CareQuality Commission

West Hertfordshire Hospitals NHS Trust

Hemel Hempstead General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Not sufficient evidence to rate
End of life care	Not sufficient evidence to rate
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

West Hertfordshire 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.

West Hertfordshire NHS Trust provides services from three sites Watford Hospital, St Albans Hospital and Hemel Hempstead Hospital.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection of Watford Hospital, St Albans City Hospital and Hemel Hempstead Hospital between 14 and 17 April 2015. We inspected and rated two services, the Urgent Care Centre and outpatients. We inspected, but did not rate, medicine and parts of the end of life care service.

Overall, we rated Hemel Hempstead Hospital as requires improvement with one of the five key questions which we always rate being inadequate (well led). Two services, the Urgent Care Centre and outpatients, were rated as requires improvement.

Overall we have judged the services at the hospital as good for caring. Patients were treated with dignity and respect and were provided with appropriate emotional support.

Improvements were needed to ensure that services were safe, responsive to people's needs and well-led.

We saw several areas of outstanding practice including:

- The trust had introduced a pilot pre-operative reminder telephone call service. The patient was called three days prior to their surgery for reminders and checks. Staff said if the service proved successful then it would become permanent.
- The service had systems in place to minimise patient visits to the hospital. For example, all negative results were reported by phone for eye tests, ear nose and throat and oral surgery.

Importantly, the trust must:

- Review the governance structure for all services at the hospital to have systems in place to report, monitor and investigate incidents and to share learning from incidents as well as complaints.
- Ensure that governance and risk management system in all services to reflect all current risks in the service and all staff are aware of the systems.
- Ensure that there is an effective audit program and the required audits are undertaken by the services.
- Ensure all patients arriving at the UCC are seen by a clinician in a timely way.
- Ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to ensure people who use the service are safe and their health and welfare needs are met.
- Ensure that medicines are always administered in accordance with trust policy.
- Ensure that all staff have received their required mandatory training.
- Ensure that all staff are supported effectively via appropriate clinical and operational staff supervisions systems.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.
- Ensure that patients' records are stored appropriately in accordance with legislation at all times.
- Ensure that all equipment has safety and service checks in accordance with policy and manufacturer' instructions and that the identified frequency is adhered to.

Summary of findings

The trust should also:

- Involve the service in wider organisational planning regarding major incidents and include in trust wide plans or training simulations.
- Enable all staff to access appropriate developmental training opportunities as required.
- Ensure all patients have an accurate record of their needs in place, include pain assessments.
- Ensure that staff understand their responsibilities to report all incidents.
- Ensure that all food products are disposed of when they have expired used by dates.
- Ensure that information on how to complain is accessible to patients in all patient areas within the hospital.
- Review issues identified and associated with transport problems when accessing outpatient appointments.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Systems were in place for reporting and managing incidents. Patients received care in safe, clean and suitably maintained environments with the appropriate equipment. Not all staff had received mandatory training within the last year, as required. We found some reception staff had not undertaken any induction or mandatory training at all, although all had had criminal records checks. Patients were generally seen within 15 minutes of arrival but training and systems for non clinical staff to support this process were not robust. The department regularly found it difficult to provide enough staff to fill its established rota. Shortfalls were covered by locum, bank and agency staff. Active recruitment was being undertaken to try and improve the vacancy rate. The department had strong leadership at local level but was sometimes left unsupported by senior management. Overall, the trust had met the national Department of Health target to admit or discharge 95% of patients within four hours of arrival.
Medical care	Not sufficient evidence to rate 	We did not gather sufficient evidence to rate the service. Staff did not always report incidents and we were not assured that learning happened from incidents. The arrangements for governance and performance management did not always operate effectively. We were not provided with or assured that the medical division had a local vision or strategy for the service. Trust vision and values were not well embedded at local level.

Summary of findings

Staff satisfaction was mixed. Most staff enjoyed working at the trust whereas others felt under pressure due to staff shortages. There were recruitment issues on the ward.
We saw good multidisciplinary working.
The trust told us that the medicine core service at Hemel was for rehabilitative care and not acute care. Therefore seven day working was not required and was currently in place only for acute unscheduled care from Watford hospital.
Most patients spoke positively about the staff and the care they received. They told us that they received good quality care and that they were treated with respect and dignity.
Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS), were aware of what to do if they had a safeguarding concern and how to escalate patient concerns out of hours.
The medicine division was unable to provide a local audit plan and details of local audits undertaken in the previous six months.
Effective infection control precautions were in place.
There were adequate levels of bed occupancy. We found medically fit patients awaiting social care packages or a rehabilitation bed at a local unit external to the trust. We saw significant evidence of the trust working with the local health economy to promote patient flow.

End of life care — **Not sufficient evidence to rate**

Facilities were overall were in a poor state of repair and potentially caused risk to staff and visitors. Where these issues were mentioned on the trust's risk register no action had been taken to mitigate risk or repair problems. Outcomes on the risk register were also out of date and not reviewed or updated within the trust's stipulated timeframe.
We saw a broken door in the mortuary which created a security risk and also an

injury risk to staff and visitors to the hospital. Although this was repaired on the day of our inspection, this had been broken for a number of weeks according to staff.
The air-change system in the mortuary was being monitored to ensure there were no risks to staff.
Serious incidents had occurred where staff had found that the fridges in the mortuary had failed. Checking systems were put into place to monitor this risk at Hemel Hempstead mortuary.

Outpatients and diagnostic imaging	**Requires improvement**		We found the service to be requires improvement overall. Incidents were not always reported in line with trust policy. This meant that data provided in relation to incidents may not have provided a reliable oversight of incidents occurring in the outpatients and diagnostic imaging services. We saw evidence that some incidents were reported and that the service had learned from incidents. We saw evidence during the inspection that the service had carried out reviews of minor incidents and that sharing of these and learning had taken place. Records were not stored securely. This meant there was a risk of people's records and personal details being seen or removed by unauthorised people in the department. Clinics were often cancelled and patients experienced delays when waiting for appointments. Risk management and quality measurement systems were reactive and not proactive. Outpatients and diagnostic imaging services had not identified all the risks to service users, and some of those identified were not being managed effectively. We saw written information about the complaints procedure and the Patient Advice and Liaison Service (PALS), but some of the patients we asked had not been given any information about complaints or knew how to make a complaint. We

Summary of findings

received consistently negative feedback from patients and staff about waiting times, the patient transport service and patient parking.

We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Some of the information given to us by senior managers was not found to be what was happening at local level.

Staff we spoke with were aware of key performance indicator targets that required appointments to be made within the 18 week referral to treat (RTT) target but there was no one managing the patient impact when appointments were double or triple booked and therefore they were not proactively managing the situation at clinic-level. The trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standard.

The processes for decontamination and sterilisation of instruments complied with Department of Health (DH) guidance. There was evidence that the service focussed on he needs of patients. There were some systems in place to audit both clinical practice and the overall service.

Emergency equipment was available in each centre, and included medication, oxygen and a defibrillator. We saw that equipment checks had been carried out regularly.

There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.

We found that staff were approachable and witnessed them being polite, welcoming, helpful and friendly.

Summary of findings

Outpatient services were caring and most patients spoke positively about the care and treatment they received and felt they were involved in their care plan.

Hemel Hempstead General Hospital

Detailed findings

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

Detailed findings

Contents

Background to Hemel Hempstead General Hospital

Hemel Hempstead Hospital has a 24/7 urgent care centre and offers other local healthcare facilities such as diagnostic services, including MRI and cold pathology, and an outpatient service that sees in excess of 100,00 patients per year. In addition it provides twelve stroke rehabilitation beds.

A local NHS Community Trust also operates intermediate care beds on site. We did not inspect these as part of this inspection.

Hemel Hempstead Hospital is situated on Hillfield Road in Hemel Hempstead town centre, minutes from the main bus station

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director, Oxford University Hospitals NHS Trust

Head of Hospital Inspections: Helen Richardson

The team included 12 CQC inspectors and a variety of specialists including junior doctors, medical consultants, senior managers, child and adult safeguarding leads, trauma and orthopaedic nurses, paediatric nurses, an obstetrician, midwives, surgeons, an end of life care specialist and experts by experience who had experience of using services.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about West Hertfordshire NHS Trust asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups, the trust development authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

Detailed findings

We held a listening event in the week leading up to the inspection where people shared their views and experiences of services provided by West Hertfordshire NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at West Hertfordshire NHS Trust.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Medical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
End of life care	Not rated	N/A	N/A	N/A	N/A	Not rated
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement

Notes

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

Urgent and emergency services

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The urgent care centre (UCC) at Hemel Hempstead hospital replaced the accident and emergency unit in 2009. It is co-located with a General Practitioner (GP) service run by a private provider, which was not included in this inspection. The UCC is a nurse led unit. It is open 24 hours, 7 days a week and always has a GP on site. In the last year the unit saw 34,760 people, this represented a 7% increase in attendances compared to the previous year.

The UCC is designed to treat adults and children with minor illness and injuries and did not admit anyone to the hospitals wards. There were protocols in place to transfer those people who required specialist care to the emergency department at Watford General Hospital. Staff had received training in the initial management and stabilisation of seriously unwell adults and children. This was supported by a protocol that staff were aware of and followed

Summary of findings

Overall, we rated this service as requires improvement.

Those arriving in the department were generally seen by a clinician in a timely way however, on some occasions it was left to untrained receptionists to escalate any concerns about a patient's condition to the clinical staff. The unit did have a nurse on the rota whose role it was to triage patients on arrival; however we saw that this role had not been filled consistently over recent months.

Not all staff had received mandatory training within the last year, as required. We found some reception staff had not undertaken any induction or mandatory training at all, except for training on the hospital's computer system. Any further information on the job role was provided by more experienced reception staff, but there was no documentation available to support this.

The majority of patients arriving at the department were seen by a clinician in a timely way. The trust provided information that showed that the target of 95% of patients seen by a clinician within 15 minutes was consistently achieved in the year April 2014 to March 2015.

Systems were in place for reporting and managing incidents. Patients received care in safe, clean and suitably maintained environments with the appropriate equipment. However, the UCC had not been included in the organisation's major incident plan and there were no plans in place should a surge of patients arrive.

Urgent and emergency services

The department regularly found it difficult to provide enough staff to fill its established rota. Shortfalls were covered by locum, bank and agency staff. Active recruitment was being undertaken to try and improve the vacancy rate.

The department had strong leadership at local level but was sometimes left unsupported by senior management. Overall, the trust had met the national Department of Health target to admit or discharge 95% of patients within four hours of arrival.

Are urgent and emergency services safe?

Requires improvement

We rated this service as requiring improvement for safety.

People arriving at the UCC initially had their details checked by a receptionist and, depending if their condition was included on a list of potentially serious conditions, were then either asked to sit in the waiting room or sent to a triage nurse.

We found that the criteria for referring to the assessment nurse was not clear and patients were streamed by a non-clinical member of staff and it could be some time before they were assessed by a nurse or doctor.

The waiting room was visible from the reception area and clinical staff were seen on multiple occasions to be reviewing the presenting complaints of those waiting to identify anyone who had been incorrectly categorised. Whilst this practice reduced the risk to patients, there was no documentation supporting clinical staff and no protocol outlining what standards the unit expected of its staff.

We also found that reception staff had not received any additional training to triage patients and in one case had not received any mandatory training except for IT training.

Not all staff had had the trust's mandatory training within the past year.

The department regularly found it difficult to provide enough staff to fill its established rota. Shortfalls were covered by locum, bank and agency staff. Active recruitment was being undertaken to try and improve the vacancy rate.

Staff said the unit had not been involved in wider organisational planning regarding major incidents and was not included in trust wide plans or training simulations. The trust's Major Incident Plan dated 2013 did include the role of the UCC in supporting the trust's main Emergency Department in case of a serious incident.

There was a system in place for reporting incidents. We saw that these were investigated and learning points fed back to staff.

