Imperial College Healthcare NHS Trust

Hammersmith 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

Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Hammersmith Hospital is an acute teaching hospital located in East Acton, London. the hospital was founded in 1912 and is currently a part of Imperial College Healthcare NHS Trust. The trust's central outpatient departments were located at St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital which were overseen by a single leadership team (Lead Nurse, Clinical Director and General Manager), with dedicated clinical and administrative leadership teams based on each site.

Our last comprehensive inspection of the trust was undertaken in September 2014 when we rated the outpatients and diagnostic imaging service at Hammersmith Hospital as inadequate. The purpose of this focused follow-up inspection was to inspect core services that had previously been rated as inadequate.

During this inspection we found the service had improved. We rated the outpatients and diagnostic imaging service at Hammersmith Hospital as good overall.

Our key findings were as follows:

- Outpatient staff learned from incidents by monitoring and discussing them at departmental meetings. The senior sister sent a newsletter staff in the department which included information about the results of incident investigations and the key learning points.
- Staff we spoke with were aware of the: 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended IR(ME)R trust policy, and how to access it.
- The trust's Executive Quality Committee monitored the number of IR(ME)R incidents. Incidents were investigated and actions were put in place to reduce similar incidents occurring in future.
- 83% of staff working in outpatients felt encouraged to report errors and near misses.
- Clinical areas in the outpatient department were clean and tidy and staff told us they were responsible for ensuring clinic rooms were cleaned daily. Managers had been unhappy with the cleanliness of the department and had put a cleaning programme in place.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients.
- There were warning signs informing staff and patients not to enter rooms when x-rays and other diagnostic test were underway. These were illuminated when the room was in use so that staff and patients knew not to enter.
- We found that medicines at the location were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad. Medicines were stored in a safe manner.
- At our inspection in September 2014 we found records were not always available in clinic when patients attended for their appointment. At this inspection we found the trust were moving towards an electronic system for all patient records and the retrieval of paper records had improved.
- Arrangements were in place to safeguard patients from abuse.
- Nursing and medical staff accessed advice from the medial assessment unit. Patients were admitted if their condition required the level of care which could only be provided on a ward.
- The diagnostic imaging service used diagnostic reference levels (DRL's) as an aid to
- optimising patients exposure to radiation. The levels of radiation for procedures were on display.
- Managers were auditing incidents where the diagnostic reference levels were exceeded.
- Staff in diagnostic imaging were aware of NICE guidelines and evidence based guidelines were in place.
- The diagnostic imaging department were working towards achieving the Royal College of Radiologist Imaging Accreditation scheme.
- Staff in the outpatient department used pathways which were based on national guidance. For example smoking cessation was discussed with patients attending the cardiology clinic.

Summary of findings

- At our previous inspection we found clinics often started late but the trust were not monitoring this. At this inspection we found the trust had started to monitor when clinics started and how long patients were waiting.
- Staff had developed a process for updating patients every thirty minutes if a clinic was running late and patients appreciated being kept informed.
- A strategy had been developed for diagnostic imaging setting out a five year plan which included amongst other things, a plan to extend the service during weekdays and introduce weekend working.
- The outpatient improvement programme was having an impact on bringing about change.
- An outpatient service level agreement had been developed which set out how the central outpatient service and specialist teams would work together to meet the targets in a new performance framework.

We saw areas of outstanding practice including:

- The trust was transforming outpatient service across the trust through the outpatient improvement programme. A Patient Service Centre was being set up as the first point of contact for patients and plans had been developed for improvements to clinic environments, improving the quality and content of patient communication, increasing the availability of patient notes and monitoring clinic start and finish times.

However, there were also some areas of practice where the trust needs to make improvements:

- The trust should improve performance against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and the 62-day GP referral to first treatment standard.
- The trust should improve performance against referral to treatment time (RTT) for non-admitted pathways for outpatient services.
- The trust should improve performance agains treferral to treatment time (RTT) for non-admitted pathways for outpatient services.
- The diagnostic imaging service should ensure they comply with updated guidance; for example, the Royal College of Radiographers guidance on x-raying patients with longstanding lower back pain.
- The trust should reduce waiting times for patients in outpatient clinics.
- The trust should reduce the number ofoverbooked or cancelled clinics.
- The trust should ensure the temperature of the outpatients clinic department is a comfortable temperature for patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Hammersmith Hospital

Detailed findings

Services we looked at
Outpatients and diagnostic imaging

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Hammersmith Hospital	5
Our inspection team	6
How we carried out this inspection	6
Our ratings for this hospital	6

Background to Hammersmith Hospital

The main outpatients department of Hammersmith Hospital is located on the ground floor with four clinic areas and 35 consulting rooms. The general outpatients department saw about 260,000 patients per annum.

There were 262,152 outpatient appointments at Hammersmith Hospital between April 2015 to March 2016.

Outpatient services includes all areas where patients are referred for investigations and diagnosis or for follow up care. Some patients are listed for admission following their visit to outpatients or they may attend on a regular basis for treatment of monitoring over time.

The general outpatients department includes a range of specialist medical teams such as oncology, cardiology, respiratory medicine, endocrinology, gastroenterology, neurology and diabetes. A phlebotomy service for taking blood samples was provided within the department.

A pharmacy was located at the entrance to the outpatient department where patients could take their prescriptions and collect their medicines.

The diagnostic imaging department was located on the first floor above the main outpatient department. The service included CT scanning, interventional radiography, ultrasound and magnetic resonance imaging (MRI). One MRI scanner was located in a portable extension which could be relocated on the site or transferred to another location if required.

The nuclear medicine service was not operating when we inspected. A new facility was planned to accommodate this.

We inspected the outpatient and diagnostic imaging departments over three days.

We spoke with 19 patients and three family members or carers. In addition, we spoke with 22 members of staff including managers, doctors, nurses, medical secretaries, administrators and receptionists.

