff, had access to patient-related information and records when required.
- Nursing staff in pre-operative assessment said there were occasions when patient records were not available at the time of their appointment. If this was the case staff would review the records when it arrived to ensure no anomalies to what the patient had told them, and then insert the pre-operative assessment paperwork. From January 2017 to August 2017, notes were not available on average 8% of the time. Whilst some appointments were walk ins for MRSA screening which meant that notes were not imperative, the trust were aware of some problems with administrative staff recruitment which impacted availability and release of notes. Plans were in place to recruit further staff and address problems with note availability at all pre-operative assessment clinics within the trust.
- Pre-operative assessment staff could access diagnostic results and surgery dates through an online computer system. Staff told us that they had received a computer upgrade which had slightly improved access speed to this system which previously was very slow.
- The hospital used paper-based patient records. The patient records we reviewed were consistently organised, up to date, and easy to follow. The records contained detailed patient information from admission and surgery through to discharge. This meant staff could access all the information about a patient any point during their pathway.

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

- Staff were required to complete training in relation to the Mental Capacity Act. St Albans reported that as of July 2017 Mental Capacity Act (MCA) training has been completed by 84% of staff in within the surgical division. This site did not meet the trust target of a 90% completion rate.
- Deprivation of Liberty training has been completed by 84% of staff in within the surgical division. This site did not meet the trust target of a 90% completion rate.
- All staff we spoke with understood how to assess a patient's mental capacity and make a Deprivation of Liberty application should a patient lack capacity and require this. Mental capacity was assessed during a patient's pre-operative assessment. There were specific prompt for this within pre-operative booklets. Patient would receive a further mental capacity review following their surgery within surgical ward. We observed these were completed on all patients during our inspection.
- We reviewed the consent forms in all 18 records we reviewed. These were all signed by patients and clinicians. The trust had an up to date consent policy that staff could access. Staff we spoke with fully understood the consent process and how to escalate any concerns in a patients ability to consent. Surgical services used consent forms that followed nationally recognised standards. For example, there was a consent form for people who lacked capacity to make informed consent.

## Are surgery services caring?

Good 

We rated caring as good because:

- All staff provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.
- Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
- Staff provided emotional support to patients and staff directed patients to clinical nurse specialists for support where required.
- Patients' and relative feedback was sought on the care they received to ensure they were happy with the care provided.
- The NHS Friends and Family test response rates were higher than the England average and 99% of patients would recommend the services.

## Compassionate care

- Patients were treated with dignity, respect and compassion throughout their care within surgical services.
- Staff responded compassionately to pain, discomfort, and queries in a timely and appropriate way. We observed caring interactions with patients whilst they were having observations taken or being assisted with mobilising.
- Dignity and confidentiality were well respected in the ward. If a patient was being assessed or repositioned then curtains would be closed to protect their privacy.
- All patients we spoke with were highly complementary of the care they had received at St Albans and many had used the services for a number of years. Patients and their relatives told us staff treated them like family and that it was a relaxed environment to be cared for

in.

- All staff introduced themselves appropriately and knocked on the door of side rooms before entering, including domestic and housekeeping staff.
- The trust obtained patient feedback via the Friends and Family Test (FFT), which allowed patient to state whether they would recommend the service and give feedback on their experiences.
- The FFT response rate for Surgery at St Albans City Hospital was 41% which was better than the England average of 25% from June 2016 to May 2017. The average percentage of friends and family that would recommend this site as a place to receive care and treatment was 99%, compared to an England average of 95%. The day surgery unit had a recommendation rate of 99% and the surgical wards had a recommendation rate of 98%.
- Thank you cards from relatives and patients were displayed within the ward.

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

- Patients and relatives said they felt involved in their care. They had been given the opportunity to speak with the staff looking after them.
- Relatives we spoke with said they had been given time with the nurses and doctors to ask questions.
- We observed relatives being included in conversations during pre-operative assessments to ensure they fully understood what steps were next prior to surgery and allow relatives to voice any concerns or queries they had.

### **Emotional support**

- Clinical nurse specialists (CNS) were available to patients. Details of CNSs were provided in pre assessment clinic where appropriate, which enabled patients to contact them prior to their operation if they had any questions. This allowed CNS's to provide any emotional support to patients prior to their surgery and answer any questions about coping after surgery.
- Patients we spoke with told us they knew who to contact if they had any worries about their care or surgery and said staff had supported them emotionally as well as physically post operatively.
- Staff had access to an on call chaplain and other spiritual advisors could be arranged to meet patients' needs.

**Are surgery services responsive?**

Good 

We rated responsive as good because:

- Clear improvements had been made in relation to care and assessment of patients living with dementia or a learning disability.
- The enhanced recovery team ran seminars for patients who had planned joint or spinal surgery which had received positive feedback.
- A pre-operative kiosk was accessible within the main entrance of the hospital. This allowed face to face bookings of appointments for patients who could not or were not able to book through other methods of communication.
- Language needs were identified at booking or within pre-operative assessments.
- Action plans were in place to look at ways to reduce waits for patients who had

exceeded their referral to treatment time (RTT) target wait.

- The day surgery unit allowed patients to have surgery and return home the same day, avoiding admission.
- Patients told us they were able to have input in their appointment times and where their care was carried out.

However:

- The trust performance with regards to meeting referral to treatment targets was in line with the England average. This was an improvement.
- Those who had surgery cancelled were not always treated within the following 28 days

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

- St Albans provided solely low risk elective (planned) surgical care, with all emergency and high risk cases being carried out at Watford site. This allowed services to be planned in advance with minimal changes except in unforeseen circumstances, for example, e.g. staff sickness.
- Patients were able to select St Albans through the NHS referral system if it was their local hospital that could provide the relevant service.
- Patients told us that appointment times were arranged in advance and could be amended to suit their needs when requested.
- Staff told us that services generally ran on time, and that patients were informed if there were any delays.
- The service had a day surgery unit, which enabled people to have minor procedures without having overnight stays in hospital.

### **Access and flow**

- From June 2016 to September 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services was in line with the England overall performance. The latest figures for September 2017 showed 72% of this group of patients were treated within 18 weeks compared to the England average of 70%. The referral to treatment rate for admitted patients showed few variations over the period although a slight improvement could be seen from May 2017 to September 2017.
- We observed action plans were in place to address RTT performance both locally at St Albans and across surgical care within the trust. Performance against RTT targets was present within the surgical division risk register and the quality improvement plan.
- Work was being carried out to assess whether any patients waiting for shoulder, foot or ankle surgery could receive their surgery in a non-laminar flow theatre to reduce their wait.
- Orthopaedic and head and neck patients were being outsourced to local private and other NHS providers where possible. ENT work was being considered to establish if any providers locally could accept waiting patients.
- Harm reviews were being carried out on all patients who had exceeded the 18 week wait. Those who were deemed at higher risk were bought back to clinics and then prioritised accordingly. No patients had exceeded the 52 week wait for their surgery.
- Two extra surgical urology lists and one extra general surgery list were planned each month across the trust to reduce patient waits. Two upper limb surgeons were in the process of joining the trust.

- The pre-operative assessment team was also carrying out adhoc Saturday clinics from 8am to 1pm to reduce the number of patients waiting for assessments.
- The work being carried out on air flow systems in all theatres, along with some consultant absence had impacted on RTTs at St Albans. The hospital scheduled theatre lists Monday to Thursday between 8am to 9pm, and 8am to 6pm on Fridays.
- The division monitored its rates of patients who did not attend (DNA) their booked pre-operative assessment appointments. Data provided by the trust showed that from April 2017 to August 2017, DNA rates were on average 4% within pre-operative assessment clinics. Staff who ran clinics told us that if a patient did not attend they would be contacted with a further appointment. If the second appointment was not attended without a reason provided then another appointment would not be booked and the patient would have to contact their referring clinician. The exception to this was patients attending for care relating to cancer, these patients would continue to be contacted to ensure an appointment was attended.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period quarter one 2015/16 (April 2015 to June 2016) to quarter four 2016/17 (January 2017 to March 2017) the trust cancelled 923 surgeries. Of the 923 cancellations 15% weren't treated within 28 days. Cancelled operations as a percentage of elective admissions at West Herefordshire NHS Trust were greater than the England average.
- Theatre utilisation was monitored and reviewed at monthly performance meetings. From January 2017 to June 2017, theatre utilisation at St Albans ranged, on average from 67% to 78% during the period January to June 2017.
- St Albans Theatre 3 and St Albans Theatre 4 had the highest utilisation rates of 78% and 77% respectively, followed by St Albans Theatre 6 with a utilisation rate of 76%. St Albans Vanguard Theatre had the lowest utilisation rate of 67%.
- Social needs that a patient may have following discharge were often identified during pre-operative assessments. There were prompts within assessment booklets and if staff felt anything would impact or delay discharge this would be document and passed onto enhanced recovery and ward staff.
- There were no medical outlier patients treated on Beckett and De La Mare wards. Medical outliers are patients who are in hospital because they require medical care rather than a surgical procedure.