Urgent and emergency services

Safeguarding procedures were in place and ensured that vulnerable people were supported effectively. There were clear processes in place for staff to identify safeguarding concerns and alert the appropriate agencies.

Incidents

- A policy was in place for the management and investigation of incidents, complaints and claims.
- Nursing staff were confident about reporting incidents, near misses and poor practice in line with the trust policy using the electronic incident reporting system. However, we found that other similar areas of the trust did not share the appropriate learning from their serious incidents with the urgent care centre. This meant that preventable incidents could be repeated in different areas of the trust. This included incidents such as medication errors.
- The division kept an incident database of all the incidents that had occurred in the previous year. All incidents were coded for severity and likelihood of reoccurrence, there was also a section that outlined the actions that had been taken to prevent reoccurrence. In this way people were protected from incidents reoccurring.
- Staff were able to describe recent incidents within the centre and clearly outlined actions that had been taken as a result of investigations to prevent recurrence. Examples of this included a patient whose condition had deteriorated quickly and had required transfer to a local emergency department.
- We saw evidence that incidents were discussed at staff meetings and that learning was shared with the whole team. Learning points were documented in meeting minutes.

Cleanliness, infection control and hygiene

- On the day of our inspection the UCC was visibly clean and stock was well organised.
- We observed the units cleaner working and saw that care was taken to ensure that areas that were high up and difficult to reach were clean. The unit manager told us that there was a good relationship with the cleaning staff and she felt able to request additional cleaning if required.
- We saw that cleaning rotas were up to date and that clinical staff were also involved in ensuring that surfaces and areas were clean.
- There was hand gel and soap available near where patient care was undertaken. Staff told us it was easy to get refills when required.
- We looked at waste disposal practice and examined three clinical waste bins at random. We found that waste segregation was effective.
- There was an effective system in place for isolating patients with potentially infectious diseases.
- Staff had access to personal protective equipment that was comprehensive and well organised.

Environment and equipment

- The UCC was bright, appropriately designed, well maintained, safe and secure.
- We saw that patients were assessed in individual cubicles with doors, which ensured confidentiality.
- There was a specific x-ray service situated within the UCC 9am to 10pm Monday to Sunday. If patients attended after 10pm they had to wait until the next day, and in urgent cases, go to Watford General Hospital.
- The radiologist at the UCC told us that if they spotted a positive fracture they had access to 'The Red Dot' service (a national radiographer alert system to reduce errors); which highlighted to clinical staff their suspicion of a fracture. This helped to expedite reporting.
- Adequate equipment was available in all areas, including appropriate equipment for children and equipment for specific procedures that might be carried out only a few times a year. Staff confirmed that all items of equipment were readily available and any faulty equipment was either repaired or replaced efficiently, through the trusts clinical engineering department.
- Equipment was checked and decontaminated regularly. We examined the checklists in place for daily, weekly and monthly monitoring of equipment such as the resuscitation trolleys and found that checks were undertaken in line with trust guidance.
- Staff were aware of alerts that had been issued by the National Patient Safety Agency (NPSA) and warnings had been shared with staff. If action was required such as removing a piece of equipment staff felt able to act, on it and communicate this to colleagues during handover.
- We looked at three items of electrical equipment and found they had all undergone Portable Appliance Testing (PAT) within the last year.

Urgent and emergency services

Medicines

- Policies were available for the management of medication and available to staff online.
- Medication was stored safely and there was a comprehensive check of all medicines stored in the UCC.
- We looked a five randomly selected medicines stored in the unit. They were all within date and stored according to manufactures recommendations. Medicines throughout the UCC were stored safely in locked cupboards
- Medicines that required refrigeration were stored in a dedicated fridge, which was kept at an appropriate temperature and monitored daily; we saw records that showed these checks were occurring daily.
- Many of the Emergency Nurse Practitioners (ENP's) had undertaken extensive prescription courses. Those that had not, administered selected medicines under guidance, known as patient group directives. We looked at three of these Patient Group Directions (PGD's) and found them to be within date and appropriately completed.
- We checked the storage and balance of controlled drugs, which include strong painkillers and sedatives. We found that the stock balance was correct.
- People using the service told us they were offered medicines, particularly pain relief when they had been seen by a clinician.

Records

- Records were held securely online and accessed by staff with a unique password. We looked at 10 individual patient records and found they were all comprehensive and included assessment to ensure anyone who was vulnerable was identified.
- We noted that allergies were recorded when appropriate.
- Staff were able to access previous attendances where appropriate.
- We saw that staff were using appropriate early warning scores for adults and children which gave them warning if a patient's condition was beginning to deteriorate.
- There was a backup plan in place in the event of computer system failure. This meant that those using the service could continue to be treated in this event.

Safeguarding

- We found that there were a number of different systems in place to ensure that patients with particular safeguarding concerns were identified.
- The Urgent Care Centre's reception staff checked on a computer based system to see if children were known to social services. All children's documentation was reviewed by the trusts health visitor liaison team and all staff had undertaken the appropriate level of training (level three) in children's safeguarding we were shown records that confirmed this.
- When staff identified an adult or child who they were concerned about there was a straightforward advice document which they followed.
- There was a specific procedure in place for alerting other agencies working with people with learning difficulties.
- Staff told us they felt supported in making safeguarding referrals and received feedback when requested regarding their concerns, we did note that feedback was not routinely given which meant learning was not maximised. We reviewed a number of referrals for both adults and children and saw these were comprehensively completed in all cases.

Mandatory training

- We looked at records for staff mandatory training. This showed that 70% of staff had completed the required training over the past year, the unit manager told us they aimed for 100% compliance.
- Staff told us the shortfall in mandatory training was due to problems accessing online part of training, and that training took place in a different hospital some distance away.
- The unit manager identified that a lack of staff meant it was not always able to release staff for training. They also identified that training took place in short sessions over a number of days making it difficult to reconcile staffs working hours.

Assessing and responding to patient risk

- We observed the UCC's processes for initially assessing patients who presented at the unit. There was a system in place for an early assessment for certain groups of patients. This included children under five.
- The process for reception staff to identify patients with serious conditions was not safe and guidance that had been produced for them was unclear. Reception staff had been provided with a list of conditions that they

should escalate to a clinical member of the team. Reception staff accepted that the list was confusing and included categories such as 'genuinely unwell' and 'going blue'. The reception staff had not received any additional training to help them identify very unwell people.

- The clinical staff had taken some steps to reduce the risk in this area by monitoring the queue of people waiting to see an ENP, and we saw them on more than one occasion taking people into the assessment room to conduct a triage to ensure they were safe to wait for a consultation.
- Most patients who attended were seen by a clinician within 15 minutes of arrival as advocated by the Royal College of Emergency Medicine. The trust provided information that showed that the target of 95% of patients seen by a clinician within 15 minutes was consistently achieved in the year April 2014 to March 2015
- The reception desk was staffed constantly during the units' opening times and this desk had direct view of the waiting room meaning help could be summoned quickly if required.
- On the day of our inspection, the reception was staffed by a permanent member of staff and a receptionist from the hospital bank. This temporary member of staff had not undergone any mandatory training including basic life support.
- Generally there were systems in place to ensure that if someone using the services condition deteriorated they could be transferred safely to a more appropriate setting. Most commonly this was to the nearest emergency department. We found that there was a protocol in place to guide staff. All clinical staff had received training and the ambulance service were involved in the transfer.

Nursing staffing

- The unit manager told us that the UCC found it difficult to cover the assessment nurse shift. We reviewed the previous month's rota and saw that the assessment nurse shift was only covered 53% of the time. This meant that other members of the clinical team had to undertake the assessments which may have led to delays; however the trust was able to maintain its compliance with the four hour standard.
- The units staffing had not been benchmarked against any recognised tool, although numbers of staff on duty where matched to when the department saw the largest numbers of people.
- We looked at the previous three months rota for Emergency Nurse Practitioners (ENPs). We saw multiple days when the number of staff working had been less than the number allocated, although there were no days when there were no ENP's available at all.
- On the day of our inspection the overall vacancy rate had 1.36 whole time equivalent (WTE) nurses less than was allocated and was 1.19 WTE nurse short at ENP level. Given that that total number of ENP's within the unit was 5.83 WTE this represented a significant shortfall of 20%.
- The unit manager told us that they always tried to fill the vacancies with the unit's staff working overtime and occasionally with regular agency workers.
- Staff communicated staff shortages with their senior managers. We were told by staff that sometimes ENP's would be moved from other departments within the trust in order cover outstanding shifts.
- Whilst none of the staff could identify an incident when a lack of staff had led to patient harm, they did tell us that people had to wait longer for treatment when there were fewer ENP's available.
- We saw that there was a plan in place to recruit additional staff in the near future, including adverts in nursing journals and identifying staff to send on ENP training.

Medical staffing

- Whilst predominately nurse led, the UCC there was also support from emergency doctors employed by the trust and based at the emergency department at Watford who would spend part of their working week supervising the ENP's. Staff said this helped develop their skills and was a useful resource.
- The unit manager told us that on some occasions there was no doctor to work in the centre, however there was systems in place to co-operate with another provider to ensure there was medical advice available from a doctor working for a local General Practitioner (GP) provider in the same location. Staff told us this system worked effectively and that both services worked collaboratively. We saw documentation in people's notes that showed this system was in use.

Urgent and emergency services

Major incident awareness and training

- Staff said the unit had not been involved in wider organisational planning regarding major incidents and was not included in trust wide plans or training simulations. The trust's Major Incident Plan dated 2013 did include the role of the UCC in supporting the trust's main Emergency Department in case of a serious incident.
- Within the UCC, staff were not aware of the information available to them regarding whom in the trust to escalate the situation to.
- Staff was not clear as to their role in the event of a major incident occurring nearby and there was no guidance for staff in the trust's major incident plan.
- Whilst the trust's major incident plan highlighted that all ambulance patients should be taken to the trust's emergency department at Watford it was not clear how the organisation would accommodate large numbers of people arriving at the walk in centre via private transport.
- Staff had not undertaken any training regarding major incident response and there was very limited advice available to them on the trust computer system.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We inspected the service but have not rated it.

We found that care was being delivered in accordance with national guidance, although there were no audits being undertaken to confirm compliance with this.

Pain relief was given effectively, although the level of patients' pain was not always documented.

Clinical supervision was not as comprehensive as the unit manager wished it to be. There had recently been a change in policy, which incorporated clinical supervision into an individual's appraisal. We saw this documentation that showed that this change had led to improved rates of clinical supervision.

Patient outcomes and treatment times demonstrated effective and timely care and staff in the UCC worked well with other members of the multi-disciplinary team.

Staff demonstrated a good understanding of relevant legislation regarding consent and capacity.

Evidence-based care and treatment

- Policies and guidance available to staff followed guidance from a number of external advisory bodies such as the Royal College of Emergency Medicine (RCEM) and the National Institute for Health and Care Excellence (NICE).
- The unit was not undertaking any clinical audits and had not been included in any wider trust clinical audits to ensure consistency of patient care and treatment.
- We reviewed 10 patient treatment records and found that decisions relating to treatment followed guidance outlined in the unit's policies and procedures. One example of this was treatment for a patient with an ankle injury which followed the unit's policy regarding x-ray and management.
- Guidance documents were available for staff online, which could be accessed in every treatment room using a trust computer.
- Changes in practice were discussed at staff meetings or emailed to staff; we saw staff meeting minutes which confirmed this.

Pain relief

- We found that pain relief was documented effectively and met patient needs. There was not always effective use of pain scores, with staff sometimes documenting that levels of pain had reduced rather than providing a score.
- We did see documentation that showed patients received pain relief in a timely manner.

Patient outcomes

- At the time of our inspection the department was not undertaking any audits.