We observed care being provided and looked at 18 care records in the outpatient department and diagnostic imaging.

We also reviewed performance information about the hospital.

The main outpatient department had two reception and waiting areas for four outpatient clinical areas each of which had 8 clinical consulting rooms.

The section of the OP area where dermatology clinics take place includes two minor procedures rooms, one of which is also used for laser treatment.

There were 262,152 outpatient attendances at the Hammersmith hospital between April 2015 and March 2016. The largest number of patients were in dermatology which saw nearly 14,000 patients. The smallest number of patients were in diabetes.

There were 80,148 attendances in diagnostic imaging.

Detailed findings

Our inspection team

Our inspection team was led by:

Inspection Manager: Michelle Gibney, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultant physician, consultant cardiologist, consultant pathologist, superintendent radiographers, diagnostic radiographer, nurse matron, nurse outpatients manager, senior nurse manager, pharmacist and an Expert by Experience

How we carried out this inspection

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

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

We carried out this inspection as part of our routine focused inspection programme. We carried out an announced inspection on 22, 23 and 24 November 2016.

Before visiting, we reviewed a range of information we held about the hospital.

During the inspection we talked with a range of staff throughout the outpatient and diagnostic imaging department, including senior managers, clinicians, nurses, healthcare assistants, administrative staff and volunteers.

We also spoke with patients and relatives of those who used the outpatient and diagnostic imaging services at Hammersmith Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Outpatients and diagnostic imaging

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

Information about the service

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There were 80,148 attendances in diagnostic imaging.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as good because:

- Outpatient staff learned from incidents by monitoring and discussing them at departmental meetings. The senior sister sent a newsletter staff in the department which included information about the results of incident investigations and the key learning points.
- Staff we spoke with were aware of the: 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended IR(ME)R trust policy, and how to access it.
- The trust's Executive Quality Committee monitored the number of IR(ME)R incidents. Incidents were investigated and actions were put in place to reduce similar incidents occurring in future.
- 83% of staff working in outpatients felt encouraged to report errors and near misses.
- Clinical areas in the outpatient department were clean and tidy and staff told us they were responsible for ensuring clinic rooms were cleaned daily. Managers had been unhappy with the cleanliness of the department and had put a cleaning programme in place.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients.
- There were warning signs informing staff and patients not to enter rooms when x-rays and other diagnostic test were underway. These were illuminated when the room was in use so that staff and patients knew not to enter.
- We found that medicines at the location were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad. Medicines were stored in a safe manner.
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- optimising patients exposure to radiation. The levels of radiation for procedures were on display.
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- The diagnostic imaging department were working towards achieving the Royal College of Radiologist Imaging Accreditation scheme.
- Staff in the outpatient department used pathways which were based on national guidance. For example smoking cessation was discussed with patients attending the cardiology clinic.
- At our previous inspection we found clinics often started late but the trust were not monitoring this. At this inspection we found the trust had started to monitor when clinics started and how long patients were waiting.
- Staff had developed a process for updating patients every thirty minutes if a clinic was running late and patients appreciated being kept informed.
- A strategy had been developed for diagnostic imaging setting out a five year plan which included amongst other things, a plan to extend the service during weekdays and introduce weekend working.
- The outpatient improvement programme was having an impact on bringing about change.
- An outpatient service level agreement had been developed which set out how the central outpatient service and specialist teams would work together to meet the targets in a new performance framework.

However

- The Trust underperformed against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and underperformed against the 62-day GP referral to first treatment standard.

Outpatients and diagnostic imaging

- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was worse than the England average. The latest figures for July 2016 showed 85.4% of patients were treated within 18 weeks.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services has been worse than the England overall performance and worse than the operational standard of 92%. The latest figures for July 2016 showed 84.6% of this group of patients were treated within 18 weeks.
- Patient experience was mixed but many patients told us they had waited for a long time in clinic to be seen.
- Some patients also told us their appointments had been cancelled and re-arranged several times or they had arrived for their appointment to find the clinic had been cancelled.
- An outpatient improvement programme had been developed which had resulted in a number of improvements but many of the objectives had still to be achieved.
- At our previous inspection we found that governance and leadership was shared between the main outpatient department and clinical directorates with no clear leadership structure At this inspection we found management was still shared between managers in the main outpatient department and the specialties and divisions which contributed to a lack of clarity about responsibilities for making improvements. Staff involved with the outpatient improvement programme spoke positively about the changes and new systems being introduced but said not all staff working in specialties were using the systems.
- Waiting times for patients in clinic were still a problem with clinics being overbooked or cancelled.
- Several patients told us they had attended clinic in the summer months and found the temperature in the outpatient clinics uncomfortable. Temperatures sometimes reached 30 degrees. The risk to patients had been identified and funds identified to make improvement but were not yet in place. There were interim solutions in place, including fans and mobile air conditioning units. The outpatient clinic environment had been identified as the service's greatest risk to patient safety and welfare.
- There were four vacancies amongst radiography staff. Managers told us recruitment was difficult and they had been using locums to cover the vacancies.
- Diagnostic imaging were not always following new guidance for example the Royal College of Radiologists guidance on x-raying patients with long standing lower back pain.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Outpatient staff learned from incidents by discussing them at departmental meetings. The senior sister sent a newsletter staff in the department which included information about the results of incident investigations and the key learning points.
- Staff we spoke with were aware of the: 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended. 'IR(ME)R trust policy, and how to access it.
- The trust's Executive Quality Committee monitored the number of IR(ME)R incidents. Incidents were investigated and actions were put in place to reduce similar incidents occurring in future.
- 83% of staff working in outpatients felt encouraged to report errors and near misses.
- Clinical areas in the outpatient department were visibly clean and tidy and staff told us the clinic rooms were cleaned daily. Managers had been unhappy with the cleanliness of the department and had put a cleaning programme in place.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients.
- There were warning signs informing staff and patients not to enter rooms when x-rays and other diagnostic test were underway. These were illuminated when the room was in use so that staff and patients knew not to enter.
- At our previous inspection we were concerned about the management and storage of medicines. At this inspection we found that medicines at the location were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad. Medicines were stored in a safe manner.
- At our inspection in September 2014 we found records were not always available in clinic when patients attended for their appointment. At this inspection we found the trust were moving towards an electronic system for all patient records and the retrieval of paper records had improved.
- Arrangements were in place to safeguard patients from abuse
- Nursing and medical staff accessed advice from the medial assessment unit. Patients were admitted if their condition required the level of care which could only be provided on a ward.