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

- The enhanced recovery team ran seminars for patients who were going to receive joint or spinal surgery. These seminars allowed staff to talk through procedures, expected outcomes/recovery times and allowed patients and relatives to look at implants and joints to understand what would be used in their surgery. Data provided by the trust showed that from January 2017 to June 2017, between 64% and 94% of patients due to have joint replacements attended these seminars. Attendance by patients receiving spinal surgery was lower, between 33% and 75%. Seminars received good feedback and posters to advertise these events were visible in several areas throughout the hospital.

- The enhanced recovery team would also contact patients two to three days after discharge to check whether they had any questions or queries about the surgery they had received.
- Within the day surgery unit there was a dedicated area containing information for patients attending with learning disabilities. This area had a booklet with pictures to show the journey they could expect through day surgery and photos of what each area looked like. Within the unit there were three disability link nurses to support patients and staff. The day surgery unit had also been awarded a purple star award for its work around caring for patients with learning disabilities.
- We observed that pre-operative assessment records had been amended following the previous CQC inspection in 2016 which had highlighted there was no area to document if a patient was living with dementia or a learning disability. The new pre-operative assessments booklets contained prompts relating to this.
- A pre-operative kiosk was accessible within the main entrance of the hospital. This kiosk allowed face to face bookings of appointments for patients who could not or were not able to book through other methods of communication. Kiosk staff were also able to recognise additional needs of those living with dementia or learning disabilities. If a patient was identified as having additional needs a double appointment slot would be booked to allow staff and patients time to go through the pre-operative process thoroughly in a way that met patients' needs.
- Language needs were identified at booking or within pre-operative assessments. Staff told us they could access face to face or telephone translation services as required. Assessments would be rebooked if the nursing staff felt translation services were required to ensure the patient fully understood all aspects of their intended care.
- Leaflets were available to patients about a variety of aspects of clinical care they may receive. Information leaflets were also available relating to each ward within the services. All leaflets could be accessed in alternative languages as required.
- Bedside guides were available in all ward bed spaces. These comprehensive guides gave patients information about the trust, the hospital, their care and hospital processes. These were available in alternative languages and print on request.
- Patients were given choices of meals, which included gluten-free and halal options. If patients were hungry outside of meal times, staff were able to access light meals and snacks.

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

- From August 2016 to July 2017 there were 120 complaints about surgical care throughout the trust. The trust took an average of 26 days to investigate and close complaints, against a target time of 25 days. All aspects of clinical treatment accounted for 32%, admissions, discharge and transfer arrangements for 19%, staff attitude for 13% and appointments, delay/cancellation (out-patient) 11% of all complaints received. These complaints were not provided by site and covered surgical care at both St Albans and Watford Hospital.
- Staff we spoke with told us they tried to resolve complaints as they occurred within departments, however if they felt they were unable to do this they would refer the patient to their manager or to the patient advice and liaison service (PALS).
- Nursing staff told us that if there had been a complaint and learning had been identified this would be shared with the area involved during meetings and also via email as necessary.
- We saw notice boards that displayed posters and information leaflets advising patients and

their relatives how to raise a concern or complaint both formally or informally. Information leaflets were also available about how to contact further agencies if patients were not happy with the trust's response. Bedside guides also referred patients to the complaints processes.

- Patients we spoke with told us they had never needed to complain about their care, but if they did they would initially approach nursing staff who were providing their care or use the information provided to them in ward booklets.

## Are surgery services well-led?

Good 

We rated well-led as good because:

- Changes in senior leadership had led to positive operational and cultural changes within surgical services.
- Senior managers had a clear understanding of risks to the service and how these were being mitigated and monitored.
- All staff spoke positively about working within the service and felt local and senior managers were approachable.
- Staff understood the trust's vision and values and portrayed these in their day to day role.
- Cross site working occurred to improve risk and quality management within the service.
- The service demonstrated a drive to improve clinical services and supported innovations.
- Governance processes were in place to identify and monitor risks to the division. Senior staff had a thorough understanding of these processes.

### Leadership of service

- There was a senior management team for surgical services based at St Albans who oversaw the service in conjunction with colleagues at Watford site. There was a divisional manager, assistant divisional manager and clinical leads based at St Albans. There were also matrons for the different surgical specialities. Staff told us their matron was, approachable, responsive and supportive. Matrons kept staff informed of trust wide developments through ward manager meetings and provided guidance where required.
- We saw strong leadership, commitment and support from the ward managers and theatre managers. The local management teams were responsive, accessible and available to support staff.
- A number of senior and junior clinical and non-clinical managers were new within their role at the St Albans site. All staff we spoke with felt this was a welcome change in leadership and that they had made a positive impact on surgical services at the hospital. Whilst a number of changes in the service had been made to improve staff functionality and patient care, we could not see if these were sustained or fully embedded due to the short time that managers had been in their role.
- Staff were aware of the chief executive officer and other senior executive staff. Staff reported that they often saw these staff within the hospital and felt them to be approachable.

### Vision and strategy for this service

- The surgery, anaesthetics and cancer division was working to meet the priorities set out in

the trust's clinical strategy and operational plan .They had made further progress towards meeting the national 'referral to treatment' standards by redesigning pathways, providing additional clinics and reorganising theatre lists.

- Staff were aware of the trust's vision to provide the very best patient care for every patient, every day, and the values of commitment, care and quality. Staff told us they felt these were relevant to them and that they demonstrated them in their daily role whilst caring for patients.
- Whilst there was not a specific documented strategy for St Albans surgical services, senior leaders were able to describe clearly the plans for the service moving forward. The aim was to further improve elective care at St Albans. This meant a need for development of facilities and estates initially, for which plans were in progress.

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

- The trust had systems in place to identify risks. The surgical, anaesthetic and cancer division held its own risk register and clinical leads and managers we spoke with were able to identify the top risks. Each risk has an assigned owner and a review date. Main risks related to staffing/recruitment, ineffective computer systems and achievement of targets.
- Senior managers had weekly meetings to discuss upcoming theatre activity, previous week's activity including any incidents or concerns and theatres utilisation for the following five weeks. This was done in conjunction with Watford site to ensure cross site working.
- Daily operations calls took place between St Albans and Watford Hospital to ensure staffing and patient levels were safe and staff told us these calls improved relationships between the sites.
- Weekly meetings were held between senior managers, finance, human resources and clinical governance teams. These meetings focused on key areas including staffing, departmental issues and incidents.
- Monthly clinical governance meetings were attended by the surgical division senior teams. Any learning or relevant information from these meetings was shared with staff either at face to face staff meetings and daily huddles, or via email/notice boards.
- The service had a quality improvement plan (QIP) in place which covered key risks and issues that required improvement across surgical services at St Albans and Watford. The QIP contained clear milestones, who owned each area and an intended end date. Included within the QIP were items relating to patient discharges, embedding WHO checklists and reducing cancellations.
- The integrated performance report for the division provided summary data on a variety of key indicators and whether targets were met. When targets were not met, there was action to improve performance.
- The divisional risk register recorded the key risks to surgical services across the trust, the controls in place and any gaps in controls. The risk register listed the assurances to address these gaps and any further action planned. There were also health and safety risk assessments completed for each individual area within St Albans.

### **Culture within the service**

- Staff were enthusiastic about working for the trust and felt respected and valued. Staff told us that there were strong team working dynamics and all staff supported one another.
- Staff consistently told us of their commitment to provide safe and caring services, and

spoke positively about the care they delivered.

- Clinical nurse specialists and enhanced recovery teams were extremely proactive and demonstrated a clear goal of improving patient care and experience within surgical care.
- Most staff felt listened to and involved in changes within the trust; many staff spoke of involvement in staff meetings. Whilst there had been several changes in leadership of surgical services at St Albans, staff saw the changes that had been made following this as positive for both staff and patients.
- Senior managers said they were well supported and there was effective communication with the executive team. There was a culture of openness and transparency.
- Senior managers told us they were most proud of the team working, improvements in governance processes and clearer joint working across the two sites.

### **Public engagement**

- Information on patient experience was reported alongside other performance data. This information was used to make informed decisions about the service.
- All wards distributed patient feedback forms regularly to ensure they captured patient comments and any concerns.
- Each clinical area displayed thank you cards from patients and relatives.

### **Staff engagement**

- Staff were encouraged to attend meetings to provide feedback on any areas of their work they felt needed improving or they had concerns over.
- The surgical wards had introduced well-being support to staff, with a notice board displaying any relevant contacts and events.
- The trust had a staff survey action plan in place to improve any low scoring areas in the most recent survey.
- If staff could not attend meetings, minutes or key issues raised were sent via email or placed on a notice board to ensure all staff had view of these.