Competent staff

- Staff told us that their unit manager was approachable and was very clinically supportive, providing ad-hoc supervision.
- The unit manager told us that more formal supervision had been difficult to accomplish due to a lack of staff,

but had recently incorporated a minimum number of supervision sessions into staff appraisals, which was already showing improvement in attendance we saw records that showed this.
- Supervision took place in the trust's emergency department at another location, which some staff told us was difficult to get to.
- Staff had access to current journals in emergency care, which were accessible in the staff room.
- All staff had undergone an appraisal within the last year and we saw records that confirmed this.
- These steps ensured that those using the service were treated by competent staff.

Multidisciplinary working

- The UCC was co-located with a General Practitioner (GP) led service provided by a private provider. Whilst not part of this inspection, we spoke to one of the GP's working with this service. They told us that the working relationship was excellent and they had no concerns at all.
- Staff at the UCC told us that the services worked well together and were able to support each other in times of difficulty.
- We saw examples where staff interacted effectively with other teams in the trust including those in the x-ray department and the ambulance service.
- The main investigation by another team on behalf of the UCC was x-rays. We saw that x-rays were produced in a timely manner and the ENP's could review them quickly and plan treatment.
- We also saw examples when staff contacted other teams within the trust, such as the orthopaedic team when they required specialist advice. If a patient was transferred we saw that copies of their notes were made available to the team taking over their care in order to ensure continuity.

Seven-day services

- The Urgent Care Centre was open 24 hours seven days a week.
- Staff told us access to and support from the hospital's pharmacy service was effective.

Access to information

- The information needed to deliver effective care and treatment was generally available to relevant staff in a timely and accessible way.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of their duties under the Mental Capacity Act (MCA) and understood the key aspects of Deprivation of Liberty Safeguards (DoLS). Although we were informed they rarely had to use it.
- Staff also demonstrated a good understanding of consent in relation to children and young people and were able to give examples of where they had used this knowledge in practice. Documentation used in the UCC included a section regarding a young person's parents or guardians.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Patients confirmed that their consent had been sought prior to care and treatment being delivered.

Are urgent and emergency services caring?

Good

We found the service was good for caring.

We observed a number of positive interactions between staff and those using the service including children. Staff used effective verbal and nonverbal techniques to reassure those who were worried. Those people who were using the service told us they felt that they were treated with dignity and respect. They also told us they felt involved in their care.

The trust was unable to provide us with data that showed that they were monitoring how those used the service felt about their care on a routine basis, such as a friends and family test, although we saw plans to implement this were at an advanced stage and already being undertaken in similar areas of the trust. This meant that on the day of our inspection the UCC did not engage fully with those using the service.

Compassionate care

- All the patients, relatives and representatives we spoke with at were positive about the care and treatment provided.
- We observed that people's privacy and dignity was respected.

Urgent and emergency services

- Staff we spoke to were clear about the importance of providing care that was non-discriminatory.
- We saw staff a number of instances where staff ensured that people's privacy and dignity were protected prior to treatment. This included not discussing their condition until they had closed the door of the treatment room, knocking before entering rooms and using curtains before undressing people to examine them.
- We observed many examples of compassionate care; staff used both verbal and non-verbal communication very effectively.
- We noticed one staff member greet every patient she saw with a friendly tone of voice and positive body language.
- The trust was unable to provide specific friends and family data for the UCC, however we saw documentation that showed that plans to do this were at an advanced stage and would be implemented shortly after our inspection. Staff had been made aware that this data would soon be collected.

Understanding and involvement of patients and those close to them

- The patients we spoke with had a good understanding of their diagnosis and what further appointments or treatments were required. Three patients remarked on how friendly and thorough staff had been and how impressed they were with the service.
- We saw staff interact very effectively with a small child, who was clearly very nervous. Staff used a number of effective techniques to reassure them.
- We noted that staff checked that those who were being treated understood their diagnosis and what aftercare and appointments such as fracture clinic were necessary.
- All those we spoke to who had used the service told us they had had the opportunity to ask questions and that these questions were answered fully.
- Staffs interaction with each other was also professional and friendly and the atmosphere was welcoming.
- When we looked at complaints made to the service a number of them remarked that whilst an aspect of their treatment fell below expectation staff were very caring.

Emotional support

- Staff clearly understood their role in providing emotional support and could access multi-faith teams if required, although staff were clear that this was rarely required.
- Staff we spoke to where aware of the impact that even a seemingly minor injury could have on a person's ability to care for themselves and we witnessed them discussing how to cope with daily activities with recently diagnosed patients.

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

Good

We rated this service as good for responsiveness.

On the day of our inspection there was an effective flow of people through the UCC. Whilst the vast majority of those arriving for treatment had relatively minor injuries, there were systems in the event of a seriously ill or injured person arriving at the unit.

The unit was well designed to meet the needs of disabled people, with no steps or trip hazards however there was no written information for those who did not read English and no separate waiting area for children.

There was a system in place for responding to complaints, identifying key themes and informing staff of the key learning points and themes to learn lessons

Service planning and delivery to meet the needs of local people

- Whilst the UCC did not provide a full emergency service, we saw that there were effective plans in place should a person become seriously ill whilst being treated at the UCC.
- The UCC was located in the area previously used as the A&E until it closed. The UCC was spacious and staff said it was very adequate to treat the number of people that they saw.
- Staff told us that a lot of effort had been made to explain to the local population the changes in emergency care, however sometimes patients who

required treatment that exceeded the remit of the UCC did arrive. We saw that there was equipment in place to provide initial emergency treatment prior to transfer to a more appropriate setting.
- There was no specific children's waiting area, which meant that young children were not effectively screened from the adult waiting room.
- When we looked at the rota for staff, we saw that it matched the hours at which the service saw the most numbers of people with the highest numbers of staff.

Meeting people's individual needs

- The UCC had good disabled access with no steps, rooms that could accommodate wheelchairs and disabled toilet facilities.
- There was an effective system in place to communicate with community teams caring for people with complex needs.
- Translation services were provided by phrasebook, and occasionally by telephone translator. Staff were not clear about how they would interpret the answer given to a question from the phrasebook. However staff working within the unit came from a variety of backgrounds and some spoke languages other than English.
- Whilst there were information leaflets available, we did see that none of these were available in languages other than English. This meant that those who did not speak English did not have information to refer to when they were discharged.
- There were a number of leaflets and resources available to people which outlined how they should manage their condition at home and where to get advice.

Access and flow

- Staff said that there was normally good flow through the department and that when there were delays it was usually the result of delays in other areas, such as getting specialist opinions or waiting for ambulance transfer.
- Data produced by the trust showed that the UCC was comfortably meeting the four hour standard. This standard is set by the Department of Health and says that departments should aim to assess, treat and discharge people within four hours.
- Data we saw from the last two months showed that the department was meeting this target in every case.

Learning from complaints and concerns

- There was a system in place for learning from complaints. The unit manager kept records of the key themes of complaints to identify trends.
- We examined data regarding complaints and saw that the rate of complaints was minimal for a service such as the UCC. In the last year the unit had received four formal complaints. When complaints were made the key themes were car parking, which was not controlled by the UCC, and the waiting time to be seen a nurse.
- Complaints were investigated by the unit manager, with support from the lead nurse. Themes and resulting actions were discussed in regular staff meetings.
- There was written information available to people who wished to make a complaint displayed in the UCC.
- Staff told us that if somebody wished to complain they would try and resolve the issue at local level but would direct the person to the appropriate service if the issue was not resolved.

Are urgent and emergency services well-led?

Requires improvement

We rated the UCC as requiring improvement for being well-led.

Not all staff were clear about the remit of the UCC.

Governance and risk managements systems were not effective and not understood by all staff.

Staff at the UCC felt that those in senior roles were very busy; however some felt that attention focused on other areas and they were sometimes forgotten.

Staff also said that senior managers sometimes failed to understand how the service worked and rarely visited.

More than one member of staff remarked how they had seen more senior members of the hospital team in the preceding few weeks.

The UCC had effective nursing leadership. Junior staff that we spoke to felt that were supported by their immediate senior colleges. However, more senior support was not as visible as staff wanted it to be.

Vision and strategy for this service

- Staff told us that they were aware of the broad aims of the organisation, although many commented that communication form senior managers and the board had only really been in evidence since the trust was given notice of the CQC inspection.
- Staff working at the UCC had a clear understanding of the purpose and strategy of the unit but they were less clear about the strategy of the trust as a whole.
- Staff told us they felt part on the unit as opposed to part of the wider organisation.

Governance, risk management and quality measurement

- The unit did not have clear governance and risk management systems in place that were fully understood by all staff.
- The unit manager was aware of the corporate risk register, performance activity, recent serious untoward incidents that had happened in the trust, and did cascade them to staff through staff meetings.
- However when we spoke to staff in other areas it became apparent that not all relevant incidents and learning had been shared with any of the UCC staff at this location. This meant that learning from incidents had not been shared effectively with all staff.
- Staff of all levels understood the importance of quality measurement but were less clear about how this was being audited and recorded, apart from complaint analysis.
- Staff told us that crucial information from the senior team was either emailed or leaflets were attached to their payslip. We saw some of these leaflets during the course of our inspection.

Leadership of service

- Staff told us that at local level the management of the unit was effective and that their unit manager was approachable. However more senior support was often not on site and staff felt that they didn't really understand the remit of the UCC. We heard examples, particularly out of normal working hours where the trust's on-call managers had not been supportive of the staff, particularly when the unit was short staffed.
- The unit manager said that their manager was very good and 'always on the end of the phone' but also had a very big remit and was not able to visit the unit as often as they would like.
- The unit manager was given time for the administration of the service, however they told us that the operational demands of the service conflicted with this role at times.

Culture within the service

- Staff told us they felt supported by their manager and there was a culture of improvement in the service.
- Staff felt confident in making suggestions to improve the way the service worked and felt these would be listened to.

Public and staff engagement

- Staff told us that during the redesign of services in 2010 there had been a lot of public engagement but that this had diminished slightly in recent years as the service became more established.
- There was no regular forum for those using the service to give their opinions on the service
- Staff received communications in a variety of ways, such as newsletters, emails, briefing documents and meetings. Staff told us that they were made aware when new policies were issued.

Innovation, improvement and sustainability

- Staff told us that the key issue for the UCC was staffing. The unit manager told us that they felt that senior managers understood this and had encouraged recruitment however it was difficult to find suitable candidates.

Medical care (including older people's care)

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

West Hertfordshire Hospitals NHS Trust provides inpatient medical services at two hospital sites, Watford General Hospital and Hemel Hempstead Hospital. There is one rehabilitation ward at Hemel Hempstead Hospital, with 22 beds, 12 of which were dedicated stroke rehabilitation beds.

We visited Hemel Hempstead Hospital, Simpson ward on the 16 April 2015.

Simpson ward provides specialist inpatient rehabilitation for adults requiring stroke rehabilitation.

We spoke with over 10 members of staff including: nurses, doctors, therapists, and housekeepers. We spoke with 12 patients. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's medical performance data.

Summary of findings

We did not have sufficient evidence to rate the service.

Staff did not always report incidents and we were not assured that learning happened from incidents. The arrangements for governance and performance management did not always operate effectively.

We were not provided with or assured that the medical division had a local vision or strategy for the service. Trust vision and values were not well embedded at local level.

Staff satisfaction was mixed. Most staff enjoyed working at the trust whereas others felt under pressure due to staff shortages. There were recruitment issues on the ward.

We saw good multidisciplinary working. However, not all services were working towards a seven day service.

Most patients spoke positively about the staff and the care they received. They told us that they received good quality care and that they were treated with respect and dignity.

Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS), were aware of what to do if they had a safeguarding concern and how to escalate patient concerns out of hours.

The medicine division was unable to provide a local audit plan and details of local audits undertaken in the previous six months.

Medical care (including older people's care)

Effective infection control precautions were in place.

There were adequate levels of bed occupancy. We found medically fit patients awaiting social care packages or a rehabilitation bed at a local unit external to the trust. We no evidence of the trust working with the local health economy to promote patient flow.

Are medical care services safe?

Not sufficient evidence to rate

We did not have sufficient evidence to rate the safe domain.