Incidents

- Staff in diagnostic imaging were aware of a never event involving the incorrect siting of a naso gastric tube which had occurred some time ago but there were no recent never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The minutes of the Central Outpatient Directorate Quality and Safety Committee showed that work was being undertaken on the investigation and closure of incidents within 20 working days. There were concerns about the relatively low number of incidents reported for outpatient services. As a result the incident reporting rates from other services were to be circulated and staff were to be encouraged to report incidents.
- Staff in outpatients told us they had all been trained to record incidents on the trust's incident reporting system. Outpatient care assistants told us they preferred to report anything to the registered nurses who would complete the incident report. When we asked if all staff were encouraged to report incidents the senior sister told us they were. Outpatient care assistants were encouraged to report incidents themselves if they felt happy to complete the reports.
- We saw an analysis of incidents in diagnostic imaging for the period January to August 2106. There were 76 incidents reported in total. 60 incidents resulted in no patient harm, 11 resulted in low harm and one resulted in moderate harm. There were four near misses reported. The largest number of incidents related to problems administering contrast media. Six incidents related to incorrect information about a patient's GP or other administrative information which resulted in reporting delays.

Outpatients and diagnostic imaging

- The minutes of outpatient departmental meetings showed incidents were discussed for example when a patient collapsed and when a patient lost the prescription they had been given in clinic.
- There were 18 patient related incidents reported for the outpatient service for the period January-August 2016. 11 incidents were clinics which were overbooked and three related to delays in patient transport taking patients home at the end of the clinic. None of the incidents reported resulted in harm to patients.
- The senior sister in the outpatient department sent a newsletter to all staff in the department which included information about the results of incident investigations and the key learning points.
- The minutes of outpatient departmental meetings showed that incidents were discussed. For example, overrun clinics or patients who became unwell.
- Staff we spoke with were aware of the: 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended IR(ME)R trust policy, and how to access it. Senior staff were aware of their responsibilities to report radiological incidents involving unnecessary exposure of radiation to patients to the Care Quality Commission (CQC).
- The trust reported 14 Imaging related IR(ME) R incidents for all sites including the Hammersmith site between April 2015 and March 2016. These were made up of incorrect exams or protocols being used resulting in patients having repeat examinations and unnecessary exposure to radiation. In the main the exposures were small and resulted in no harm to the patient. IR(ME)R related incidents were reportable if the patient received 1.5 times more than the intended radiation dose or above (CT, Interventional radiology procedures) and 20 times more than the intended radiation dose for general x-ray procedures.
- We saw the Executive Quality Committee monitored the number of incidents and discussed how the number of ionising radiation incidents could be reduced.
- Staff within the diagnostic imaging department were able to describe examples of learning from incidents for example when an incorrect dose of radiation was given. Managers had reviewed the methodology and re-designed the process to reduce the risk of similar incidents occurring again.
- The diagnostic imaging service risk committee reviewed processes for requesting investigations to improve quality and safety.
- The results of a staff opinion survey carried out by the trust showed 83% of staff working in outpatients felt encouraged to report errors and near misses.
- Staff in diagnostic imaging and the outpatient department were aware of the duty of candour requirements and the importance of making patients aware an error had occurred.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

Cleanliness, infection control and hygiene

- Clinical areas in the outpatient department were visibly clean and tidy and staff told us the clinic rooms were cleaned daily.
- We observed checklists and 'clean' stickers had been completed to indicate when areas had been cleaned. Patients' toilets and waiting areas were clean and cleaning schedules had been completed to show the tasks undertaken. Outpatient care assistants were allocated responsibility daily for checking the cleanliness of treatment rooms at the beginning of each day and at the end of each clinic.
- We saw the list of scheduled cleaning tasks for the outpatient clinics. Staff within the outpatient department were allocated tasks to complete from the checklist. Staff had signed the sheets once they had completed their allocated checks. We saw records of similar checks carried out on the resuscitation trolley and drugs cupboards. Records of the checks were completed daily and weekly and showed these had been fully completed. The cleaning checklists included records of the rooms staff had cleaned.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients. Weekly hand hygiene audits were undertaken by the senior sister. When non-compliance with hand hygiene protocols were found, feedback was provided to the individual staff members.

Outpatients and diagnostic imaging

- We found all the curtains for drawing around patients in the treatment rooms were disposable and dated to indicate when they needed to be replaced. None of the curtains we saw were overdue for replacement.
- When inspected the x-ray rooms in the diagnostic imaging department, these appeared clean but we saw cleaning records had not been completed for two weeks.
- Hand hygiene audits were carried out in diagnostic imaging.
- Infection control monitoring was carried out by each clinical division. This included hand hygiene and compliance with the trust's bare below the elbow policy. Audits of the outpatient department were included in the figures for the women and children's division. These showed levels of compliance of 99% for bare below the elbows and 99% compliance with the trust's hand hygiene policies.
- Link nurses were responsible for infection control and the senior sister in the outpatient department carried out a weekly audit. The results were posted on a noticeboard in the department. The figures displayed showed 96% compliance with the cleaning audits carried out.
- Clinic rooms in the outpatient department where an MRSA patient was seen were not used again until the room had been deep cleaned. The senior sister told us they were responsible for ensuring the department was clean and they checked cleanliness daily. 'I am clean stickers' were attached to items of equipment dated on the day of our inspection. This meant staff knew the equipment was clean and ready or use.
- There were records of daily checks carried out on the resuscitation trolley equipment. These showed checks had been completed daily.
- Staff told us they could contact the cleaning department who would attend to clean up spillages.
- We observed staff washing their hands and they followed the trust's bare below the elbow policy. Staff were also used the sanitising hand gels.
- Personal protective equipment such as disposable gloves and aprons were readily available and we saw staff used these when caring for patients.