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

- There were a number of improvements and innovations across surgical services within the trust. These included:
- The introduction of gold standard prostate cancer pathway resulting in significant improvement in diagnostic and treatment cancer targets.
- The introduction of new minimally invasive stone removal surgery; percutaneous lithotomy, providing local treatment of complex stones rather than being referred to other providers.
- The introduction of new surgical treatment for symptoms of prostate enlargement with first operation within the trust in July 2017. This is a day case procedure with minimal side effects.
- The introduction of urology virtual clinics to reduce waiting times for patients and also reduce outpatient visits. This resulted in a significant reduction in new to follow up ratios.
- The introduction of the Prostate Cancer Survivorship programme – a community based follow up scheme introduced to allow patients to be followed up in the community once stable in the community, reducing hospital visits, increasing oncology clinic capacity and providing more localised service for patients. The trust told us that over 80 patients have been enrolled in this programme.

- At this inspection, there had been the following improvements noted since our inspection in September 2016.
  - Standardisation of five steps to safer surgery checklists across all surgical services.
  - Improved medicines management processes, including controlled drugs.
  - Resident medical officer induction processes were in place.
  - Incident reporting was embedded within all areas, with staff receiving feedback and sharing of any learning points.
  - Clear progress had been made in the care and assessment of patients living with dementia or a learning disability within pre-operative assessment areas.
  - All out of hospital transfers were being reviewed at a monthly transfer meeting to review root causes and any themes.

# 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 114,152 of those appointments at St Albans City Hospital.

Outpatients includes all areas where people 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. St Albans City Hospital provides outpatient services across a wide range of specialities, including cardiology, gynaecology, urology, dermatology and rheumatology.

The outpatients department at St Albans City Hospital has 20 consulting rooms, two treatment rooms and a separate breast care unit. There is a large reception desk and two electronic booking in stands.

Children and young people aged from 0 to 18 years are seen in dermatology, audiology and ear nose and throat (ENT) clinics. Children and young people are seen in ophthalmology from age nine and phlebotomy from age five.

The general outpatients department is managed within the trust's medical division. The surgical division manages some clinics, such as ophthalmology. The clinical support services division manages phlebotomy and pathology. Divisional managers had oversight of all three trust sites, so there are similarities between the findings in this report, the Hemel Hempstead General Hospital and Watford General Hospital reports.

During this inspection, we visited the following specialties at St Albans City Hospital: the breast care unit, ENT, cardiology, dermatology, ophthalmology, colorectal and phlebotomy clinics; and administrative areas such as the booking office and clinic scheduling team. We also visited the diagnostic imaging department, which carries out x-ray, mammography and ultrasound scanning.

We spoke with 35 members of staff including nurses, doctors, healthcare assistants, radiographers, administrators, and domestic staff. We spoke with 16 patients, observed the environment and looked at 16 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 outpatient 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. Performance data had improved and the service was performing in line with their planned trajectory.
- There was a positive incident reporting and learning culture across the services provided. Duty of candour was evident in incident investigations we reviewed.
- Radiation protection in the diagnostic imaging department was robust. Medical physics experts and radiation protection supervisors actively worked with staff to provide advice and ensure compliance with safety standards.
- 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.
- The main outpatient department was due to have a full nursing establishment by the end of 2017.
- Waiting lists for outpatient appointments were reviewed weekly and risk assessments were completed for patients who waited 30 weeks or more. At the time of our inspection, no clinical harm had occurred 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.
- A local audit programme included monitoring compliance with best practice. The outpatient department regularly achieved the trust target.
- 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). Results showed consistent compliance and actions taken to improve.
- 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 this inspection in August 2017, we found that appraisal rates had improved to meet the trust target of 90%.
- 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 care.
- The service communicated regularly with patients' GPs and had worked with the trust's GP liaison manager to share information with local doctors.
- 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.
- 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.

- Chaperones were available throughout the outpatient and diagnostic imaging services. All patients we spoke with had been offered a chaperone or to have a friend or relative accompany them.
- 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.
- Patients we spoke with described being offered emotional and social support.
- Outpatient and diagnostic imaging services were planned and delivered to meet people's needs.
- The facilities at were generally suitable for the services provided.
- 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 hearing loops and written information in languages other than English.
- The departments tailored care to meet the needs of patients with learning disabilities and the main outpatient department was working towards gaining a Purple Star accreditation for this.
- 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.
- All staff we spoke with felt respected and valued. The culture across outpatient and diagnostic imaging services encouraged openness, candour and honesty.
- Patients, relatives and visitors were actively engaged and involved when planning services. Clinical leads led an outpatient user group to gather information on patient experience.
- Leadership of the diagnostic imaging department was focused on driving improvement and delivering high quality care to patients. Radiology governance and risk management processes were robust and effective.

However:

- We saw evidence that learning within the clinical divisions was shared across Watford General, Hemel Hempstead General and St Albans City Hospitals. However, this was not always communicated to the outpatient services in other divisions.
- 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.
- There was an infection control concern regarding the use of one treatment room in the

main outpatient department. The room was used for leg ulcer care in the morning and by ENT to suction patients' ears in the afternoon. This posed an infection control risk as leg ulcers are open wounds that have been infected by the air or bacteria.

- Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.
- Some clinic rooms did not have non-slip finish flooring to minimise falls and infection control risk, which was not in line with Department of Health guidance. This had been recognised as an issue and floors were scheduled to be replaced by October 2017.
- Although naso-endoscopes were cleaned manually to keep patients safe, the service did not follow best practice guidelines for scope decontamination.
- 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.
- 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.
- Changing facilities for patients in the ultrasound department were not in a discreet location to maintain privacy and dignity.
- 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.
- In the main outpatient department, we could not be assured that there was robust risk assessment or management as staff could not provide us with evidence.
- At the time of inspection, there was only one risk on the department risk register. 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.
- There was an infection control concern regarding the use of one treatment room in the main outpatient department. The room was used for leg ulcer care in the morning and by ENT to suction patients' ears in the afternoon. This posed an infection control risk as leg ulcers are open wounds that have been infected by the air or bacteria.
- Hand hygiene and environmental infection control audits were not carried out in the phlebotomy department.
- Some clinic rooms did not have non-slip finish flooring to minimise falls and infection control risk, which was not in line with Department of Health guidance. This had been recognised as an issue and floors were scheduled to be replaced by October 2017.
- During our previous inspection in September 2016, the service did not audit how many patients were seen in the outpatient department without their full medical record being available. This had not improved at the inspection in August 2017. However, there were

systems in place at the trust's other two outpatient sites which were due to be implemented at St Albans City Hospital.

- 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.
- Radiation protection in the diagnostic imaging department was robust. Medical physics experts and radiation protection supervisors actively worked with staff to provide advice and ensure compliance with safety standards.
- The main outpatient department was due to have a full nursing establishment by the end of 2017.
- 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, FP10 prescription pads and equipment 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.

## 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 happened 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 100%.
- 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.
- 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 considered 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.
- Incident reporting data 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 St Albans City Hospital.
- From June 2016 to July 2017, the trust reported no never events at St Albans City 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.
- Learning from a never event that occurred in an ophthalmology clinic at Watford General Hospital had been shared with the ophthalmology department at St Albans City Hospital.

Staff could describe what had happened and we saw actions taken to improve. The never event involved misidentification of a patient which resulted in inappropriate administration of eye injections at Watford General Hospital. As a result, patient identification wrist bands had been introduced in the ophthalmology departments across the trust to reduce the risk of a similar incident occurring. Using identification wrist bands for procedures such as eye injections is in line with best practice. The World Health Organisation (WHO) surgical safety checklist had also been introduced for minor operations. We saw evidence of this in patient notes.

- We saw evidence that learning within the clinical divisions was shared across Watford General, Hemel Hempstead General and St Albans City Hospitals. However, this was not always communicated to the outpatient services in other divisions. For example, staff in the main outpatient department which was run by the medical division were unaware of any learning from the never event that occurred in ophthalmology, which was run by the surgical division.
- In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SI) in outpatients at St Albans City Hospital that met the reporting criteria set by NHS England from June 2016 to May 2017.
- From May 2016 to June 2017, there were no incidents reported under Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) requirements by the radiology department at St Albans City Hospital. IR(ME)R states that NHS trusts must notify CQC when a patient receives radiation exposure that is much greater than intended.
- 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 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.
- Nurses and healthcare assistants attended daily huddles where incidents and safety were discussed. This included the expected activity level of the clinic, any staffing issues and learning from previous incidents. There were also monthly team meetings where staff discussed safety and performance.
- Information on recent patient safety incidents was displayed in the main outpatient waiting area. This included what action had been taken to improve.

## **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. The local rules summarised the key working instructions intended to restrict exposure in radiation areas.

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 IR(ME)R and action taken to improve areas of non-compliance. Radiation warning signs were clearly displayed as appropriate, outside all rooms in the diagnostic imaging department.