Staff did not always report incidents and feedback was not always provided on incidents reported. We were not reassured that learning had happened form all incidents.

Senior staff we spoke with were aware of the Duty of Candour legislation and able to describe the responsibilities involved.

We found gaps on the administration records and the reasons for not giving patients prescribed medicines were not recorded. This meant that we were not assured that patients were receiving their medicines as prescribed.

Effective infection control precautions were in place.

Nursing staff were aware of what to do if they had a safeguarding concern and how to escalate patient concerns out of hours.

Incidents

- Staff told us that they were encouraged to complete incident reports on the electronic reporting system. Most staff told us that they had feedback from the reports. However, some staff told us that they did not always complete incident reports because they did not feel that they made a difference or that incidents would be addressed. This meant that data provided in relation to incidents may not have provided a reliable oversight of incidents occurring in medicine.
- There had been 13 incidents reports between October 2014 and January 2015. Eight of these were different types of patient falls. They were all categorised a no harm or low harm. One category three pressure ulcer was reported in Octobers 2014. The incident reports stated that all staff had been made aware of the incident but we saw no evidence of this. There was only once 'lesson learnt' documented for the 13 incidents on the information the trust provided us with. This did not reassure us that staff were learning from incidents.
- Senior staff we spoke with were aware of the Duty of Candour legislation and able to describe the responsibilities involved.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- Areas we visited were visibly clean and wards had cleaning schedules in place.
- Equipment had green "I am clean" stickers on them so staff would know which equipment was safe to use.
- Staff had access to personal protective equipment such as gloves and aprons.
- We observed staff adhering to the trust's 'bare below the elbow' policy, applying gloves and aprons as required, and washing their hands and using hand sanitising gel following their time spent with patients.

Environment and equipment

- The ward was the only active ward in the hospital block. The sister told us that at night all the doors are locked and that there is security on site.
- We inspected the resuscitation trolley that was centrally located on the ward. It was visibly clean and the defibrillator had been serviced in line with trust policy. We found that staff had documented daily equipment testing for the resuscitation trolley to ensure equipment was fit-for-purpose.

Medicines

- We looked at the prescription and medicine administration records for four patients on the ward. We saw arrangements were in place for recording the administration of medicines and a coding system indicated any reasons why medicines were not administered. We found two medication gaps on the administration record for one patient and the reasons for not giving patients prescribed medicines were not recorded. This meant that we were not assured that patients were receiving their medicines as prescribed.
- We asked ward nurses if these discrepancies could be explained. They told us that they could not explain the reasons why medication had not been given and that staff all did different things in terms of noting the reasons for not giving patients prescribed medicines
- If patients were allergic to any medicines this was recorded on their prescription chart.
- There had been on medication incident reported since October 2014, where a patient was given the incorrect does of methotrexate (a drug used to treat auto-immune conditions such as rheumatoid arthritis, psoriatic arthritis and vasculitis). The outcome was rated as low harm to the patient and staff were informed about patient dose and how pharmacists dispense the medication.
- On Fridays, the doctors ensured that all medication patents would need over the weekend were prescribed to prevent any delays over the weekend when they were not available. Nurses were aware that they needed to contact the on call registrar at Watford General hospital should they need further prescriptions.

Records

- All healthcare professionals used the medical notes to record patient care. Medical notes were up to date.

Safeguarding

- Nursing staff were aware of what to do if they had a safeguarding concern and were able to tell us what constituted such a concern. There was a safeguarding team and staff on the ward knew how to contact the team when they required support.
- We checked nursing staff safeguarding records and found that all the permanent nurses on the ward had received safeguarding adults level 1 training.

Mandatory training

- Senior staff told us that they requested that mandatory trainers came to the ward to deliver training to staff to avoid groups of staff travelling to Watford General Hospital where the training was usually delivered. However, only the safeguarding trainer had agreed to do this so far. This meant that the ward had to arrange for staff to take long periods of time off the ward to received mandatory training, which often left the ward short staffed.

Assessing and responding to patient risk

- Patient care plans and clinical risk assessments were up to date. These included assessments for pressure ulcers, nutrition and National Early Warning Score (NEWS).
- If patients required chest physiotherapy, therapists were aware that they needed to escalate the patient back to Watford General Hospital for this service. They told us that this rarely happened but when it did they were always about to promptly obtain a bed for the patient.
- The ward sister told us that although they tried to avoid weekend admissions, when they did happened nurses contact the out of hours GP service to assess the patient

or the on call registrar if the patient was poorly. Nursing and medical staff told us that they were concerned weekend transfers into the ward because of the reduced medical cover.

Nursing staffing

- The trust provided data that showed between January 2014 and November 2014 agency nurses formed an average 21% of the nursing workforce in the medicine division. This was most significant on Simpson ward at Hemel Hempstead Hospital with 55% reliance on agency staff. There was a plan in place to recruit registered nurses from other areas of the UK.
- Nursing staff told us that staff were being constantly moved to address shortfalls at Watford General Hospital. On the Friday we visited, three staff had been moved that week. Staff told us that they found this unsettling to the continuity of teams and the care provided to patients.
- The trust informed us that there was focus on targeted nursing recruitment campaigns including overseas recruitment. As a result of the recruitment campaign they were anticipating 172 new nurses to join from September 2015. The latest nursing vacancy rate was 15% in May 2015.

Medical staffing

- There was a registrar on call at Watford General Hospital. Consultant cover rotated once a month.
- Out of hours staff could contact the out of hours GP service or in urgent cases the emergency services via 999.
- Doctors told us that their consultants always offered them support.
- The NHS Deanery**,** a regional organisation responsible for postgraduate medical and dental training, had provided information that it had removed educationally approved registrar training due to their workload and lack of consultant supervision and reported a lack of consultant cover on Fridays. Consultant support was generally perceived by junior doctors to be variable.

Major incident awareness and training

- Staff could describe the major incidents policy and there was a link to the policy on the trust intranet home page.

Are medical care services effective?

Not sufficient evidence to rate

We did not have sufficient evidence to rate the effective domain.

We saw good multidisciplinary working. However, not all services were working towards a seven day service.

Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS).

The medicine division was unable to provide a local audit plan and details of local audits undertaken in the previous six months.

Pain management was effective and none of the patients we spoke with told us that they were in pain.

Evidence-based care and treatment

- The tissue viability team told us that the 'Best Shot' pressure ulcer care plans were based upon the NHS 'stop the pressure' campaign and April 2014 NICE guidelines (CG179). The team told us that the care plans had been peer reviewed by clinical nurse specialists (CNS) and dieticians to ensure best practice across multiple disciplines. Ward staff told us that they had felt engaged with the implementation of the care plan.
- The medicine division was unable to provide a local audit plan and details of local audits undertaken in the previous six months.
- We found trust policies and guidelines available on the intranet, such as medicines management and insulin pump therapy guidelines.

Pain relief

- We saw nurses asked patients if they were in pain, identify the location of the pain and deliver pain relief medication where necessary.
- None of the patients we spoke with told us that they were in pain.
- In the National Cancer Patient Experience Survey 2014, the trust scored in the top 20% of trusts nationally for patients feeling that hospital staff did everything to help control pain all of the time.

Nutrition and hydration

Medical care (including older people's care)

- One patient commented, "The food is fantastic": "You can have a cup of tea whenever you like"; and "You get snacks in between meals".
- We found a yoghurt for a patient in the ward fridge that had expired best before date two weeks before our inspection. We reported this to the housekeeper who disposed of the food.
- Patients with special dietary requirements or who required assistance with eating were highlighted on the kitchen board.
- Patients who were nil by mouth or had food or drink texture recommendations had signs above their bed to alert staff what the patient could tolerate.
- We looked at four patients' records where Malnutrition Universal Screening Tool (MUST) risk assessment had been recorded correctly.

Patient outcomes

- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than expected. According to the Board's Performance Report for March 2015, the HSMR was 83.6, which was much better than the national average target of 100. The HSMR had reduced from 85.8 to 83.6 over the past three months.
- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. According to the Board's Performance Report for March 2015, the SHMI was 90.3, which was better than the national target of 100. The SHMI had reduced from 97.6 over the previous three months. It was acknowledged an element of this reduction was due to better reporting and data management.
- Therapy services were in the process of developing clinical key performance indicators for patient outcomes. At the time of our inspection there was no inpatient outcome data to review.

Competent staff

- The tissue viability team told us that they offered monthly study days for registered nurses and that they were planned to introduce 'skin champions' in the trust to provide ward level advice. They provided micro teaching sessions on request to staff groups such as physiotherapy and midwives. However, there were no competencies in place for staff regarding tissue viability.
- The tissue viability team told us that they received regular one to ones and that some staff within the team were being supported to complete a degree course with tissue viability elements. They told us that they were able to attend study days such as Wound UK.
- There was monthly in-service training for therapy services to update staff on new guidance.
- Physiotherapists told us that they attended weekly in-service training at Watford General Hospital.

Multidisciplinary working

- Staff reported excellent multidisciplinary team working. There was a weekly multidisciplinary team meeting, attended by the consultant, junior doctors, nurses and therapists. Staff told us that everyone had a chance to speak at meetings and were always listened to.

Seven-day services

- Physiotherapy provided an onsite service Monday to Friday, 8.15am to 4.15pm.

Access to information

- Staff could access further clinical guidelines and pathways on the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained verbal consent before carrying out patient interventions.
- Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS) and could give examples of where the safeguards should be applied or considered.

Are medical care services caring?

Not sufficient evidence to rate

We did not have sufficient evidence to rate the caring domain.

Patients spoke positively about the staff and the care they received. They told us that staff were friendly and treated them with respect and dignity.

Medical care (including older people's care)

The majority of patents had a drink within reach but only 50% of patents to reach a call bell if they required assistance.

Compassionate care

- We saw staff speak with patients in a respectful way, engaging and laughing with patients.
- One patient told us: "Staff are nice and friendly".
- We saw a junior doctor pull the curtains around a distressed patient. They demonstrated a sensitive and reassuring approach to the patient who was confused and upset.
- Patients felt that their privacy and dignity was respected by staff.
- The NHS Friends and Family Test had a 41% response rate for medical inpatients. The March 2015 results showed that 93% of the medicine inpatient respondents said that they were either likely or extremely likely to recommend the trust to friends and family. Results were comparable to the national average of 94%. However, 6% of respondents on Simpson ward at Hemel Hempstead Hospital were either unlikely or extremely unlikely to recommend the wards.
- We audited if patients could reach their call bell on Simpson ward. We found five out of 10 patients were able to reach their call bell. This meant that only 50% of the patients we observed were able to alert staff using the call bell system if they needed help.
- We audited if patients had a drink within reach on Simpson ward. We found eight out of nine patients had a drink within reach. This meant that 89% of the patients we observed were able to reach a drink.

Understanding and involvement of patients and those close to them

- We saw staff explaining to patients the treatment and care they were delivering.
- We saw evidence of families being involved in patient care and discharge. For example, within the patient notes there was documentation of planning meetings involving family members.

Emotional support

- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received.

Are medical care services responsive?

Not sufficient evidence to rate

We did not have sufficient evidence to rate the responsive domain.

There were adequate levels of bed occupancy. We found medically fit patients awaiting social care packages or a rehabilitation bed at a local unit external to the trust. The trust provided evidence of ongoing work undertaken with the local health economy to promote patient flow.

We found evidence that patients being admitted into the wards after 8.50pm weekdays and during weekends. We saw no evidence of staff trying to resolve this issue.

The therapy gym was fully equipped with all the equipment therapists required. We found a lack of activities for patients on the ward.

Service planning and delivery to meet the needs of local people

- The ward recognised that there were some delays in discharge. The ward had nine patients medically fit for discharge awaiting social care packages or a rehabilitation bed at a local unit external to the trust. Staff told us that it was difficult to get a rehabilitation bed at some units and patients could wait up to eight weeks on the ward before being transferred or patients would end up being discharged home without going to a rehabilitation unit because the wait for a bed was too long. The trust provided evidence of ongoing work undertaken with the local health economy to promote patient flow.