Environment and equipment

- The section of the outpatient department where dermatology clinics were held included two minor procedure rooms, one of which was used for laser treatment. The rooms had simple air conditioning without filtration so anything other than a simple surgical procedure was carried out in a suitable surgical area. There was a plan to use a different outpatient room with appropriate air filtration in place for more extensive outpatient procedures. The trust's risk register highlighted that there were specialised procedures being carried out in the environment for some group of patients treatment without sufficient preventative measures in place. We saw the trust had put a number of measures in place to reduce the risks to patients. These included appointing an external specialist company to provide the service with laser protection advice, ensure adequate numbers of staff had received laser safety training and there was a member of staff within the local nursing team was identified as a lead for laser safety.
- The risk register also highlighted problems with excessive heat and the lack of ventilation in the outpatient clinic with temperatures reaching 30 and sometimes 35 degrees. Several patients we spoke with told us they had attended in the summer months and found the temperature uncomfortable particularly when they waited a long time before being seen. We saw the trust had identified funds to improve the ventilation and the general environment in the outpatient clinics but the work had not taken place when we inspected.
- Equipment used to examine or treat patients was used only once and then discarded. A proctoscope was cleaned in the clinic using a local decontamination process. A risk assessment had been carried out to highlight any risks associated with the cleaning process and actions had been taken to minimise them.
- Waste was appropriately segregated and needles were disposed of in sharps disposal bins units which were signed, dated and were not overfilled.
- All the rooms in the diagnostic imaging department where imaging equipment was located had secure, controlled access. Staff accessed rooms using a code entered on to a key pad on the door.
- There were warning signs informing staff and patients not to enter rooms when x-rays and other diagnostic test were underway. These were illuminated when the room was in use so that staff and patients knew not to enter.
- Personal protective equipment (PPE) lead aprons, were available to staff for use to protect them from ionising radiation exposure.

- There was a large room where mothers could change their babies' nappies.
- Toilets were accessible for patients in a wheelchair.
- The diagnostic imaging department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Local radiation protection rules were available for staff to refer to. It was the responsibility of the radiation protection supervisor (RPS) to supervise work and observe practices to ensure compliance. The service was complying with the regulations.

Medicines

- We found that medicines at the location were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad.
- All medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures were within the recommended range of 2-8°C. We saw evidence that room temperatures were taken and below the recommended 25°C. This meant medicines were stored in a safe manner. In the treatment room we found completed weekly checklists for medicines (which had recently been introduced by the trust) which ensured effective medicines management.
- Staff had access to the trust pharmacy department for medicines information advice and medicines supply for unlicensed medicines. There was a pharmacy top-up service for stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- We found that medicines used for resuscitation and other medical emergencies (for example anaphylaxis) were readily available, accessible for immediate use and tamperproof. We saw evidence of weekly checks to ensure the appropriate medicines were stocked and had not expired.
- Arrangements for the supply of medicines were good. A private pharmacy contractor served all outpatient prescriptions on the ground floor. They were open between 09:00-18:30 Monday to Friday, and 09:00-13:30 on Saturday and Sunday. The latest figures provided showed that more than 75% of prescriptions were dispensed within 15 minutes, and more than 99% within 30 minutes. We saw that prescriptions were prescribed to patients electronically via Cerner® (The IT system at the trust), and also via paper based prescriptions. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Medicines errors and safety incidents were reported quarterly to the Medicines Safety Committee. These were reviewed and information to staff was communicated via a variety of channels such as newsletters, emails and face-to face monthly clinical governance meetings if required. We saw evidence that clinical staff had recently participated in a learning event for the administration of Sandostatin®(a medicine used in oncology) by subcutaneous injection. This demonstrated that staff had learnt from a training requirement to administer medicines safely to patients.

Records

- Outpatient care assistants(OCAs)were responsible for ensuring records were available, complete and up to date. OCAs updated electronic and paper records with height, weight and blood test results prior to patients being seen by medical staff.
- Diagnostic imaging staff told us about the 'pause and check' system used in the department and we observed this being used This was a clinical imaging examination IR(ME)R checklist for ensuring the correct procedures were always performed. Staff checked the patient identification details were correct, that the test was justified, the anatomical area, the system and equipment settings were all correct and that the radiation dose was recorded. We checked 10 patient records and found these had all been fully completed.
- We reviewed eight sets of records in the outpatient department and found these contained correspondence from GPs and relevant clinical histories. All the notes were clearly written, signed and dated by the clinician who had included their contact details. There were clear instructions for staff on how staff should complete patient records.
- We spoke to one member of staff who was allocated to records management who recorded when the patient arrived and confirmed the records were available for the doctor to collect when they saw the patient. The system recorded when the patient was seen by the doctor
- The trust used a clinical information system for recording patient information. This was used in addition to patients' paper records and was still being implemented across the trust.

Outpatients and diagnostic imaging

- The trust's risk register highlighted the risk of missing records. An audit was carried out which found between 1.5% - 2.2% temporary notes in use compared with a national threshold of 4% for the period April- August 2016. A separate audit was undertaken to review availability of clinical document on the electronic system for example referral letters. This showed on in sixty records had items of information which were missing. The outpatient service audited the completeness and availability of records regularly and planned to improve this as part of the outpatient improvement plan.
- The diagnostic imaging service used an electronic patient information system (RIS). Information could be shared with the other hospitals in the trust (St Mary's and Charing Cross). This meant cross site reporting could also be carried out. Cross site reporting was carried out at week-ends and out of hours.
- Patient information in radiology was stored electronically. We reviewed 10 patient records and found radiology staff had carried out safety checks, for example checking the correct information had been included on the referral and checks on women of child bearing age who may have been pregnant.
- We observed staff using smart cards when they were accessing patient information on the computer. They removed these when they left the reception area.