### **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.
- There were monthly audits to monitor the cleanliness of the environment. The main outpatient department achieved the trust target of 95% in December 2016 and February 2017, but compliance declined to 89% in April 2017. The areas of non-compliance included equipment not clearly labelled as being clean, dirty and clean equipment not stored separately and staff not complying with arms bare below the elbow policy. This had improved during our inspection; equipment had 'I am clean' labels indicating the date they were last cleaned and staff were compliant with 'arms bare below the elbows'. The most recent audit results for July 2017 showed compliance had improved to 96%.
- Actions were recommended after each infection, prevention and control (IPC) audit. However, we saw that some recommendations had not taken place. For example, the action plan from the audit in February 2017 recommended replacing chairs in a patient waiting area as they were ripped and therefore posed an infection control risk. At the time of our inspection in August 2017, the chairs had not been replaced and were still in use. We raised this with the senior nurse who advised that they were planning to have them replaced but this had not been done.
- There was an infection control concern regarding the use of one treatment room in the main outpatient department. The room was used for leg ulcer care in the morning and by ENT to suction patients' ears in the afternoon. ENT suctioning involves inserting devices into the patient's ear to reduce blockage so carrying out this procedure in an environment where leg ulcers are treated poses an infection control risk; leg ulcers are open wounds that have been infected by the air or bacteria. We raised this to senior staff at the time of inspection. We were advised that the room was cleaned between clinics and saw evidence in daily cleaning logs. The senior sister in the department then contacted the trust's infection control team to arrange a risk assessment for the use of the area. We did not see the risk assessment as it was not completed during our inspection.
- The main outpatient services monitored compliance with hand hygiene and had actions to improve. However, hand hygiene and environmental infection control 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 in phlebotomy during our inspection.
- A weekly hand hygiene audit programme had been introduced in the main outpatient department in January 2017 and a hand hygiene competency assessment tool had been implemented in March 2017. Audit results showed the main outpatient department achieved 100% in July 2017. Information on hand hygiene best practice was displayed and all staff we observed were compliant.
- Hand washing facilities, sanitising gel and personal protective equipment (PPE), such as gloves and aprons, were available in clinical areas. Sinks in clinical areas were compliant with infection control standards, for example, no-touch taps and not having removable

plugs. Staff we observed used PPE appropriately.

- 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.
- The trust tested water outlets in clinical areas for legionella (a disease-causing bacteria) and pseudomonas aeruginosa (a bacterium which can affect the lungs) 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.
- There were disposable privacy curtains in the department that should be changed every six months, as a minimum. Curtains were dated with when they were last changed and all were in date, except one in the diagnostic imaging service, which was dated as last changed in November 2016.
- 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. There was a washer-disinfector in the department that ran twice a day with no equipment to flush out any bacteria, but it was not being used to clean scopes. The reasons for not using the washer-disinfector were that they did not have enough trained staff or enough scopes to run clinics as the wash cycle took over one hour. Senior staff recognised that this was an area for improvement and advised that they would have capacity to train more staff members when their ongoing recruitment was completed in November 2017. The cleaning methods used at the time of inspection were appropriate to keep patients safe.
- The four re-usable naso-endoscopes in the main outpatients department were tested for leaks after each use, in line with the manufacturer's guidance. If a scope failed a leak test, they were removed from practice and sent for repair.
- 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 logbook and in the patient's notes. This allowed identification of patients who may be affected if cross-infection occurred.
- Some re-usable medical devices and instruments were used in ophthalmology. All equipment was appropriately decontaminated and managed. Sterile devices arrived to clinics sealed, labelled and dated from the sterilisation and decontamination unit. Used equipment was placed back into the packet and stored separately in a blue container in the dirty utility area for returning to the decontamination unit. Used items were labelled and a tracer label was recorded in the patient's notes for tracking purposes.
- 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.
- 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 kept people safe. However, some clinic rooms had flooring that was not compliant with the Department of Health, Health Building Note 00-01 Part A. The Health Building Note states that dry clinical areas, such as consulting rooms should have seamless, non-slip flooring to minimise falls and infection control risk. Flooring in four of the 22 clinical rooms was not compliant. This

had been recognised by management as an issue; however, it was not included on the departmental risk register. There had originally been six rooms where flooring was non-compliant but two had been replaced in August 2017. The remaining four were due to be replaced in September and October 2017.

- There were maintenance systems in place and staff could describe how to report any issues. The maintenance logbook documented faults being reported and resolved promptly.
- All equipment we observed had evidence of electrical safety testing where appropriate.
- Adult and paediatric resuscitation equipment was available throughout the department and there was evidence of appropriate daily and weekly checks. Oxygen cylinders and emergency medicines were all in date at the time of our inspection. We saw evidence of staff escalating issues with equipment and it being resolved the same day. For example, a fault recorded with the suction unit on the resuscitation trolley in main outpatients was appropriately managed that day.
- 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.
- 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.
- 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 lead aprons for staff to wear during examinations. Lead aprons were checked for cracks on an annual basis. The latest copies, dated January 2017, were stored in hard copy and showed all aprons were safe for use.

## Medicines

- Medicines were generally managed in line with trust policy. However, staff were not recording minimum and maximum temperatures of the medicines fridge in the main outpatient department. The current temperature was recorded on a daily basis but they were not monitoring the range of temperatures reached each day. If temperatures fell out of the range between two to eight degrees Celsius, the efficacy and shelf life of medicines can be affected and pharmacy advice should be sought. We saw that staff had contacted the pharmacy if current temperatures were noted to be outside of the recommended range; however, we could not be assured that temperatures always remained within recommendation. At the time of inspection, the medicines in the fridge included insulin products that have a reduced shelf life if stored over eight degrees. Staff we spoke with could not demonstrate how to determine the minimum and maximum temperatures on the fridge. We raised the issue with senior staff and were advised that they would address this immediately. Fridge temperatures were appropriately monitored in all other outpatient areas. When we returned on our unannounced visit, we found minimum and maximum fridge temperatures were recorded daily since our inspection and staff could demonstrate how to monitor this information.
- Ambient room temperatures were recorded in areas where medicines were stored to ensure non-refrigerated items were stored at appropriate temperatures. Staff we spoke with could describe the escalation procedure if temperatures exceeded the recommended 15 to 25 degrees Celsius. We saw evidence that staff had escalated an issue with a thermometer in the clean utility area of the main outpatient department. Staff identified that

the thermometer reading did not seem accurate and the estates team attended to re-calibrate the thermometer that day.

- We checked medicines in ophthalmology and the main 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; however, the emergency bag for treating diabetic patients who became hypoglycaemic contained an insulin product that had expired in June 2017 and a glucose-drink that expired in August 2017. Hypoglycaemia occurs when a person's blood sugar suddenly declines. Insulin and glucose preparations (such as glucose-drinks) are used to increase blood sugar levels. This was raised with senior staff at the time of inspection and was removed from the kit. There were no other medicines that were found to be out of date in the department.
- Staff dated the packaging of medicines to indicate the date it was 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.
- 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.
- Patient group directives (PGDs) were used in the ophthalmology service to cover the supply and/or administration of eye drops and eye ointments. A PGD is a document signed by a doctor and agreed by a pharmacist, to give direction to a nurse to supply and/or administer specific medicines to a pre-defined group of patients using their own assessment of patient needs, without necessarily referring back to a doctor for an individual prescription. We saw that these had been authorised and signed appropriately.

## Records

- Patients' individual care records were written and managed in a way that kept them safe. We reviewed 16 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.

- Administration staff based at St Albans City Hospital requested patient notes for clinics one week in advance, where possible. Notes arrived and were sorted into lockable trolleys according to clinics. Trolleys were labelled with the consultant name, date and time of the clinic and stored in the on-site medical records office which was kept locked when unattended. Trolleys were then delivered to the department on the day of the clinic. We spoke with four members of staff who co-ordinated medical records. They advised that the main reason for notes not arriving in time for clinics was short-notice referrals, particularly where patients had been referred during a hospital admission. This meant that their notes may not have been released from the inpatient service in time for their outpatient appointment.
- 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. All staff we spoke with, including medical records staff said that the availability of records no longer caused problems for the running of clinics. However, we could not confirm this with data evidence as the service was not auditing the availability of notes at the time of inspection. The audit documentation we reviewed showed that the version used at St Albans City Hospital did not include missing notes. Some staff reported missing notes as incidents and we saw evidence of this in the incidents we reviewed; however, not every occasion was reported. We were advised that this would be improved and the service would begin to collect information on missing notes after our inspection.
- 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.
- In the six months prior to inspection, 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. During our inspection, administration staff demonstrated how they tracked patient notes that had not arrived for clinics that week and reported that this had improved record availability for clinics.
- 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 with 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. The senior sister in the main outpatient department was a safeguarding link nurse, which meant she provided advice and guidance to staff where needed. The safeguarding link nurse received communication from the trust's safeguarding lead and described them as helpful and accessible.
- Information on safeguarding from abuse was displayed in waiting areas so patients and visitors could see. The information included telephone numbers to contact for advice. There was also information displayed in staff rooms, such as flowcharts for referring vulnerable adults and children.
- 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. The ophthalmology department also used the WHO checklist for minor invasive procedures.