Access and flow

- The ward had increased its bed capacity from 16 to 22 in January 2015 to manage demand.
- The ward had three vacant beds when we visited. Staff told us that the stroke unit at Watford general hospital were the main referrers into the ward.
- The physiotherapists aimed to provide each patient with a 45 minute one to one session three times per week. They provided some patient rehabilitation groups sessions where appropriate.

Medical care (including older people's care)

- We found evidence in the admission and discharge book that between 07 March 2015 and 29 March 2015 seven patients had been admitted to the ward at weekends. One was admitted at 5.45am from Watford General Hospital.
- Three patients had been admitted to the ward on weekdays after 8.50pm all from Watford General Hospital. Bed managers told us that the trust policy was not to move patients after 8pm.

Meeting people's individual needs

- We found a lack of activities for patients on the ward. Televisions were available to hire for a fee from a contracted company.
- A translations service was available for non-English speakers. Staff reported that this service was effective.
- Patients had a choice of meals. Meals to meet cultural and clinical requirements were available, such as Halal or gluten free food. Cold snacks were available for patients outside of meal times and relatives were able to bring food in for patients.
- The therapy gym was fully equipped with all the equipment therapists required. They told us that if they required specialist equipment they only needed to request this via the consultant.

Learning from complaints and concerns

- We saw literature about the complaints procedure and information about the patient advice and liaison service (PALS) on display on most wards.
- Staff explained that they would always try to resolve informal complaints on the ward. Formal complaints were directed to PALS who initiated an acknowledgment. The complaint was then passed to the relevant person in the unit to respond fully.

Are medical care services well-led?

Not sufficient evidence to rate

We did not have sufficient evidence to rate the well led domain.

We were not provided with or assured that the medical division had a local vision or strategy for the service. Trust vision and values were not well embedded at local level.

Staff satisfaction was mixed. Most staff enjoyed working at the trust whereas others felt under pressure due to staff shortages. There were recruitment issues on the ward.

The arrangements for governance and performance management did not always operate effectively.

We found no examples of innovation on the ward. We found examples where the ward engaged and responded to patient feedback.

Vision and strategy for this service.

- Some staff were aware of the trust's vision and values, whereas others could not describe what these were.
- We were unable to speak to all the medical leaders of the division due to staff being on leave. We were not provided with or assured that the medical division had a local vision or strategy for the service.
- Therapy managers told us that they had team objectives for the year based upon the trust's strategic plan. We requested a copy of the objectives but the trust did not provide this. Therapy services had no annual plan.

Governance, risk management and quality measurement

- Senior staff told us that management meetings, including length of stay meetings, were always held at Watford General Hospital. This meant that staff had to travel to the hospital and have at least two hours off the ward for an hour meeting. When staff from the ward were unable to attend meetings, they told us that meeting minutes were not always circulated to them and therefore they were not informed of discussions and actions that had taken place.
- Therapy managers could not measure the effectiveness or responsiveness of the service. They did not always collect required data or had access to the most recent data due to lack of administrative support. Data was not added to the electronic system in chronological order and the last data available was from December 2014. Therapy managers had noted that the system was not ideal however; they did not feel this was a risk to their service and had no plan in place to address this issue. This meant that the service had poor quality measures four months out of date.

- Therapy managers and the chief pharmacist who was accountable for the service admitted that governance, risk management and quality measures could be scrutinised and challenged better within the service.

Leadership of service

- Managers told us that they were proud of their teams and recognised that staff worked hard within their roles.
- Some staff told us that they did not know the structure of the organisation.
- The ward sister was meant to work in a supervisory manner. However, due to staff shortages they told us that this rarely happened. This meant that local leadership was compromised.

Culture within the service

- Most staff reported that they were happy working at the trust and felt supported by their managers.
- Staff told us that recruitment and retention was a problem within the trust. Some staff believed that nurses had left the trust due to increased work pressures. Nurses in some areas expressed low levels of satisfaction, high levels of stress and work overload and in some cases were clearly distressed and tearful. They particularly did not feel valued when they were moved to work at Watford General Hospital at late notice.
- The sister told us that there were five whole time equivalent (WTE) band five nursing vacancies, one band six vacancy, and one band two vacancy on the ward. Trust wide recruitment from other countries was underway for nurses but senior nurses admitted this was slow.
- Staff told us there was a lack of urgency to reduce vacancy rates within the medicine division. The trust told us it had an active recruitment programme at the time of the inspection and was focusing on staff retention.

Public and staff engagement

- The ward information board showed 'You said, we did' comments. For example, one patient had feedback that it was noisy at night. The ward response was to reduce the ring volume on telephones and answer call bell quicker.
- The ward board displayed their 'I want great care' score. The ward had scored 4.86 out of 5 for March 2015 with a 62% response rate.

Innovation, improvement and sustainability

- We did not collect any evidence to support innovation, improvement and sustainability.

End of life care

Safe	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

West Hertfordshire Hospitals NHS Trust serves a population of approximately 600,000 people.

We visited the hospital and also the Mortuary at Hemel Hempstead Community Hospital.

Summary of findings

We inspected the Mortuary and did not gather evidence across four of the five key questions. Facilities overall in a poor state of repair and caused a potential risk to staff and visitors. Where these issues were mentioned on the trust's risk register no action had been taken to mitigate risk or repair problems. Outcomes on the risk register were also out of date and not reviewed or updated within the trust's stipulated timeframe.

We saw a broken door in the mortuary which created a security risk and also an injury risk to staff and visitors to the hospital. Although this was repaired on the day of our inspection, this had been broken for a number of weeks according to staff.

The air-change system in the mortuary was being monitored to ensure there were no risks to staff.

Serious incidents had occurred where staff had found that the fridges in the mortuary had failed. Checking systems were put into place to monitor this risk at Hemel Hempstead mortuary.

End of life care

Are end of life care services safe?

Not sufficient evidence to rate

We did not gather sufficient evidence to rate this service for safety.

Where concerns were mentioned on the trust's risk register no action had been taken to mitigate risk or repair problems in an effective and timely way.

Facilities overall in a poor state of repair and caused a potential risk to staff and visitors.

We saw a broken door in the mortuary which created a security risk and also an injury risk to staff and visitors to the hospital. Although this was repaired on the day of our inspection, this had been broken for a number of weeks according to staff.

The air-change system in the mortuary was being monitored to ensure there were no risks to staff.

Serious incidents had occurred where staff had found that the fridges in the mortuary had failed. Checking systems were put into place to monitor this risk at Hemel Hempstead mortuary.

Incidents

- Staff in the mortuary explained the process for reporting accidents and incidents and showed us examples of these on the electronic computer system that the trust used. We saw that staff had reported a high instance of slips and falls in the examination room due to the floor being unsuitable. Staff in the mortuary told us that the trust had gained quotes for the floor to be replaced as a result of these reports in April 2014, but that the flooring had not been corrected. We spoke to a manager in the estates department who told us that they were unsure why this had not been corrected as the funds had been allocated in April 2014. We were assured that the flooring will be addressed as soon as possible.
- We were told about an incident where mortuary fridges at Hemel Hempstead had failed and the alarm system had not alerted staff to this issue. This resulted in fridges reaching 48 degrees when the issue was discovered by mortuary staff. As a result of this issue the trust instigated a checking system where the fridges were checked every two hours by porters during hours that staff are not working in the mortuary. We saw these records of temperature checks.
- We noticed that the floor had been identified as a slip hazard by staff but this was not listed on the risk register. The trust confirmed that they were aware of this issue in April 2014 and the quote had been arranged, but the work had not been carried out and they could not say why.
- The back door posed a security and injury hazard to staff and visitors and although this had not been repaired for a number of weeks this was not listed on the risk register.

Cleanliness, infection control and hygiene

- We saw the Human Tissue Authority (HTA) report from their inspection of the mortuary at Hemel Hempstead on the 26th of July 2014. This report highlighted that the number of air changes in the mortuary was found to be less than the recommended 10 changes an hour for air supply and 12 changes an hour for extraction. We saw that this was added to the trust's risk register with a note for the estates department to provide a report by the 30th of July 2014, but no further entries had been made. The air-change system in the mortuary was being monitored to ensure there were no risks to staff.
- The trust told us it had approval from the HTA following their report of 2014 to continue using the mortuary taking note of the observed reduced air changes. Subsequent work undertaken in 2014 and 2015 demonstrated further improvements, meeting the HTA requirement for no further degradation of flow and falling within accepted design parameters.

Environment and equipment

- The mortuary at Hemel Hempstead had security and safety issues with the rear access doors. The left hand door had become rotten and the lower of two hinges had come away with rotten wood. Staff had shut the door and used a sliding bold at the top to secure it, and attached to it was a label which stated; "broken, do not use". We were told this door was used by members of the public and staff, and therefore put people at risk of harm should the door fall from its remaining hinge. This created a security risk due to the fact that this door

opened directly into the mortuary. The manager told us that this had been reported to estates "some weeks ago", and when we contacted the trust they repaired the door the same evening.

Major incident awareness and training

- Mortuary staff told us that porters in the trust received training in the use of the fridges and the alarm systems and they followed a procedure to alert mortuary staff if there is storage or other issues relating to the mortuary. We spoke to a porter at Hemel Hempstead Hospital who confirmed that they had received this training.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate
Overall	Requires improvement

Information about the service

West Hertfordshire Hospitals NHS Trust has outpatients departments at three hospital sites, Watford General Hospital, Hemel Hempstead Hospital and St Albans Hospital. They provide outpatient services across a wide range of specialisms; for example, cardiology, ophthalmology, respiratory, urology, radiology. The trust had approximately 435,959 appointments across the three hospitals between July 2013 and June 2014: this is within the mid-range compared to all trusts in England.

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.

We visited the general outpatient area in Hemel Hempstead Hospital which included radiology, cardiology, ophthalmology, respiratory and urology clinics amongst others. The majority of patients that attended the hospital were coming to attend outpatients or for investigations. For example, radiological procedures or phlebotomy.

We spoke with 13 patients and relatives and 28 staff, including consultants, radiologists, sisters, nurses, healthcare assistants, medical and administration staff. We observed care and treatment, and looked at records. During our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

We found the service to be requires improvement overall.

Incidents were not always reported in line with trust policy. This meant that data provided in relation to incidents may not have provided a reliable oversight of incidents occurring in the outpatients and diagnostic imaging services.

We saw evidence that some incidents were reported and that the service had learned from incidents. We saw evidence during the inspection that the service had carried out reviews of minor incidents and that sharing of these and learning had taken place.

Records in the cardiology outpatients department were not stored securely. This meant there was a risk of people's records and personal details being seen or removed by unauthorised people in the department.

Clinics were often cancelled and patients experienced delays when waiting for appointments.

Risk management and quality measurement systems were reactive and not proactive. Outpatients and diagnostic imaging services had not identified all the risks to service users, and some of those identified were not being managed effectively.

We saw written information about the complaints procedure and the Patient Advice and Liaison Service (PALS), but some of the patients we asked had not been

Outpatients and diagnostic imaging

given any information about complaints or knew how to make a complaint. We received consistently negative feedback from patients and staff about waiting times, the patient transport service and patient parking.

We found senior staff each had visions for the service at local-level, yet there seemed to be a lack of combined objectives and strategy to achieve an improved service. Some of the information given to us by senior managers was not found to be what was happening at local level.

Staff we spoke with were aware of key performance indicator targets that required appointments to be made within the 18 week referral to treat (RTT) target but there was no one managing the patient impact when appointments were double or triple booked and therefore they were not proactively managing the situation at clinic-level. The trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standard.

The processes for decontamination and sterilisation of instruments complied with Department of Health (DH) guidance. There was evidence that the service focussed on he needs of patients. There were some systems in place to audit both clinical practice and the overall service.

Emergency equipment was available in each centre, and included medication, oxygen and a defibrillator. We saw that equipment checks had been carried out regularly.