Safeguarding

- Arrangements were in place to safeguard patients from abuse. The trust's procedures were based on relevant legislation and local requirements. Staff we spoke with understood their responsibilities and adhered to safeguarding policies and procedures.
- The trusts clinical information system contained a safeguarding alert for children and adults when there were any safeguarding concerns.
- Staff were able to access the trust's safeguarding policy, copies were available in the outpatient department and radiology.
- Diagnostic imaging staff were aware of the trust's safeguarding policy and who they should contact if they had any concerns. Staff had level two training for safeguarding adults. The department did not provide a service for children. Prevent training had been provided for staff by the safeguarding team.
- MCA and DoLS training was included in level 2 safeguarding adults training.

Assessing and responding to patient risk

- The diagnostic imaging department had a protocol in place which staff followed if they found something unexpected or if a patient's condition deteriorated. Staff informed the patient's GP and the patient would be referred to accident and emergency or a multi disciplinary team within the hospital for assessment.
- Patients who became unwell in the department were admitted to a ward or were referred to the appropriate medical team if attending as an outpatient. Staff were required to complete a transfer form for handover.
- A room was allocated in the outpatient department for any patients who became unwell. The rooms used contained a couch and oxygen.
- The risk of IR(ME)R incidents occurring was reviewed regularly by the diagnostic imaging Risk Management Steering Group meeting and scored according to the number of incidents reported. AIR(ME)R incidents were also reported to the Radiation Protection Advisor who assessed the radiation dose the patient had received.
- There were clear protocols which staff in radiology and the outpatient department followed which included using the National Early Warning Score (NEWS) system to assess what interventions were required.
- Nursing and medical staff accessed advice from the on call medical registrar. Patients were admitted if their condition required the level of care which could only be provided on a ward.
- There were signs on display throughout the radiology department informing patients and staff when machines were working and where there was a risk of radiation exposure.
- There were notices in different languages in the department highlighting the risk of radiological tests for women who might be pregnant and staff asked patients if they might be pregnant before carrying out the investigation.
- The World Health Organisation (WHO) surgical checklist was being used in the radiology department as a safety check for all procedures that took place in the department. Compliance with the WHO checklist was audited. We saw the results of the audit were reported to the Imaging Risk Management Steering Group which showed 100% compliance at Hammersmith hospital.
- Diagnostic reference levels were audited by the radiological protection advisor.

- The hospital used a vacuum system for transporting samples to the pathology laboratory and we observed samples which carried a high risk of a transmittable disease were clearly labelled.

Nursing staffing

- Nurse staffing in the outpatient department comprised 15 outpatient care assistant posts and 8.4 professionally registered nurses. There was one vacant OCA post and one phlebotomy vacancy. An outpatient department assistant had recently been appointed and was due to take up post shortly. The other posts were full however two trained staff were on maternity leave. Vacant posts were covered by bank staff, employed by the trust, with experience of working in an outpatient department. There were no agency nurses used at the service.
- The senior outpatient nursing staff completed a weekly spread sheet with information about clinic cancellations as a basis to plan the outpatient nurse staffing requirements over the week.
- Nursing staff told us the staffing establishment had improved with the appointment of additional senior nursing staff. Support for staff for example with access to education had improved, together with improvements to environment has improved. Staff told us they were supported to maintain their competencies and access to mandatory training had improved.
- The outpatient department senior sister planned staffing levels to ensure sufficient numbers of staff were available to support the clinics. Staffing was planned according to the number of clinics, the number of appointments offered and in consultation with medical staff. When we spoke to the senior sister they told us they did not use a staffing acuity tool. They said there was no recognised best practice national acuity tool for safe staffing within outpatient areas. Safe staffing within the outpatient department was reviewed on a day by day basis by the clinical teams and any concerns were escalated to the senior nurses for resolution.
- The trust was beginning to monitor safe staffing in outpatient areas using the trusts e-roster system and was part of a national NHS improvement project to develop a model for safe staffing within outpatient areas.
- A skill mix review had been carried out which had resulted in the creation of additional outpatient department assistant posts. The senior sister had also developed a weekly clinic plan which showed each day's activities and which staff were allocated to clinics and tasks. Staff were familiar with the plan and with the clinic pathways used by each specialty to describe which tests and investigations or other tasks were required for each consultant and clinic.
- As at August 2015 and July 2016, the trust reported a vacancy rate of 13.6% in Outpatients; the vacancy rates ranged from 0% to 26.1% across reporting units trustwide.
- As at August 2015 and July 2016, the trust reported a turnover rate of 6.6% in Outpatients and 16.8% in Diagnostic Imaging. Turnover was greater among unqualified nursing staff in Diagnostic Imaging rather than qualified staff trustwide.
- As at August 2015 and July 2016, the trust reported a sickness rate of 4.7% in Outpatients and 2% in Diagnostic Imaging trustwide.

Medical staffing

- The clinical directorates were responsible for providing medical cover for clinics. The directorates identified the grade and number of medical staff required based on the number of patients who needed to be seen.
- Locum medical staff were used to provide cover on occasions, but the senior sister told us medical teams were relying less frequently on locums and providing cover within their own teams. Consultants supported by junior medical staff led most clinics.