### **Mandatory training**

- The trust's mandatory training included adult basic life support (BLS), 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 95% 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 eleven out of twelve modules; however, compliance with BLS was 81%. One staff member who had not completed their BLS training told us that this was due to staffing shortages at the time the last course was run. This staff member planned to attend the next course.
- 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 with fire safety training was 76%. Nursing staff compliance was 40% for clinical staff and 80% for non-clinical staff.

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

- 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.
- Risk assessments were completed for patients undergoing minor procedures in the outpatient department, including The WHO five steps to safer surgery. Dermatology staff used a standard pro-forma that included risk assessments to be carried out before the administration of local anaesthetic, before and after the procedure. This included if the patient had any allergies, a pacemaker, mental capacity concerns and if they were taking any anti-coagulants (blood thinning medicines). Patient records we reviewed contained evidence of appropriate risk assessments.
- 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. Staff could also send patients for assessment at the on-site minor injuries unit, where appropriate. For example, we were told of a recent incident where a patient in the outpatient area had fallen. Nurses attended to assess the patient who was able to get into a wheelchair and be taken to the minor injuries unit for further assessment.
- 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. Staff we spoke with were aware of the process and what action they would take if a patient deteriorated. There had been a recent incident where a patient had suffered a cardiac arrest whilst attending outpatients. Staff described how this was managed in line with policy and the patient was safely admitted to Watford General Hospital.
- 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 St Albans City Hospital site. Bleep devices were tested daily to ensure they were working correctly.
- An appointed resuscitation officer attended the outpatient departments to run scenario training. Senior nurses told us that the resuscitation officer was accessible and gave examples of when they contacted them for advice.
- Phlebotomy staff were aware of the procedure for managing 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. Patients with low

blood sugar were given glucose-drinks or biscuits to stabilise their sugar levels.

- There were emergency grab bags for patients living with diabetes who may have a hypoglycaemic episode (low blood glucose) while attending an outpatient appointment. This contained glucose-drinks and emergency insulin products to be administered, where appropriate. Staff we spoke with could describe this process.
- Areas where radiation took place were clearly signposted and there were lights outside each room to indicate when imaging occurred. This was to prevent any unintended radiation to patients, staff and visitors.
- 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 were pregnant. Staff we spoke with were aware of the importance of checking the pregnancy status of female patients.
- 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.
- A review of nursing skill mix had identified the need for three additional healthcare assistants on each of the trust's three sites. At St Albans City Hospital, the vacancies had all been recruited to and staff were expected to start before December 2017.
- During our previous inspection in September 2016, we were told a business plan had been submitted to increase to 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 five nursing staff had been recruited.
- While recruitment was ongoing, nursing staffing levels were sometimes low. Senior nurses recognised this and used bank staff to fill shifts, where possible. At the time of inspection, staffing levels were below planned. The department was staffed by four nurses in the morning and four in the afternoon. This was compared to a planned staffing level of seven nurses in the morning and eight in the afternoon. There were ten healthcare assistants on shift in the morning and six in the afternoon. This was compared to a plan of eleven and nine respectively. However, two clinics had been cancelled so the actual staffing levels were appropriate for the services provided that day. Rotas for the previous five months showed staffing levels generally met service demand.
- The outpatients department had a nursing establishment of 19.25 whole time equivalent (WTE) staff. In May 2017, there were 16.79 WTE nursing staff employed. This meant there was a nursing vacancy rate of 13%. This was worse than at the previous inspection when the nursing vacancy rate was 9%. However, at the time of inspection in August 2017, recruitment had taken place and the service was due to be fully established by December 2017. One Band 5 nurse had a start date in September 2017.
- There were no vacancies in the phlebotomy department at the time of inspection.
- Bank staff were used to cover 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.

- Nursing and healthcare assistant staffing levels were displayed in waiting areas.
- Student nurses undertook clinical placements in the outpatients and diagnostic imaging department. Student nurses told us they had opportunities to learn, work with their mentors and felt supported.

### **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 staffed for outpatients to access diagnostic imaging from 8am to 5pm, 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 we spoke positively about the new way of working and felt it had improved service delivery.
- The sickness rate for radiology staff at St Albans City Hospital was 1%, which was better than the trust target of 3.5%. Turnover across the trust's diagnostic imaging department was 5%. The data provided did not specify rates at each location.
- In July 2017, there was a medical vacancy rate of 23.4% across the trust's diagnostic imaging services. 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**

- Individual specialities arranged medical cover for their clinics, in line with activity and demand on the service. Clinicians and divisional managers agreed the structure of clinics and patient numbers. 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. A junior doctor we spoke with described the support they received in clinics, for example having a consultant of the same specialty in the adjoining room for advice if needed.
- 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 most recent review had just been completed in August 2017. The appointed fire safety officers completed assessments in line with trust policy. Fire safety officers made recommendations and action plans were managed by departmental fire marshals. The fire safety assessment from August 2015 highlighted that the fire doors were not compliant with safety regulations due to not closing properly and having gaps between the doorframes. We saw that this had been resolved at the time of inspection.
- There were seven appointed fire marshals in the main outpatients and three in the phlebotomy department. The senior sister for main outpatients advised that they intended to train all staff to be fire marshals so that everyone was aware of the risks.
- 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.
- 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.

## 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, such as the percentage of patients offered smoking cessation advice in line with NICE guidance. The outpatient departments regularly achieved the trust target. The latest results from May to July 2017 showed 100% compliance.
- 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). Results showed consistent compliance and actions taken to improve.
- 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 in August 2017, we found that appraisal rates had improved to meet the trust target of 90%.
- 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 in various specialties so that all necessary staff were involved in assessing, planning and

delivering patient care.

- The service communicated regularly with patients' GPs and had worked with the trust's GP liaison manager to share information with local doctors.
- 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.

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 based on 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 dermatology specialty followed a care pathway for skin lesions based on the NICE guidance, 'Improving outcomes for people with skin tumours including melanoma'. We saw evidence of this in patient notes.
- 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.
- Treatment provided in ophthalmology was in line with NICE clinical guidance CG85, 'Glaucoma: diagnosis and management'. Patients in glaucoma clinics received slit lamp testing for eye abnormalities and visual fields testing to monitor deterioration.
- Staff in the breast care unit could describe how the service followed national guidance. For example, patients who attended with breast symptoms were offered ultrasound and mammography if aged over 40 and mammography alone if aged under 40. This was in line with national recommendations and staff we spoke with, including nursing staff knew to follow this practice.
- 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 monitored by the trust's medical physicist and were cross-referenced to national audit levels. High levels were reported to the radiation protection adviser. 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%. Monthly meeting minutes showed audits and actions were discussed.

### **Nutrition and hydration**

- Nutrition and hydration was not routinely assessed as part of the outpatient services. The main outpatient and phlebotomy areas were in close proximity to the hospital café where 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. 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. We observed staff members bringing drinks to patients in waiting areas.
- The water cooler in the ophthalmology department was kept in the nurses' office. There were signs at reception and in the waiting area informing patients that they could access water by asking a staff member. This was in line with safety recommendations as spilled water is particularly a risk in areas where patients may have visual impairment.
- Glucose preparations, drinks and biscuits were available in the outpatient department for patients with diabetes if their blood sugars were found to be low.

### **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. For example, ophthalmology stored paracetamol for patients who attended clinics for eye injections. The ophthalmology clinic also had access to local anaesthesia preparations, which were used if prescribed by a doctor.
- 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 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 our 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 regularly achieved the trust target. The latest results from May to July 2017 showed 100% compliance. Up to date results were displayed on information boards in public areas.
- From February 2016 to January 2017, the follow-up to new rate for outpatient appointments 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 in the outpatient and diagnostic imaging department reviewed competency folders. Areas for development were 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.
- Clinicians who were specialists in their field ran outpatient clinics. For example, the group of consultants who lead the breast care unit all had a major interest in the diagnosis and treatment of breast disease. The medical staff also included doctors and nurses who

specialised in breast care and oncology.

- Band 5 nurses who expressed interest in developing their knowledge in specialist breast care had been encouraged and supported to do so. Nursing staff we spoke with had been invited to attend the weekly multidisciplinary meetings where surgeons, oncologists, radiotherapists, and pathologists discussed patient cases. They spoke positively about this and felt it had improved their knowledge in the area.
- 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.
- 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.
- A radiology assistant we spoke to during the inspection was being supported to become a radiology assistant practitioner.
- 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.
- Study days were held for areas such as leg ulcer management and brief interventions for smoking and alcohol.
- 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.
- In phlebotomy, there was a process for identifying and managing variable staff performance. Blood samples were sent to the pathology labs at Hemel Hempstead General Hospital 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. St Albans City Hospital reported a low error rate in phlebotomy.