There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.

We found that staff were approachable and witnessed them being polite, welcoming, helpful and friendly.

Outpatient services were caring and most patients spoke positively about the care and treatment they received and felt they were involved in their care plan.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated the service as requiring improvement for safety.

Patients in radiology were being given medication without a prescription. Staff we spoke with had no understanding of the administration of "buscopan" medication before a procedure. They were not aware that a prescription was needed and did not know about the contraindications that meant, for some people it was not safe to give it and they would be at risk of harm.

Incidents were not always reported. This meant that data provided in relation to incidents may not have provided a reliable oversight of incidents occurring in outpatients.

Records in the outpatients department were not secure and stored inappropriately.

Incidents

- Staff were familiar with the electronic reporting system to report incidents within the department. However, we spoke with one member of staff in the outpatients department who told us they did not access the computer to report incidents via the electronic reporting system. One health care assistant said they were not allowed to complete incident forms and needed to report to nursing staff.
- We spoke with staff about the electronic incident-reporting system and were told that there was no formal training on how to use the system. As a result, it was clear that staff had different opinions on which incidents should be reported.
- Some staff told us they did not always report concerns on the incident system. We were given examples of incident reporting in outpatients where clinics were cancelled at short notice and patients were already in the clinic. Staff said they used to report these issues as incidents but nothing ever changed as a result so they no longer reported them.
- Some staff told us that they rarely got any feedback as to the reason for what happened unless the incident was really serious and nothing seemed to change as the

same situations around cancellation and overbooking of clinics continued to occur. This meant that data provided in relation to incidents would not provide a reliable oversight of incidents occurring in outpatients.
- Two staff in outpatient diagnostic services gave examples of lessons learnt and practice changes as a response of incidents which showed they understood their responsibilities.

Cleanliness, infection control and hygiene

- We looked at most areas of the outpatients department including: the clinical and office areas in the radiology department, clinic areas for cardiology, ophthalmology, urology and respiratory clinics, service user waiting areas and facilities, along with clerical areas and records storage areas. All the areas we looked at were clean and tidy.
- The lead nurse took responsibility for monitoring the trust policy on hand washing and took responsibility for training staff. We observed that staff complied with the trust policy of being bare below the elbow and wearing minimal jewellery.
- Hand gel was available in all clinical areas. Notices were displayed regarding hand washing and infection control.
- Regular hand hygiene audits demonstrated high compliance rates throughout the department and infection control guidelines were clearly displayed in the outpatients department.
- There were systems in place for the segregation and correct disposal of waste materials such as x ray solutions and sharp items. Sharps containers for the safe disposal of used needles were available in each clinical area. These were dated and were not overfilled. Notices were displayed in clinical areas explaining the actions staff should take in the event of an injury from a needle.
- Information leaflets and notices were displayed to remind people of the importance of notifying the radiologist of any the associated risks. For example, whether they were pregnant.
- Staff told us they received mandatory training in infection prevention and control training. Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- The outpatients and radiology departments regularly undertook infection control reports, although we did not see these. Regular physical audits were also undertaken. Trolleys and clinical areas were cleaned down by the staff on a daily basis.
- The trust commissioned an external provider to manage its cleaning schedules within the hospital.

Environment and equipment

- Staff told us maintenance was a problem and equipment had not been maintained in line with manufacturers' recommendations. For example, we found two couches in everyday use in treatment rooms had tears and tape placed over the tears.
- We saw a risk assessment dated July 2014 that highlighted equipment was "non-compliant with CQC regulations and "couches were unsuitable, unsafe and infectious couches for bariatric patients". The risk assessment stated that staff must use disposable plastic sheets to cover the couch .However; several nursing staff we spoke with were not following this and did not know a risk assessment was in place. Staff told us they had asked to replace the couches but had been refused. We saw the trust was aware of concerns about couches in outpatients as they were listed on the trust risk register dated July 2014. However the trust later confirmed that in fact approval for charitable funds was awaited to purchase the couches.
- We saw evidence of daily performance checks of equipment.
- Equipment we looked at was visibly clean and stored appropriately.
- The trust's electrical maintenance engineering department were responsible for annual portable appliance testing (PAT) and equipment we looked at complied with regulations.

Medicines

- We found that the trust had carried out audits on the secure storage of medicines and controlled drugs in early 2014. This audit had identified many deficiencies in the safe storage of medicines, but many of the recommendations of the audit remained to be implemented. This meant that patients could be given medication that could cause them harm.

- There was a pharmacy on site. They checked and replenished stock medicines in all departments and provided an outpatient dispensing service.
- In outpatients, radiology medicines were stored in locked cupboards in the department. Lockable medicines fridges were in place, with daily temperature checks. This meant that the department were following the appropriate guidance on the safe handling and storage of medication.

Radiology outpatients

- Radiographers showed us the procedure for minimising exposure to radiation and the personal protective equipment in place for staff to use. We were told that patients were asked a series of questions, for example to check if they may be pregnant, to reduce the risk of exposure. We saw signs in the changing area that reminded patients to inform staff of key information.
- The radiology department used patient group direction (PGD) policies to allow staff who were not trained to prescribe medication to give one or two specific medications for certain procedures. We looked at these policies and saw that, although staff had signed to agree with the procedure and instructions in the PGD, there was no authorising signature on any of these documents. This meant that the documents were invalid and therefore staff were administering these medications without authorisation. This is contrary to the guidance provided by the Medicines and Healthcare Products Regulatory Agency (MHRA), which regulates medicines and medical devices, and by the National Institute for Health and Care Excellence (NICE).
- Radiology staff were administering medication (buscopan) prior to treatment with no prescriptions. This was an antispasmodic medication for relieving pain and spasms in the stomach and bowel. We had found the same situation at Watford General Hospital and had informed senior managers. Staff told us they had been contacted by managers after we had raised this with them and they had not known that a prescription was needed and did not have a written copy of safety questions to ask.

Records

- On the reception desk in cardiology outpatients we saw there were over ten patient notes. Records were placed upright in plastic boxes with patient's personal information visible on a paper protruding from the record. Anyone standing at the desk could read this information.
- Records in the outpatient's department were stored inappropriately; records were stored in areas that were not secure; office and storage rooms were unlocked for cleaning and patient notes were kept on open shelves or left stacked on portable trolleys. Patient's personal information could be viewed or removed by unauthorised people accessing the room. Records were not stored appropriately or safely.
- Concerns were raised with us by staff and patients that said they had to wait to be seen as records had not turned up and sometimes patients were seen without their records. For example: The trust were aware of concerns as they had been put on the risk register in September 2012 and again in August 2014 where it stated that they had "persistent issues with patient medical notes being unavailable, missing, lost, damaged, have not been filed correctly, which will include the incorporation of other patient medical notes. Not all the relevant notes were available for the clinic and files were too large for all outpatient sites". This was confirmed by the trust information we saw that stated that the "current system was not effective" for tracking patient notes. The trust had stated on the risk register that they planned to audit the number of missing notes; however this information was not available as audits had not yet started. The trust had plans to audit the number of missing notes. We saw that some audits had started and we were informed this was a work in progress.
- Incidents were not always reported in line with trust policy. The trust "incidents and serious incidents reporting management policy" policy stated that "all patient safety incident", For example; "patients? notes lost, unavailable, incomplete" should be reported on the trust's electronic incident reporting system. We saw that records were sometimes not available for clinics or the wrong records arrived and an action point on the trust risk register stated that incident reports for missing records should only be completed "where mass files were unavailable". This meant that the trust would not be individually reporting on every record that met the above criteria and therefore would not have an accurate record of the extent of the problem.

Outpatients and diagnostic imaging

Safeguarding

- Staff were aware of their role and responsibilities and knew how to raise matters of concern appropriately.
- The senior nurse in the radiology outpatients department described a safeguarding incident a member of staff dealt with and the procedure that was followed.
- Staff were aware of how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- We saw there were safeguarding policies in place and clear procedures to follow if staff had concerns.
- We saw safeguarding was included in the on-going mandatory training. Senior staff informed us dates were being arranged to capture all outstanding training. Staff confirmed they had received a copy of the safeguarding policy.

Mandatory training

- Staff told us that their mandatory training was up to date. The trust provided information after the inspection that showed outpatient service staff were compliant with mandatory training.

Assessing and responding to patient risk

- Outpatients and diagnostic imaging services had not identified all risks to service users, and those identified were not being managed effectively.
- Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for elderly or frail patients with more than one medical condition.
- The emergency trolley was kept in a clinic room that was used by staff and patients for treatments. It was not kept in the corridor as staff told us children had tampered with it in the past. Records showed the trolley was checked daily.
- Processes were in place within outpatients to manage patients who deteriorated or became unwell in the department. There was an emergency response team in place who could be summoned rapidly.
- We observed two radiographers following the ionising radiation (medical exposure) regulations (IRMER) that requires radiographers to routinely check previous images before continuing with a scan or x-ray. Incidents discussed at the "radiation summit meeting" suggest some radiographers are not routinely doing this. The outcome from this summit did not suggest any changes to protocols or practice to minimise risks for patients.
- Staff said they knew about the trusts lone working policies and adhered to them. No concerns were raised by staff.

Nursing staffing

- Extra clinics were required to meet the needs of the local area and this was often covered by permanent staff working over and above their normal contracted hours.
- Most nursing staff told us that although they were busy, they felt they provided good and safe patient care in outpatients
- Some outpatient nurses felt that staffing was generally sufficient but when clinics were overbooked then they did not have enough staff to manage this.
- Temporary staffing percentages across all outpatients were around 12% for agency and 1.5 % for non-medical bank.

Medical staffing

- The individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.
- Consultants were supported by junior colleagues in some clinics where this was appropriate.
- The individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.

Major incident awareness and training

- The trust had a major incident policy which staff were aware of.
- There were business continuity plans in place to ensure the delivery of the service was maintained.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate this service for effectiveness.

People were at risk of not receiving effective care or treatment. Staff did not always have the complete information they need before providing care and treatment.

The outcomes of people's care and treatment were not always monitored regularly or robustly. Systems to manage and share care records and information were cumbersome and uncoordinated. For example: radiology staff were unable to access the main IT system to view patient's full medical history and were reliant on information provided by the referrer.

Staff worked well together in a multidisciplinary environment to meet people's needs. Information relating to patient's health and treatment was obtained from relevant sources prior to clinic appointments.

Evidence-based care and treatment

- We saw integrated care pathways for cardiac devices, cardiac catheterisation, ablation/electrophysiology studies and day case angiogram. These followed NICE guidelines on best practice.
- Protocols were in place for radiology examinations such as orthopaedic x-rays.
- We saw protocols in place to ensure fast tracking where there were significant imaging findings for known or unknown cancer diagnoses, as well as severe abnormalities relating to benign or malignant growths. These findings were reported to the referrer and passed immediately to the multidisciplinary team for review and action. We saw evidence staff were following the guidance.
- We compared the practice we saw with the Society and College of Radiographers' recommendations and saw that the department's practice was in line with professional guidance.

Pain relief

- Pain relief could be prescribed within the outpatient's department and subsequently dispensed by the pharmacy department.
- Patients could be referred to the pain management clinic if assessed as needing this by their consultant.

Patient outcomes

- For the period June 2013 to June 2014 the trust ratio between new and follow up patient appointments was similar to England average.

Competent staff

- Trust data that showed completed appraisal rates across different departments was not available.
- Some staff told us that they had received an annual appraisal and that it was a useful process for identifying any training and development needs. Staff in the radiology department told us they had yearly appraisals.
- An induction process was in place for new staff. We spoke with one staff member who told us that they found both the trust wide induction and their local induction useful.
- There was evidence that staff competency was checked on recruitment there were opportunities for further training. We found examples of multidisciplinary working both within and across teams.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together. For example; staff told us they helped each other in the clinics. If one clinic was very busy then staff would support patients if they needed it and share information to ensure the right information was available for doctors.