Radiology staffing

- There were four vacancies amongst radiography staff. Managers told us recruitment was difficult. The service used agency staff to cover vacancies. Managers tried to use the same agencies and agency staff who were familiar with the department. The department was not supporting radiographers in training because of the staffing levels. The service had recently recruited to two of the four vacant posts. The new staff were due to start work at the service in January 2017. Managers told us agency staff were monitored for four weeks. There were two radiographers on duty out of hours and a duty radiographer.
- The imaging service did not operate a shift system for medical staff. Medical staff supported an agreed number of clinical sessions for an agreed range of subspecialties or specialisms. Junior medical staff were allocated according to subspecialties such as neurology or

gastroenterology depending on where they had reached in their training. Registrars were rotated approximately every 4 months into the different sub-specialities of radiology across the trust's three hospital sites.
- The vacancy rates for imaging staff trust wide were as follows: Imaging – All Areas (All Medical and Dental) 19.7%, consultant 6.8% and doctor (training grade) 30%.

Major incident awareness and training

- There were plans for dealing with major disruptions to outpatient services which meant patients could continue to be seen in the event of a major service breakdown.
- Staff were aware of the trust's major incident policy and training records showed staff had received training for major incidents

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate the effective domain because we are not confident we can collect enough evidence to make a judgement. However, we found the following areas of good practice:

- The diagnostic imaging service used diagnostic reference levels (DRL's) as an aid to optimising patients exposure to radiation. The levels of radiation for procedures were on display.
- Managers were auditing incidents where the diagnostic reference levels were exceeded.
- Staff in diagnostic imaging were aware of NICE guidelines and evidence based guidelines were in place.
- The diagnostic imaging department were working towards achieving the Royal College of Radiographers Imaging Accreditation scheme.
- Staff in the outpatient department used pathways which were based on national guidance. For example smoking cessation was discussed with patients attending the cardiology clinic.

However:

- Diagnostic imaging were not always following new guidance for example the Royal College of Radiographers guidance on x-raying patients with long standing lower back pain.

Evidence-based care and treatment

- Managers in the diagnostic imaging service told us they were working on achieving the Royal College of Radiographers Imaging Services Accreditation Scheme (ISAS) This is a patient focused scheme aimed at services improving the service provided to patients. The Department Of Health recommended that all radiology departments achieve accreditation. However, when we spoke with staff in the department they were unaware of the ISAS or ISO 9001 standards or the work that was underway to meet these standards.
- The diagnostic imaging service had adopted the use of diagnostic reference levels (DRL's) as an aid to optimising patients exposure to radiation. The levels of radiation for procedures undertaken in the department were on display.
- An audit of IR(ME)R incidents was carried out in February 2016. The audit found that most of the incidents were the result of human error. Root cause analysis had been carried out to identify the causes and these found a range of factors which had contributed to the errors. These included for example pressure of increased workload in terms of volume of examinations to be booked, insufficient time taken when booking and lack of attention to detail, requesting errors by referrers not picked up by imaging staff when protocolling or booking examinations. A range of actions were agreed to address the factors contributing to the errors including feedback being given to referrers who had made errors. The service had set a target of reducing reportable IR(ME)R incidents by 25% by March 2017.
- When we asked managers about the process for implementing national guidelines we found they were not familiar with the NICE image reporting guidelines. However, they were aware of recent NICE guidance on CT dosage and siting of naso gastric tubes. We also found the service was still carrying out x-rays on patients' spines for long standing back pain despite current guidance from the Royal College of Radiographers suggesting this was no longer considered appropriate practice.
- A policy had been developed for checking the correct siting of naso gastric tubes in response to NICE

guidelines. The policy required the siting of naso gastric tubes to be checked the radiology service. These were checked by radiology and the ward were informed if it was safe to use. However, no records were kept to indicate that the service had informed the ward.
- There were outpatient clinic guidelines and protocols for all staff to reference.
- We observed radiographers checking previous images and justifying the investigations, recording the information on the radiology information system (RIS) system. We reviewed 15 x–ray requests and found all were justifiable, according to Royal College guidelines.
- We reviewed the trusts records of IRMER regulations for staff. The versions we reviewed in the department were out of date and the procedure for inappropriate exposure of radiation to a patient documents did not provide guidance about the level of investigation required for example root cause analysis. When we asked managers about this they told us the documents were available via the trusts intranet.
- The diagnostic imaging department kept a list of non medical referrers. Incident reports were submitted if any inappropriate referrals were received.
- Staff in the outpatient department used pathways which were based on national guidance. For example smoking cessation was discussed with patients attending the cardiology clinic.

Pain relief

- The department did not keep pain relief medicines in the department. If a patient required pain relief medical staff provided a prescription and the medicine was dispensed by the pharmacy which was located just outside the outpatient department. Some patients told us they were unhappy because they had to wait for up to an hour for their medicine to be dispensed.
- Some patients were aware of the pain service run by the trust, base at Charing Cross hospital. They said they were told they could be referred to the pain service but there were long waits.

Nutrition and Hydration

- Nutrition and hydration needs were not routinely assessed as part of the outpatient process.
- The outpatient department's risk register highlighted the risk of patients receiving inadequate nutrition and hydration because of delays in clinic and patient transport and the lack of access to food and drink. The risk register highlighted that some patients were still waiting in clinic at eight pm in the evening.
- Water dispensers were available in waiting areas. Our inspection took place during warm weather. Some patients and carers had been waiting for over an hour to be seen but staff did not offer people drinks.
- The senior sister told us they offered patients a drink if they waited for a long time in clinic and they could order a meal from the catering department. However, one disabled patient we spoke withy told us they had spent eight hours at the hospital in outpatients and the patient transport lounge and never been asked if they would like a drink or something to eat. They were disabled and when they returned home they were unable to prepare any food.
- When we visited the patients transport lounge we saw there was a water dispenser and we observed staff offering patients warm drinks.