### **Multidisciplinary working**

- Outpatient and diagnostic teams worked together to plan and deliver care and treatment. Staff in different teams and services worked together to assess, plan and deliver co-ordinated care.
- During our previous inspection of outpatient services across the trust, there were communication issues between administration, nursing and medical staff regarding changes to clinics. The clinic scheduling team were based at St Albans City Hospital and felt that communication had improved since our previous inspection. There were

standardised templates for setting up, suspending and cancelling clinics so that clinicians recorded all relevant information needed by scheduling staff. The forms were accessible on the trust intranet. The clinic scheduling team had a central email address so that workload could be distributed evenly. However, scheduling staff told us that they still received requests from clinicians to their personal email addresses, which made it more difficult to keep track of changes. This had been raised to divisional management who had sent reminders to clinical staff to use the central email address.

- There were multidisciplinary team (MDT) meetings held across the specialties to provide effective assessment and treatment. For example, there were weekly meetings in the breast care unit, which involved oncologists, surgeons, radiologists and pathologists. Meetings were held on Wednesday mornings so that patients could receive results and treatment options in the clinic on Wednesday afternoons. MDT meetings were also held in other specialties, such as surgical specialties.
- Staff in the breast care unit described having communication links with a local cancer care centre run by another NHS trust. They gave examples of staff from the cancer care centre being involved in MDT meetings to facilitate patient referrals.
- 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, ENT and breast care. A one-stop clinic involves a multidisciplinary team providing consultation, diagnostic testing, results and treatment options in one visit. For example, there were multidisciplinary one-stop clinics for prostate cancer diagnosis. Ultrasound-directed biopsies were carried out on the same day as outpatient appointments to facilitate prompt diagnosis and treatment.
- Specialist nurses worked in clinics, including respiratory, dermatology and pre-operative assessment clinics.
- Booking and clinic co-ordinators were based at St Albans City Hospital. They worked together with divisional managers and the individual specialties to continuously manage waiting lists for outpatient services. Staff in the booking and scheduling offices described improved communication with the clinical specialties since our last inspection.
- The trust had a vetting system for diagnostic imaging requests to prevent unnecessary x-rays. 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 outpatient services. This was not in place at the time of our 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 St Albans City Hospital from 8am to 6pm, 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. Not all staff could demonstrate how to access policies on the trust intranet; however, hard copies were available in folders in the senior nurse's office. 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 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.
- Electronic summaries of patients' care and treatment were sent to their GPs to enable continuous care. Administration staff sent the letters within 24 hours of discharge from the outpatient service.
- 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. Urgent results were also faxed to the relevant consultant if requested. Staff were trained to use this system and could access patient information quickly and easily.
- 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 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 66% 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.

- We also observed staff behaviours that demonstrated their understanding and compliance with MCA. For example, a patient who was living with dementia attended the department with their partner and relative. When the patient was called, the relative asked if they could also come into the consulting room. The staff member asked the patient directly and the patient answered that they would prefer just their partner in the room. The staff member then respected the patient's wishes. This showed that the staff member had considered the principles of MCA as capacity is decision-specific and it should not be assumed that a person with a cognitive impairment cannot make decisions.
- 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 having treatment options 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 understood people's personal, cultural, and religious needs and provided care in a considerate manner.
- Chaperones were available throughout the outpatient and diagnostic imaging services. All patients we spoke with had been offered a chaperone or to have a friend or relative accompany them.
- 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 generally 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.
- All patient feedback we received on inspection was positive about the treatment staff

provided. 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 locally, as well as the nationally reported statistic. For July 2017, the ophthalmology department at St Albans City Hospital scored 100% of patients recommending their service. The main outpatient department scored 98%.
- Feedback forms were accessible in the patient waiting area and we saw staff encouraging patients to fill them in. Thank you cards from patients were displayed throughout the service. Comments included, 'I felt very comfortable and assured when attending the clinic' and 'I cannot thank you enough for all you have done for me'.
- Chaperones were available throughout the outpatient and diagnostic imaging services. Information on the chaperone policy was displayed in clinical rooms and waiting areas. The senior sister in main outpatients planned to stamp patients' notes when a chaperone had been present so that they could monitor how the service was being used. All patients we spoke with said they had been offered a chaperone or to have a friend or relative accompany them.
- Staff in the breast care unit recognised the cultural and religious needs of patients attending their service. For example, nurses we spoke with described how they organised female clinicians for patients based on their religious beliefs.
- During our inspection, we saw staff politely introducing themselves to patients and relatives. Observational audits from July 2017 showed 100% of staff had introduced themselves.
- The main outpatient 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.
- In the ophthalmology department, we observed staff using plastic folders to cover patient identifiable information on sheets they were using at the time.
- Staff recognised and took action in areas where the environment did not always maintain patients' privacy and dignity. For example, in ophthalmology there was one room with two vision tunnels used for testing patients' eye sight. A curtain had been put between the two machines and we observed staff closing the curtains between patients. This was also the case in phlebotomy where blood-taking chairs were in one room. Chairs were divided by curtains and we observed staff asking patients if they would prefer them closed. Staff were therefore recognising the importance of maintaining patient privacy and taking action to improve the environment, where possible.
- We observed some examples of patients' privacy and dignity not being maintained; however, this had improved during our unannounced visit. During our announced visit, patients in the breast care unit waited for examinations in hospital gowns in an area, which was accessible to the public. Male visitors were regularly present. This did not maintain privacy and dignity of patients, as they were vulnerable due to not being fully dressed. We raised this with staff at the time of inspection who had not recognised that this was an issue. Staff advised that patients were not exposed and usually brought dressing gowns to wear in the waiting area, but this would not ensure their privacy and dignity were maintained. Also, during our inspection we observed five female patients who did not have dressing gowns in the waiting area where male visitors were seated. This occurred on both days of our inspection. When we returned on the unannounced visit, we found staff had taken action to improve; patients were offered a private room to wait in when in their gowns. A review of the appropriateness of the environment was scheduled at the end of

September 2017.

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

- 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. For example, administration 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.
- Staff took 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 felt comfortable asking questions about their care and described staff as 'friendly' and 'helpful'.
- We saw patients given copies of letters that the hospital consultant was sending their GP. This included details of whether a follow-up appointment or diagnostic test was required.

### **Emotional support**

- Patients we spoke with described being offered emotional and social support. For example, one patient who had been diagnosed with cancer told us that staff had put them in contact with a support group for people with the same condition.
- Phlebotomists understood the 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.
- The breast care unit had four Macmillan breast care nurses to provide emotional support for patients. There was also a clinical nurse specialist in dermatology to provide additional support.
- There was a St Albans macular degeneration support group for patients who were diagnosed with this condition. The group met on a fortnightly basis and information was displayed in the ophthalmology department.
- The department used volunteers as 'meet and greeters' to support patients, carers and relatives. We observed the volunteer reassuring patients who seemed anxious and talking with carers and relatives. 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, 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 hearing loops and 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 living 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. For example, phlebotomists carried out home visits for housebound patients who were on blood-thinning medicines.

However:

- The changing facilities for patients in the ultrasound department were not in a discreet location to maintain privacy and dignity.
- 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.  
Five out of 16 specialties were not meeting the England overall performance for patients being seen within 18 weeks of referral.

### **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. The outpatient quality improvement plan included actions to address this issue and we saw evidence at St Albans City Hospital. All patients we spoke with had received letters before their appointments and knew what to expect. Letters now contained contact details, date and time of appointment, consultant name, information on any tests, samples or fasting required and car parking. The letter also included links to the hospital website for further information on car parking charges.
- The facilities were generally suitable for the services provided. There was a separate purpose-built unit for breast care. The clinics, x-ray department, breast care nurses, secretaries and receptionist were located next to each other to improve the experience for outpatients.
- The radiology department had four ultrasound rooms, three x-ray rooms and a mammography machine. However, the changing facilities for patients in the ultrasound department were not in a discreet location to maintain privacy and dignity. The changing

cubicle was directly opposite chairs where people waited. This meant patients who were changed into hospital gowns for their examinations could be walking past members of the opposite sex, which was not in line with best practice. We raised this at the time of inspection and were advised that this waiting area was rarely used by visitors. We did not observe anyone waiting in this area during our inspection.