Seven day working

- The outpatients department was open from 8.30am to 5pm, Monday to Friday. However, extra clinics were also scheduled in the evening and at weekends to meet the needs of the local population. These were mainly staffed by current trust staff working additional hours.

Access to information

- Information radiology received about patients was dependant on the referrer including all personal information and relevant information, such as any

allergies, health issues that might impact on their treatment. They had their own IT system which did not allow them access to all patient information available to the trust. This meant that if the referrer did not include relevant information the radiologist would not know unless the patient was able to explain themselves. This meant that when the electronic referral information was not accessible staff would follow the Business Continuity Plan to ensure that patients were not inconvenienced. We saw incidents that had been reported where the wrong personal information had been included on the referral.

- Referrals for x-rays and scans were received as either paper or as an electronic referral. Referrals that came in by paper were put onto the system by administration staff. Staff told us the IT system was unreliable and they would have periods without being able to access it. The trust told us when the electronic referral information was not accessible staff would follow the Business Continuity Plan to ensure that patients were not inconvenienced.
- Administration staff told us about the challenges in their department. We were told that referrals to clinics for example cardiology clinics had grown rapidly. Managing the workload and storage issues was a huge pressure for staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at the radiography department's policy on consent. Radiographers told us that they followed the policy to ensure that patient consent was gained for each scan or procedure. We observed staff following this policy as they gained consent from patients.
- Staff received training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and were confident about seeking consent from patients.
- Staff were able to explain benefits and risks in a way that patients understood.
- We saw training records that evidenced that staff had undertaken training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic.

Are outpatient and diagnostic imaging services caring?

Good

We rated this service as good for caring.

Patients were treated with privacy and dignity. We found that staff were approachable, kind, polite and friendly. Staff had a good awareness of patients with complex needs. We observed staff took extra time to communicate with patients if they needed it and saw that staff were aware that patients with complex needs may need additional support.

Patients we spoke with told us that the staff were "very good" and the outpatient's survey results contained positive comments about the caring ability of the staff in outpatients and diagnostic imaging services.

In ophthalmology waiting times were written on a small whiteboard board outside clinic rooms. We observed staff regularly updated the times during our visit.

In other outpatients clinics on the same day; For example urology and cardiology we saw no information on how long patients might wait to be seen.

Compassionate care

- Patients were admitted into individual rooms so that they could discuss their procedure in privacy.
- We observed staff greeting patients in a friendly, but appropriate manner. Patients praised the staff and told us they were, "really helpful. And communicated well"
- We saw that clerical staff in clinics assisted patients promptly and were friendly and efficient in busy clinics.

Understanding and involvement of patients and those close to them

- We observed staff supporting one patient to understand their care and treatment in the ophthalmology department.
- Patients were aware of why they were attending the outpatients department.
- Patients were asked whether they wanted their family or friends to be present during consultation and treatment.
- We spoke with three patients about their treatment options. One patient told us they "just do as they are

told" and did not feel they were involved in decisions made about their care. Another patient told us they were encouraged to be part of the decision making process and were given information about what would happen.

- Several patients told us they had to wait a long time to be seen and when they did appointments were rushed which did not give them enough time. One patient who regularly attended the hospital told us they were normally seen within 20- 30 minutes but knew that some clinics had long delays. Another patient told us they saw the specialist nurse and always had to book months ahead to get an appointment. If they cancelled or needed to change it they were likely to have to wait another couple of months to be seen after that.
- We observed staff did not always inform patients of waiting times. Patients we spoke with told us they had waited two to three hours in some cases and not been told of delays. This caused them anxiety as they had paid for parking. One patient told us they were worried they would lose their place as had to go out to pay for more parking and never knew how long they would be waiting.
- We observed staff walk past patients who had to sit on the floor to wait as there was not enough seating and who clearly uncomfortable, staff present did not acknowledge this or offer any support.

Emotional support

- We observed staff speaking with patients about their condition and giving appropriate information.
- Staff had a good awareness of patients with complex needs and those patients that required additional support should they display anxious or challenging behaviour during their visit to outpatients.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated the service as required improvement for responsiveness.

The organisation of some clinics was not responsive to patient's needs.

Some patients were not able to access services in a timely way for an initial assessment, diagnosis or treatment.

Performance in meeting on the planned RTT was improving.

Some patients experienced long waits for some services. For example; dermatology and respiratory clinics frequently over-ran and some patients told us they had experienced long delays in their appointment time. Some clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled often several times.

Clinic non-attendance was in line with the national average.

Diagnostic waiting times were compliant with the national standard of 99% and no patient was waiting over six weeks at the time of the inspection.

Services were not always planned, organised or delivered in a way that met patient's needs. For example staff told us that it was difficult to arrange patient transport which was confirmed with patients we spoke with. Patients often waited hours to be collected from appointments

Patients who drove themselves to their appointment told us they found car parking difficult as the demand for spaces was high. Some people told us they had problems find the department due to poor signage.

Patients concerns and complaints did not always lead to improvements in the quality of care. For example: verbal complaints were not recorded so data provided by the trust would not give a true record of the number of issues or concerns raised by patients.

Service planning and delivery to meet the needs of local people

- There was no evidence that service was evaluated to ensure it met the needs of local people.
- There were no regular audits of service delivery or of feedback from patients to ensure the service met the needs of the local population.

Access and flow

- 2911 patients had their first outpatient appointment at Hemel during April. On average, they waited 35 days

(five weeks). By 30th April, there were 2491 patients waiting for their first appointment demonstrating the focus the trust had to improve performance in meeting on the planned RTT was improving.

- Between July 2013 and June 2014 the trust 'did not attend' (DNA) rates were similar to the England averages.
- Challenges in radiology included an increase in demand for imaging in CT, MRI and ultrasound referrals. There was an on call service; however, routine requests were not accommodated out of hours. Evidence we saw confirmed this.
- The trust did not meet its 18 week referral to treatment (RTT) standard of 95% from September 2013 onwards. The trust was consistently worse than the England average for that entire period. The trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standard.
- The national target for urgent GP referral is two weeks. However, the trust met this target between April 2013 and April 2014 and fell below the target between May 2014 and August 2014. Between September 2014 and January 2015 the trust had performed above the target.
- Staff told us that the trust did not collect full details for waiting times for RTT and follow up appointment timeframes for outpatient's appointments at Hemel. The trust told us that all patients on an 18 week pathway, including review patients were tracked and were reviewed weekly at the trust's Access meeting where actions were agreed to ensure all patients have a plan.
- The Board performance report for March 2015 showed the clinic cancellation rate as 13% which was worse than the trust target of 8%, the year to date figure for March 2015 was 11% of outpatients clinics cancelled.
- However, staff told us outpatient clinics were regularly cancelled often with little notice and there was no effective system to deal with it. They told us they did not always record this information on most of the clinics; however they had information on respiratory clinic cancellations. This showed that between January and March 2015, 510 patient appointments had been cancelled. This meant that patients would need to have new appointments booked. Any treatments they needed would be delayed and they would have to wait longer to be seen. However, the trust told us that some cancellations would have been made in order to bring patients in earlier.
- Staff did not know if anyone was responsible for checking that people might be at risk of their condition worsening because of the wait or cancellation of clinics as nobody monitored it.
- The central booking administration system was responsible for cancelling clinics. The process did not work as all patients did not get told their appointment was cancelled. Staff told us some patients regularly turned up for their appointments. Complaints from people who turned up were that they had not received a letter telling them the clinic was cancelled. Staff told us patients were angry and complained they had taken time off work and paid to park to be told there clinic had been cancelled.
- Overbooking of appointments was evident across all the outpatient clinics and staff told us this was so the trust did not breech the 18 week RTT target. Clinics were regularly overbooked with double and triple booked appointments. Consultants could have two or three patients for the same time slot. This meant patients had to wait for much longer periods than necessary and might not get the same consultation time as they would have if clinics had not been so busy.
- We saw clinic lists confirming overbooking of appointments and were told by staff and patients of frequent cancelled clinics in some specialisms.
- Staff confirmed that if appointments were double booked and running late then patients were less likely to get enough time with the doctor. One patient said they had waited between "one and two hours to see the doctor for four or five minutes"
- We found patients experience was variable dependent on which service they were accessing. The majority of examples were negative with patients waiting in clinic for long periods to be seen. Most patients identified waiting times as an issue.
- In radiology, the number of patients waiting for an examination was less than six weeks. This was better than the England average
- Between July 2013 and June 2014 the trust 'did not attend' (DNA) rates were similar to the England averages.

Outpatients and diagnostic imaging

- Challenges in radiology included an increase in demand for imaging in CT, MRI and ultrasound referrals. There is no out of hours on call service however, routine MRI and Ultrasound requests were accommodated out of hours.
- We were unable to gain full details for waiting times for referral to treatment (RTT) and follow up appointment timeframes for all outpatients' appointments at Hemel Hempstead. Staff said he trust did not collect this information. The trust told us that all patients on an 18 week pathway, including review patients were tracked and were reviewed weekly at the trust's Access meeting where actions were agreed to ensure all patients have a plan.
- The target for people waiting less than 31 days from diagnosis to first definitive treatment is 96%. The trust achieved the performance standard with the exception of May 2014 from April2013 to June 2014.
- The target for people waiting less than 62 days from urgent GP referral to first definitive treatment was 85%. The trust performance has not been below the England average since April 2014 but there was a poor performance of 76% for in January 2015, but since then trust performance has been better than the England average.

Meeting people's individual needs

- The reception area at the entrance to main outpatients was well signposted and clear, however signage in some other areas of the hospital was either absent or confusing. For example, we could not find our way to toilets on the ground floor and had to ask several members of staff before locating them. We saw feedback from patients that had raised concerns about signage at the hospital.
- Staff told us that most outpatient clinics were regularly overbooked, with ophthalmology, dermatology, cardiology and respiratory clinics most under pressure due to demand. Staff told us there were not enough doctors to manage the waiting list. There was not enough nursing staff to cover the clinics when they were overbooked and they were encouraged to work extra shifts.
- Overbooking of appointments was evident across all the trust outpatient clinics. Staff said that ophthalmology and respiratory clinic appointments were regularly double and triple booked due to the volume of people needing to be seen and there were long waiting lists.
- We saw urology clinic lists had patient appointments listed every five minutes and regular appointments doubled up. For example, two at 9am another at 9.05, 9.10 etc. and then two at 10am. Staff told us this was not long enough for some patients, for example frail and elderly patients could need that amount of time to get undressed before an examination.
- Staff told us the fracture clinic was always overbooked. One clinic the previous week to our inspection should have had 15 patients booked in. However it had more than tripled that number of patients booked. One patient told us their appointment was 11am and they did not get seen until 12.30pm. They said other people that arrived after them were seen before them. There had been no communication as to how long they had to wait or why there was a delay.
- Staff told us outpatient clinics were cancelled with little notice and there was no effective system to deal with it. Staff responsible for booking respiratory appointments at the hospital told us clinics were repeatedly cancelled and rebooked. The patient was due to be seen in the thoracic clinic in September 2013; appointments were cancelled and then booked again for February 2014 and April 2014. They were 15 months overdue for a 6 month check-up.
- Reasons for cancellations given by staff included: Consultants not turning up, appointments being booked as if they had two or more doctors available when only one consultant and they did not have enough doctors to cover the demand. Staff were under pressure from managers to provide extra clinics and one told us they "do not care how".
- Information from the trust was available on how many respiratory clinic appointments had been cancelled. Between January 2015 and March 2015, 651 appointments were cancelled. This meant that patients would need to have new appointments booked. Any treatments they needed would be delayed and they would have to wait longer to be seen.
- Administration and nursing staff told us they dealt with the verbal complaints from patients about waiting times and cancelled clinics. Two staff told us "patients turn up every week, sometimes nine or ten and so far this week one member of staff had three people booked onto an ear, nose and throat (ENT) clinic that turned up for

cancelled clinics." Concerns had been raised with management but staff said "nothing ever changed". We spoke with the manager who confirmed they knew there was a problem.