Patient outcomes

- There was a tracking system in place for patients who left the outpatient department without making a follow up appointment or for further investigations as requested by medical staff.
- The care and treatment provided was evidence based care and followed National Institute for Health and Care Excellence (NICE) guidelines where relevant. . For example smoking cessation was discussed with patients attending the cardiology clinic.
- Several patients we spoke with told us they had been referred to the hospital for specialist treatment which was not available locally.

Competent staff

- Diagnostic imaging staff told us they had appraisals annually. New staff were given a mentor and support when they started. They kept a training record as part of their induction.
- The senior sister kept records of the mandatory training staff completed. They told us staff had completed 98% of the trust's mandatory training requirements.
- Outpatient department assistants rotated between carrying out clinical duties, working on the reception desk and as a floor walker greeting patients when they arrived in the department. We spoke to three staff about this and they told us their knowledge of the

appointment system and clinic booking rules helped them answer patients' questions. Three patients we spoke with told us they appreciated being greeted by staff who were able to answer their questions and direct them to where they needed to be.

- Staff told us they had records of the training they received which described the level of competency they had achieved. Staff told us they had mentors who provided professional supervision. They said they met with their supervisor approximately every six months to discuss their clinical skills and development needs
- We saw examples of the competency booklets which were based on national guidance for outpatient care assistants.
- Staff told us they were supported and encouraged to develop. They said they were supported by their assigned mentors and the clinical nurse manager.
- Staff in diagnostic imaging told us if they were required to carry out a new role or procedure they received the appropriate training. There was an education team to support professional development and training.
- The results of a staff opinion survey carried out by the trust showed only 50% of diagnostic imaging staff reported that they were given regular helpful feedback by their line manager. 76% of staff working in outpatients said they had received feedback through appraisal.
- There was a poster on display showing local rules but staff we spoke with were unaware of these and what they meant.
- Laser competencies for practising clinicians were signed off every year and recorded in a log book within a laser procedures file which we looked at in the laser treatment room. The file also included local rules and a clinical check list that is completed by a clinician before every procedure.
- The dermatology clinical nurse specialist (CNS) had completed a dermoscopy course which meant they were competent to carry out mole mapping.
- Staff met daily before the clinics started and were allocated their roles for the day.
- Mandatory and statutory training figures provided by the trust showed that 97.3% clinical staff and admin staff in radiology had completed infection control training. 92.8% of MRI staff and 90.0% of managers had completed the training. 97.4% of clinical staff and admin staff, 100% of MRI staff and 90% of managers had completed safeguarding adults training. 97.4% of clinical and admin staff, 92.8% of MRI staff and 90% of managers had completed safeguarding children training. 97.4% clinical and admin staff, 100% of MRI staff and 100% managers had completed equality and diversity training. 96.5% of clinical and admin staff, 100% of MRI staff and 90% of managers had completed information governance training. 96.5% of clinical and admin staff, 100% of MRI staff and 90% of managers had completed health and safety training. 92% of clinical and admin staff, 92.8% of MRI staff and 90% of managers had completed equality and diversity training. There were similar high levels of training compliance with fire safety, moving and handling and conflict resolution.

Multidisciplinary working

- Staff briefings were held every morning to plan the day's work.
- Senior outpatient nurses met every two weeks across the Trust to discuss trust wide issues which affected outpatients. Monthly outpatient department meetings were held to discuss performance and service development.
- Staff told us there were good working relationships between medical and nursing staff. Nursing staff contacted medical staff if they were more than 10 minutes late for clinic. They described how interactions were improving which meant clinic staff could keep patients informed about any delays. Nursing staff described how the use of a new electronic system meant they could track when patients arrived and were seen and medical staff were able to check if patients had arrived and check their results before calling them in for their consultation.
- Patient seen in clinic who required inpatient treatment were referred to a specialty specific multidisciplinary care team who planned the treatment required.
- Clinical nurse specialists provided nurse led clinics for example in diabetes and dermatology.

Seven-day services

- The renal clinic operated seven days a week and patients could drop in for treatment f they had concerns or noticed a change in their condition.
- Clinics in the main outpatient department were provided Monday to Friday between 9am and 5pm.

Outpatients and diagnostic imaging

There were no early morning or late evening clinics for people who worked during the day. Incident reports showed clinics ran over with the last patients seen after the clinics usual closing time.

- Staff told us plans were being developed to extend access to outpatient services but these were not yet in place.
- Consultant radiologists had remote access for reporting via PACS Web which could be accessed any time. The diagnostic imaging service operated between Monday and Friday from 8:30am to 5pm, with extended lists for MRI until 8pm Monday to Friday, and 8am to 5pm on Saturdays. CT also operated extended days once or twice a week.

Access to information

- All staff working in the department had access to the electronic patient record system. We saw staff had their own cards for accessing the electronic records system which we saw they removed when they left the room. The system identified which member of staff entered the information into the patient's record. There were also paper records for patients which the trust was planning to withdraw once all patient's had an electronic record.
- Patients were provided with information about their condition. For example we saw a range of leaflets for dermatology patients.
- We saw copies of letters to the patient and their GP following their outpatient consultation.
- Outpatient referral to treatment (RTT) times were the responsibility of business managers in individual departments.
- All referrals apart from choose and book were uploaded to the booking system and triaged by consultant medical staff.
- Clinic templates were set by consultant medical staff.
- Reports from diagnostic imaging showing evidence of incidental findings were faxed to GPs to avoid any delays in diagnosis and treatment. All other reports were transmitted electronically to the GP practices.
- When we reviewed patients' gastroenterology records we saw letters which had been dictated by medical staff immediately after the clinics in August 2016 but there were delays in the letters being typed. One letter had been typed 37 days after the clinic. The shortest period between a letter being dictated and typed was 15 days. This meant there were delays in communicating with patients and GPs about the care provided. Following our inspection, the trust told us that in November 2016 the maximum time between a clinic taking place and the letter being produced in gastroenterology was 19 days. The trust was making progress in reducing the time it took to type up clinic visits.
- The time taken to send letters to GPs was being monitored as part of the outpatient improvement programme. The average time taken to send a letter to the GP following an outpatient consultation in July 2016 was 7.8 days. As part of the improvement programme letters were being emailed to GPs via the clinical document library (CDL). In July 2016 80% were issued within 10 working days.
- The trust used a system for medical staff to record patient information but not all clinicians were using this.
- Staff checked to ensure patients had returned their follow up cards to reception and any follow up action was recorded by the doctor.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed eight patients' paper records and found these contained patients agreement to investigations and treatment.
- However, staff within the diagnostic imaging department were not familiar with the requirements of the Mental Capacity Act (2005). They were unsure who might carry out a mental capacity assessment or about making and recording best interest decisions if a patient did not have the mental capacity to consent to treatment.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- An outpatient care assistant greeted patients when they arrived, provided reassurance and guided patients to their clinics.
- The majority of patients told us staff were kind and helpful.