- There was an electronic booking-in stand 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.
- Signs for the outpatient department were in black text on a yellow background. This was in line with national guidance for healthcare environments where people may be visually impaired. The ophthalmology department was separate from the main outpatient area and was signposted in yellow and black. However, some patients felt that the text was not large enough for people with visual impairment.
- There were volunteers present to direct people around the hospital. Patients we spoke with described the department as easy to find. We observed volunteers directing patients to the electronic check-in desk to reduce queuing.
- Waiting areas were comfortable with adequate seating to meet demand. There were magazines and television screens displaying features from the trust. Toys and books were available for children and there were separate playrooms adjacent to the main outpatient and ophthalmology waiting areas.
- Drinks and snacks were available from a vending machine in the waiting room and water was available on request from the receptionists.
- The waiting area for the x-ray department had improved since our last inspection. Chairs were now arranged around a central area with a table and chairs with toys for children. Previously, this area had been rows of chairs with no facilities for children.
- High-back chairs were available in most waiting areas to accommodate older patients or those with mobility issues. The senior nurse in the main outpatient department was ordering more to ensure this was available in all waiting areas.
- Patients told us that car parking facilities were adequate to meet their needs. All patients we spoke with who had driven to the department said they found it easy to find a space.
- Most outpatient specialties provided clinics across all of the trust's three sites and patients we spoke with were a choice for their appointment. The radiology department was smaller at St Albans City Hospital than at the other two sites; more specialist scans, such as magnetic resonance imaging (MRI) and computed tomography (CT) were available at Watford General Hospital and Hemel Hempstead General Hospital.
- Information was available in accessible formats. For example, ophthalmology staff could request information to be sent in large text for patients who were visually impaired. Letters in ophthalmology were not routinely sent in the recommended yellow and black format; however, staff could request this, if appropriate.
- The chronic pain service offered telephone advice to reduce the need for patients to attend the department in person.
- The radiology department had adapted how they delivered 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. They also ran a warfarin clinic. This was on an appointment basis.
- At the time of inspection, there were no evening or weekend clinics offered to accommodate people outside of regular working hours. However, the phlebotomy department had recognised that patients often arrived to the department earlier than the

8:30am start time. In response to this, staff had implemented a trial of opening the clinic at 8am, two days per week. They planned to evaluate the impact this had on patient flow and decide whether a permanent change would be beneficial.

### **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 the inspection in August 2017, 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
- 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.
- 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.
- At the end of August 2017, there were 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.
- 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.
- 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.
- 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. This included reviewing the breast care service and engaging with GPs earlier if a patient did not attend their first offered appointment. A breast practitioner had put in a business case to support extra lists to meet increasing demand. At the time of inspection, the business case was being reviewed and the breast care unit offered nine clinics per week.

- From February 2016 to March 2017, the 'did not attend' (DNA) rate for outpatient appointments was similar to the England average. 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 for diagnostic imaging was 0.8%, which was lower than the England average of 1.8%.
- 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. The average percentage of clinics that were cancelled at short notice (within 6 weeks) was 4%, which was slightly higher than the trust target of 3%. 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.
- At the time of our inspection, two clinics had been cancelled; one was a short notice cancellation due to medical staff sickness. Where cancellations were requested over six weeks prior to the clinic date, letters were sent to patients with new appointments. If cancellations were 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. These occasions were reported as incidents. Staff in the ophthalmology department described making arrangements to see these patients that day, where possible.
- The service aimed 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.
- Waiting times in the department 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 45 minutes. An electronic dashboard system had been introduced across the trust's outpatient services, which captured data on the timeliness of clinics. However, this was not yet in place at St Albans City Hospital. It was due to be introduced as part of the quality improvement plan.
- Clinics were often overbooked and 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 coordinators 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. However, staff we spoke with told us that there were occasions where all patients turned up to overbooked clinics and therefore experienced delays. The electronic dashboard that was due to be introduced monitored information on clinic overbooking, however this had not been implemented at St Albans City Hospital the time of inspection.

- 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.
- There were audits monitoring how long outpatients waited in the department for medicines from the pharmacy department. From June 2016 to June 2017, outpatients waited on average 25 minutes for their medicines. During our inspection, patients we spoke with had waited no longer than 30 minutes for their medicines.
- The trust had introduced urology virtual clinics to reduce waiting times and also reduce hospital visits and outpatient burden for patients. This resulted in a significant reduction in new to follow up ratios.
- Patients could choose which of the trust's three hospital sites they attended for their outpatient appointment, where possible. This could be done via their 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. Clinic scheduling staff also used this tool when managing requests and cancellations. The amount of ad-hoc clinics provided to meet demand varied. Staffing was the main reason for ad-hoc clinics not being able to go ahead as recruitment for nursing posts was ongoing.
- 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 people's needs, including those in vulnerable circumstances. This had improved since our previous inspection. In September 2016, the outpatient and diagnostic imaging services did not provide information for patients in languages other than English. They also did not have hearing loops in place in the department. When we inspected in August 2017, we found that both of these points had improved. The service now provided leaflets in the most spoken languages other than English, based on their local population. Information in other languages could be accessed electronically. Hearing loops were in place in reception areas throughout the department.
- Translation services were also available and the electronic booking-in stand 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.

- Care for patients who had cognitive impairment was tailored to meet their individual needs. For example, staff described working with the local authority health liaison team to plan and deliver care for patients who were living with a learning disability. The health liaison team were a group of social workers who specialised in adult learning disability. Staff described contacting them for advice when organising appointments and providing care and treatment to patients who required additional support. Contact information for the health liaison team was visible in staff areas with photographs of each team member.
- 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 be living with a learning disability or dementia, to minimise distress during their visit. During our inspection, we observed this system in practice; a patient who was living with dementia arrived for their appointment and was seen within five minutes.
- Children were also given priority when they arrived at clinics.
- When diagnostic imaging staff were aware that an examination had been booked for a patient who was living 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.
- Nurses 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. Dementia awareness posters were displayed in staff areas we visited.
- Visual aid signs were used in some areas of the department, such as a picture of an eye directing people to ophthalmology. Visual aids can be used to communicate with people who have cognitive impairment.
- 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 radiology department had equipment to meet individual needs. For example, there was a specific pat slide to accommodate bariatric patients. Pat slides are used to safely transfer patients in reclining or lying positions. The service also used 'twiddle muffs' for patients living 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 living with a dementia, which can be particularly beneficial in

environments such as x-ray rooms.

- 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 living with dementia.
- Some of the facilities had been adapted to accommodate wheelchair users, such as reception desks. However, the toilet facilities in phlebotomy and ophthalmology were small and could be difficult to manoeuvre a wheelchair.
- 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 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. All staff we spoke with were aware of this procedure and reported all patient transport issues via the electronic incident reporting system. There were examples of patients waiting up to three hours for return transport. Staff tried to mitigate this by making requests for return transport as far in advance as they could. They chased any late pick-ups and logged all phone calls to the transport provider. Patients were kept comfortable while they waited.
- There was one example where a patient had arrived to their appointment on a stretcher via the patient transport service. Staff responded to this patient's needs by asking the transport team to stay on-site until the appointment finished. The patient was given priority and immediate return transport was possible.
- Staff were not always informed in advance if a new patient had mobility issues, a learning disability or 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**

- The trust reported 112 complaints related to outpatient and diagnostic imaging services from July 2016 to July 2017. Themes included delayed or cancelled appointments (52), communication with patients (25) and attitude of staff (20).
- The trust aimed to complete investigations into complaints between 25 and 35 working days after they are received, depending on the nature of the complaint. In the outpatient and diagnostic imaging department, 80% of complaints were managed within this timescale.
- 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). Information on

how to complain and contact PALS were visible in some areas of the department, however we did not see any information in the main outpatient waiting area during our inspection.

- A complaints management team dealt with formal complaints. 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.
- There were 'you said we did' boards in the outpatient areas. This displayed recent patient comments and what action had been taken to improve. For example, a patient had commented that the clinic boards did not include the current waiting times in the department. The learning from this was to introduce half-hourly checks to ensure boards were updated.

## 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 all issues raised during the previous inspection and 14 out of 15 had been completed in August 2017. Performance data had improved since the plan was implemented and the service was performing in line with the planned trajectory.
- 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.
- All staff we spoke with felt respected and valued. The culture across outpatient and diagnostic imaging services encouraged openness, candour and honesty.
- Patients, relatives and visitors were actively engaged and involved when planning services. Clinical leads led an outpatient user group to gather information on patient experience.
- Leadership of the diagnostic imaging department was focused on driving improvement and delivering high quality care to patients. There were effective governance and risk management processes in place.

However:

- In the main outpatient department, we could not be assured that there was robust local risk assessment or management, as staff could not provide us with evidence.
- 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

- Outpatient departments were led by clinical leads, divisional and directorate managers. At St Albans City Hospital, the main outpatient department was managed by the medical division, ophthalmology was managed by the surgical division and phlebotomy was managed by clinical support services. The diagnostic imaging department was also part of the trust's clinical support services.
- One matron was responsible for nurses working in the main outpatient department and

another was responsible for nursing staff in ophthalmology. 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.