- The central booking administration was responsible for cancelling clinics. The process did not work as all patients did not get told their appointment was cancelled.
- Staff told us patients were not told why clinics were cancelled and not given any information to contact them if their condition deteriorated. We saw the generic appointment letter sent out by administration staff and it did not mention what patients should do if their condition deteriorated. GP's were not informed of delays.
- Staff did not know if anyone was responsible for checking that people might be at risk of their condition worsening because of the wait or cancellation of clinics as nobody monitored it.
- Radiology staff were unable to access full patient's case notes and care and risk assessments as they did not have permission to do this. They could only see what the referrer had written on the referral in their local IT system. The trust told us Radiology staff have access to PAS and Clinicom to access the full patient record. Staff were also able to access the referral system (ICE) to source the information required.
- Patients told us that it was not easy to access translation services and they were expected to bring a family member with them who could translate. We saw that information displayed on trust noticeboards said that services were available on request. Feedback from patients groups highlighted lack of access to translation services.
- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any recommendations for treatment. These could be provided in different formats if required. For example large print.
- We observed staff speaking with people about their condition and giving appropriate information.

Learning from complaints and concerns

- Most complaints were about delays in clinics. Staff and patients told us most were verbal and dealt with at the time. However staff said they highlighted concerns with line managers but said the same situations continued to happen and nothing improved.
- The trust "I want great care" (iWGC) survey asked people for feedback on their visit. Staff told us they had to give patients a form on every visit. Several staff told us patients regularly refused to complete them as said they had done before and complained and nothing changed. "It was a struggle to get people to complete them and they often found them on the floor under peoples seats".
- Initial complaints were dealt with by reception staff and if more serious by the outpatient senior staff. If they were unable to deal with the person's concerns satisfactorily, they would be directed to the Patient Advice and Liaison Service (PALS). If the person still had concerns, they would be advised how to make a formal complaint.
- Feedback from an external "listening event" held to gather patient's views about the trust highlighted concerns from patients commenting that "they often don't answer the phone and when messages are left they don't always phone back". We saw an example of this on the trusts respiratory complaints list that stated the complaint was about postponements of outpatient appointments. The patient contacted the consultant's secretary and PALs with no outcome. Then waited 14 months for appointment.
- Complaints were not handled in line with the trust's policy. This stated that the (PALS) will "provide advice and support" and that when a "concern needs to be escalated to the clinical team or department to assist resolution... These concerns usually need a rapid investigation; a response can often be given verbal". Feedback from staff and patients was that verbal complaints were not recorded or passed onto PALS so data provided by the trust would not give a true record of the number of issues or concerns raised by patients.
- PALS leaflets were available in some of the waiting areas. These informed patients of the PALS service and invited patients to provide feedback and comments. All those we saw were written in English.
- In all the areas we visited poster information on how to make a complaint was displayed. Most patients we spoke with had seen the posters.

Outpatients and diagnostic imaging

- Staff confirmed that they were aware of some complaints and had received feedback via the staff meetings.
- In radiology complaints were discussed in staff meetings. We saw minutes of these and evidence of learning, for example, wrong information on referral that had not been checked with the patient correctly. There was a discussion regarding the correct procedure and signposting to the relevant policy. Changes had been made in the way checks were done using a "6 point test" to ensure the correct personal details were known.

Are outpatient and diagnostic imaging services well-led?

Inadequate

The service was rated as inadequate for being well-led.

Significant issues that threatened the delivery of safe and effective care were not identified and adequate action to manage them was not always taken.

There was no effective system for identifying, capturing and managing issues and risks at team, directorate and organisation level.

Whilst there was a statement of vision and guiding values. Most staff were not aware of or did not understand the vision and values. However, staff were aware of the practice ethos to provide a caring and responsive service.

There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported and appreciated. Most staff told us that they had not been listened to on key service changes and that outpatients had not been a priority for the trust. However two staff highlighted improvements in morale over the last few months and felt changes were beginning to happen and they had good support from their immediate line manager.

Staff told us that the managers were approachable and the culture within the service was seen as open and transparent.

There was a commitment from the managers to learn from feedback, complaints and incidents. However, some staff told us they did not record verbal complaints and they had little if any feedback on incidents.

Quality and safety were not the top priority for leadership. The impact of service changes on the quality of care was not well understood. For example, all staff told us the main priority for the trust was to ensure patients did not breach the 18 week referral to treat target (RTT) target. Staff could not provide evidence to suggest this strategy was underpinned by any detailed, realistic objectives and plans. However, the trust told us that since January 2015 they had taken significant improvement actions regarding RTT and at the time of the inspection they were on trajectory to meet the standard.

Information on complaints was unreliable as all patient complaints were not recorded. There was minimal engagement with people who used services.

Vision and strategy for this service

- Staff said they were aware of the trust's strategy which was discussed during appraisals but could not give us any detail on what that meant in their work.
- Staff were loyal and keen to support the trust in implementing changes. However, other staff said they did not feel there was an overall strategy and everyone in their own specialities was doing their own thing.

Governance, risk management and quality measurement

- On the trust's risk register we saw that all risks were rated according the likelihood of them happening and their risk to the patients, business continuity, or staff. There was a completion date for all risks; however, very few of them appeared to have regular updates of progress. This meant that the trust's board may not have had current oversight of risk or assurance the risk was being managed or minimised.
- Risks identified by staff and known to the trust were not all on the risk register. There was a significant difference in what staff raised as concerns and what were recorded as risks. For example: double and triple booking of appointments in a number of different outpatients departments, leading to long delays to be seen.
- Radiology reviewed their risks at their monthly multi-disciplinary meeting. We saw minutes of meetings that confirmed this.
- A review due to take place in September 2014 did not take place. This was repeated in February 2015 and March 2015 to ensure Radiology of their compliance with the WHO guidance.

Outpatients and diagnostic imaging

Leadership of service

- Some staff told us they did not feel felt well supported by their managers and that the managers were not always available to assist if they had a concern. Other staff said immediate line managers did listen but then nothing happened after that and the issues continued. Managers we spoke with at both middle and at senior level whilst they understand the challenges could not identify the actions they needed to make to ensure all patients have good quality care.
- Not all staff we spoke with were clear about their roles and understood what they were accountable for.
- Outpatients as a service was managed by the divisional director. Day to day management was the responsibility of each individual division and these management groups meet monthly. Staff told us there were no meetings where issues and concerns could be shared and a joint strategy identified to address the issues around overbooking, cancellation of clinics and long waiting times for patients. However the trust told us that issues relating to clinics and waiting times were discussed at weekly Access Meetings which were minuted.
- Staff in outpatients were concerned that repairs and maintenance took a long time to get done after the initial visit. Getting them to return after their initial visit to fix anything was difficult and sometimes things never got sorted.
- The trust had polices in place to ensure people were not discriminated against. Staff we spoke with were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.
- Communication between senior and middle managers and staff was not good. Staff told us it was difficult to get concerns discussed and actions taken when they highlighted issues that impacted on patients and staff.
- Staff in outpatients said they tried to work together to resolve any conflict and everyone shared the responsibility to deliver good quality care.

Culture within the service

- Some staff told us they were not consulted and were not clear how decisions were made. For example: the addition of extra clinics meant staff were pressurised and clinics ran later meaning staff were unable to go home on time. Staff told us this happened on a regular basis and they had complained about the impact on staff and patients but staff said complaints to their manager had made no difference as the same things still happened and nothing improved.
- Staff told us they worked well together and there was obvious respect between different roles and responsibilities within the multidisciplinary teams working in the different outpatient departments.
- Throughout the inspection, all staff were welcoming and willing to speak with us.
- Staff in some clinics were unhappy as did not feel the service they gave to patients was good enough and they had no control over what happened. Some staff told us they felt well supported at a local team level and highlighted individual senior managers who were contributing to making change happen as the trust restructured.
- Staff raised concerns about the impact of recent re-organisation that had involved changes of job roles. Managers had had to take on additional responsibilities without any additional training or support.

Public and staff engagement

- Targeted patient surveys had not been undertaken to measure quality and identify areas for improvement within the services.

Innovation, improvement and sustainability

- Staff told us that financial pressures had compromised care and that repairs and maintenance were not followed through because of budget pressures.
- We were unable to gather enough relevant information to make a view on how the impact on quality and sustainability is assessed and monitored when considering developments to services or efficiency changes.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had introduced a pilot pre-operative reminder telephone call service. The patient was called three days prior to their surgery for reminders and checks. Staff said if the service proved successful then it would become permanent.
- Staff had recognised patient's frustration regarding their length of wait for surgery. This resulted in staff creating and had produced a letter informing patients that their appointment time is not their theatre time.
- The service had systems in place to minimise patient visits to the hospital. For example, all negative results were reported by phone for eye tests, ear nose and throat and oral surgery.

Areas for improvement

Action the hospital MUST take to improve

- Review the governance structure for all services at the hospital to have systems in place to report, monitor and investigate incidents and to share learning from incidents as well as complaints.
- Ensure that governance and risk management system in all services to reflect all current risks in the service and all staff are aware of the systems.
- Ensure that there is an effective audit program and the required audits are undertaken by the services.
- Ensure all patients arriving at the UCC are seen by a clinician in a timely way.
- Ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to ensure people who use the service are safe and their health and welfare needs are met.
- Ensure that medicines are always administered in accordance with trust policy.
- Ensure that all staff have received their required mandatory training.
- Ensure all staff are supported effectively via appropriate clinical and operational staff supervisions systems.
- Review the cancellation of outpatient appointments and take the necessary steps to ensure that issues identified are addressed and cancellations are kept to a minimum.
- Review waiting times in outpatients' clinics and take the necessary steps to ensure that issues identified are addressed.
- Ensure that patients' records are stored appropriately in accordance with legislation at all times.
- Ensure that all equipment has safety and service checks in accordance with policy and manufacturer' instructions and that the identified frequency is adhered to.

Action the hospital SHOULD take to improve

- Involve the service in wider organisational planning regarding major incidents and include in trust wide plans or training simulations.
- Enable all staff to access appropriate developmental training opportunities as required.
- Ensure all patients have an accurate record of their needs in place, include pain assessments.
- Ensure that staff understand their responsibilities to report all incidents.
- Ensure that all food products are disposed of when they have expired used by dates.
- Ensure that information on how to complain is accessible to patients in all patient areas within the hospital.
- Review issues identified and associated with transport problems when accessing outpatient appointments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1)(a),(c),(f),(g) HSCA 2008 (Regulated Activities) Regulations 2014 **Safe care and treatment** Care and treatment must be provided in a safe way for service users ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. There were concerns regarding timeliness of assessing the health and safety of service users of receiving the care or treatment in UCC. Medicines were not stored safely. Patients in radiology were being routinely being given medication without a prescription or a patient group directive in place.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1)(b),(c),(e) HSCA 2008 (Regulated Activities) Regulations 2014 **Premises and equipment** All premises and equipment used by the service provider must be suitable for the purpose for which they are being used. Concerns were found regarding the suitability of the premises in end of life care.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a),(b),(c) HSCA 2008 (Regulated Activities) Regulations 2014 **Good Governance** Systems or processes must be established and operated effectively to ensure compliance with assessing, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity, maintaining and keeping secure appropriate records and evaluating and improve their practice in respect of the processing of the information The regulation was not being met because governance arrangements for auditing and monitoring clinical services were ineffective and unclear. Although there was some evidence of nursing audit and learning, information and analysis were not used proactively to identify opportunities to drive improvements in care. Risks identified were not always responded to in a timely manner. Records were not stored in accordance with trust procedures.
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1), (2),(a),(b) HSCA 2008 (Regulated Activities) Regulations 2014 **Staffing** Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed and receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Requirement notices

Staffing was not always optimum in medicine. There was not a robust system in place for staff supervision and appraisal across all services. Not all staff had had mandatory training as required by the trust's policies. Opportunities for developmental training was limited.