- The senior nurse who led the main outpatient department was new in post. All staff we spoke with had positive feedback and felt that the service was improving since her appointment. The senior nurse for ophthalmology was based at Watford General Hospital and visited St Albans City Hospital on a weekly basis. Band 6 nurses were in charge of clinics when the senior nurse was not present. Ophthalmology staff all spoke positively about their leadership.
- Senior staff reported feeling supported by matrons, clinical leads and divisional managers. They had regular one-to-one meetings and had been supported to undertake leadership courses provided by the trust. One nurse was on a leadership masters course at the time of inspection.
- 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. We observed positive, friendly and caring interactions between them and local staff. Matrons and managers had developed supportive, appreciative relationships with staff across the service and that was evident on our inspection.
- An assistant divisional manager led the administration and operational staff for the outpatient departments. These teams were based at St Albans City Hospital. All staff we spoke with, including booking co-ordinators, waiting list managers and clinic scheduling co-ordinators felt supported by the divisional management. They described feeling more valued than at the previous inspection and felt that their concerns and ideas for improvement were now listened to.
- Matrons reported to their divisional heads of nursing. They described open, honest relationships and gave examples of when they had contacted them for advice.
- The trust's Chief Nurse visited the outpatient departments and staff reported being known by name. Staff also felt that the Chief Executive was initiating positive change for the trust.

### **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's quality safety group for escalation to the trust board.
- 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 for invasive procedures (NatSSIPs). At the time of inspection, LocSSIPs were in place for steroid injections and the task group were focusing on implementing LocSSIPs across the specialties. 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 affecting 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.
- 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. This had been presented to all managers and senior nurses; however, data collection at St Albans City Hospital had not begun. The dashboard had been rolled out at Watford and Hemel Hempstead General Hospitals and was due to be implemented at St Albans City Hospital. Senior nurses could demonstrate how to access the dashboard during our inspection.
- At the time of inspection, there was only one risk on the department risk register. This was related to clinics being overbooked and the impact this had on staff ability to manage and patient satisfaction. However, during our inspection we identified other risks, which should have been recognised. For example, some floors in the department were non-compliant with health building safety standards and not all patients were seen within 18 weeks of referral. Senior staff we spoke with recognised the issues as risks but they had not been added to the risk register.
- A clinical governance manager reviewed service level risks at quarterly meetings with senior nurses. Risks were added to a departmental risk register if they were deemed as high risk. Local risks in the outpatient departments were assessed and managed by senior nurses and matrons. In phlebotomy and radiology, risks were assessed and managed by service managers or radiology superintendents. Some risks relating to outpatient services were recorded on the surgical division risk register, such as issues with IT systems. This meant that risk management could be disjointed and not all senior staff we spoke with could describe the risk management system.
- Comprehensive risk assessments were in place in phlebotomy and ophthalmology; however, in the main outpatient department we could not be assured that there was robust risk assessment or management as staff could not provide us with evidence. Across the trust's three outpatient sites, risk assessments were stored on-site in hard copy; however, this was unclear in the main outpatient department. Senior staff we spoke with were unaware of risk assessments that had taken place and reported that there were no risks on the departmental risk register. We raised this with the matron who was aware of the situation, could describe current risks and explained how they were being managed. The

matron was meeting with the St Albans City Hospital team the week after our inspection to review this issue; however, when we returned on our unannounced visit, the meeting had not taken place and risk management in the department remained unclear.

- In phlebotomy, we saw evidence of assessments, such as health and safety of the environment, lone working in the community and securing the building at night. This was overseen by the phlebotomy supervisor who had completed a course with the Institution of Occupational Safety and Health. Staff were aware of procedures to mitigate risks.
- In the diagnostic imaging department, risks to staff, patients and service delivery were identified, managed and reviewed. 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.
- 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.
- Quality was continuously monitored and improved in the diagnostic imaging department. There were monthly radiology clinical governance and discrepancy learning meetings. 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.
- 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 2014 and three had been held at the time of 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.
- The outpatient strategy for 2017 to 2027 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 the clinic utilisation tool that was recently implemented to improve the service's ability to meet demand.
- 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.

## **Culture within the service**

- All staff we spoke with felt respected and valued. There was positive feedback from the recognition staff received from their divisional managers, service managers, matrons and senior nurses.
- In the main outpatient department, there was a 'star of the month' awarded to a staff member who displayed excellence and put patients first. This was displayed in the waiting area and the staff member was given a certificate for their continuous professional development. At the time of inspection, the star of the month award had been given to a healthcare assistant who consistently came into work early and picked up additional tasks to facilitate the smooth-running of clinics.
- The culture in across outpatient and diagnostic imaging services encouraged openness, candour and honesty. There were several 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.
- Duty of Candour was followed throughout the services and we saw evidence of this discussed in team meetings.
- 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 had attended health and wellbeing events that had been organised by the trust. For example, outpatient nurses and healthcare assistants told us about mindfulness sessions, yoga classes and deep tissue massages offered to reduce staff stress.
- Each area we visited had positive staff morale and teams were collaborative and inclusive. For example, domestic staff who worked for an external company were invited to social events in the ophthalmology department and reported feeling part of the team.
- Most feedback from medical and nursing students was that they enjoyed working in the outpatient departments. For example, comments from a thank you card from a student nurse in ophthalmology included, 'I have learned so much' and 'I am considering a career in ophthalmology'. A medical student we spoke with described having access to a supportive network of consultants. However, some nursing and medical students described not having enough protected time with their mentor.

## **Public engagement**

- People 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.
- One project that included involvement from the patient panel was the outpatient experience group. This group aimed to gain insight into the services they provided, directly from patients. There was a rota established to include Watford General, Hemel Hempstead General and St Albans City Hospital. The group, including the outpatient matron and divisional management, visited services and handed out specially designed feedback forms to gather information from patients and visitors. Feedback forms included timeliness of appointments, quality of information received and open questions where patients could

add suggestions for improvement. The first session had been conducted at Watford General Hospital and actions had been taken to respond to feedback. The second session was at St Albans City Hospital. Results from this visit had not yet been reviewed as the session took place one week prior to our inspection.

- The 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 their views and raise concerns.
- 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 and health promotion. Champions were nurses or healthcare assistants who received up to date communication in their respective area of interest.
- 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.

### **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.
- A Band 5 nurse had been supported to get involved with innovative research in an area of interest. Currently, researchers are looking at how blood tests can be used to identify micro-metastases in patients who have cancer. The aim of this research is to reduce the need for invasive procedures, such as biopsies and could also be used to individualise patients' treatment plans. The nurse we spoke with had attended study days and could explain the benefits of this innovative practice.
- 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.
- 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 had not been fully decontaminated in an endoscope washer-disinfector at the end of each clinic.
  - There were no plans to introduce seven-day services.

## Outstanding practice

### Surgery:

- The enhanced recovery care of patients at St Albans was working effectively to improve patient outcomes. Staff managing the enhanced recovery care pathways were proactive and passionate about improving patient care.

### OPD

- 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**

- To ensure that there are effective triage/ streaming systems in place in the unit and all staff have had appropriate training to carry out this process.
- Ensure that systems and processes are in place to monitor and review all key aspects of performance to identify areas for improvement.
- Develop a clinical audit process in the MIU to monitor compliance with clinical guidelines and protocols 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 less than 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**

- Undertake a safety review of the medicines cupboard located in the reception area.
- Processes should be in place to avoid waste and dirty linen to be removed from the vanguard theatres without travelling outside or through a clean area.
- Those who had surgery cancelled should be treated within 28 days of the cancellation.
- Improve the availability of patient records during pre-operative assessment clinics.
- 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.

- Risk assess the multiple uses of the treatment room in the main outpatient department at that is used for the treatment of leg ulcers and consider using a separate room.
- Damaged chairs in the main outpatient department should be replaced.
- Consider providing outpatient services at evenings and weekends.
- Staff are should be up to date with Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DOLS) training.
- Patients in radiology should have their privacy and dignity maintained at all times.
- All patients across all specialties should be 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.
- 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
<p>Treatment of disease, disorder and injury Diagnostic and screening Surgical procedures</p>	<p>Regulation 12 HSCA (RA) Regulations 2014 (1)(2)(a) Safe care and treatment.</p> <p><u>How the regulation was not being met:</u></p> <p>There was no formal process to prioritise adult patients who needed to be seen and assessed quickly.</p> <p>Adults and children were not assessed routinely using a nationally recognised tool to detect deterioration.</p>
<p>Treatment of disease, disorder and injury Diagnostic and screening procedures</p>	<p>Regulation 17: (1) (2) (a) (b) Good governance</p> <p><u>How the regulation was not being met:</u></p> <p>There were no robust systems in place to assess, improve and monitor performance and quality of services. There was no monitoring of patients waiting times to their initial assessment.</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, managed and placed 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 3 safeguarding children training, which was not in line with national guidance.</p> <p>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.</p> <p>Compliance with fire safety training in the radiology department was worse than the trust target of 90%. Clinical staff compliance was 40% for and 80% for non-clinical staff.</p>