Outpatients and diagnostic imaging

- Staff in outpatients told us they had received customer relations training which they had found helpful in responding to patients' needs.
- Discussions and examinations took place in the consultation rooms to ensure privacy. Nursing and medical staff used curtains and around the examination couch and patients were covered up whilst sensitive or intimate examinations took place.

However:

- Staff did not always notice when patients were feeling unwell and ensure they were seen quickly.

Compassionate care

- An outpatient care assistant greeted patients as they arrived and directed people to the appropriate clinic or waiting area. Outpatient assistants took it in turn to carry out the 'floor walking' role. We observed several members of staff carry out this role during our inspection and observed they were all warm and friendly towards patients.
- We observed one patient who was unwell. They told us they had been waiting for forty minutes to be seen. They said they had recently been discharged from another hospital and described how unwell they were feeling. We asked if staff had checked how they were feeling as they looked so unwell. They said no one had spoken to them since they arrived. We made the nurse in charge aware that the patient was feeling unwell and asked if they could check they were well enough to continue waiting to be seen.
- Patients told us staff were, "Friendly and understanding." One patient told us, "I had a heart attack a year ago and the information given on my treatment had been faultless.
- A patient told us, "Staff gave me privacy when examining me." Another patient told us, "If I need help I ask. I am happy to ask because I know staff will help me. I need to use the disabled toilet and staff are always happy to help."
- Healthcare assistants told us they had received customer relations training. We observed they were confident when communicating with patients and approachable. We saw several patients approach the outpatient assistants for information and directions.
- The majority of patients we spoke with told us staff in the outpatient department were caring and friendly.
- Two patients we spoke with in diagnostic imaging were positive about the service saying it was a good service and staff were kind and explained things clearly.
- Discussions and examinations took place in the consultation rooms to ensure privacy. Nursing and medical staff used curtains and around the examination couch and patients were covered up whilst sensitive or intimate examinations took place.

Understanding and involvement of patients and those close to them

- Patients attending the diagnostic imaging department were offered chaperones for examinations.
- One patient told us, "The staff listen and are informative and kind." My doctor supported me to come off my medicine." Another patient told us," I feel staff are keeping me informed about my treatment. The doctors have discussed the options and all aspects of my treatment."
- The diagnostic imaging department had a dementia ambassador who ensured staff knew how to support patients with dementia. Staff were also aware of the needs of patients with a learning disability and used their communication passports to understand the persons needs and concerns.
- One patient who had been waiting over fifty minutes to be seen told us they were happy to wait because the doctor took time to explain everything to them and they were able to ask questions about their condition and what they might expect to happen. They said the hospital had offered to send appointments by email but they preferred to receive a letter.
- We observed a patient who was attending with a relative. The patient had a condition which meant they could become unsettled. Nursing staff observed the patient becoming unsettled and showed them and their relative to a quiet room in the department.
- Other patients we spoke with told us medical and nursing staff explained their care and they were offered choices and options about the timing of their treatment. Patients and relatives told us they felt able to ask questions and medical staff provided them with the information they needed to address any concerns.

Emotional support

- Staff told us chaperones were always available. The use of chaperones was not audited but 'the doctors recorded the use of chaperones in the medical notes'.

Outpatients and diagnostic imaging

- We observed patients using the phlebotomy service to have their bloods taken. There were four cubicles each had curtains which were drawn around the patient during the procedure to maintain their dignity. Staff treated patients with respect introducing themselves and putting them at ease.
- Several patients were accompanied by relatives or carers and we saw they accompanied the patient during the consultation. One patient told us it meant a lot that their partner could attend to support them because they were often frightened or worried about their condition.
- Nurses were available to provide emotional support for patients who had received bad news within the rheumatology, renal, diabetic, endocrine and respiratory clinics.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as required improvement because:

- The Trust underperformed against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and underperformed against the 62-day GP referral to first treatment standard.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was worse than the England average. The latest figures for July 2016 showed 85.4% of patients were treated within 18 weeks.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services has been worse than the England overall performance and worse than the operational standard of 92%. The latest figures for July 2016 showed 84.6% of this group of patients were treated within 18 weeks.
- Patient experience was mixed but many told us they had waited for a long time in clinic to be seen.
- Patients also told us their appointments had been cancelled and re-arranged several times or they had arrived for their appointment to find the clinic had been cancelled.

However:

- At our previous inspection we found clinics often started late but the trust were not monitoring this. At this inspection we found the trust had started to monitor when clinics started and how long patients were waiting.
- Staff had developed a process for updating patients every thirty minutes if a clinic was running late and patients appreciated being kept informed.

Service planning and delivery to meet the needs of local people

- Staff told us there had been a significant increase in the number of patients attending outpatient clinics. Staff told us work had been taking place to improve waiting times for initial assessment and reduce waiting times in clinic.
- The trust worked with local clinical commissioning groups to plan capacity and demand requirements as part of the local sustainability plan.
- The trust was involved in collaborations across north west London health and social care, including development of sustainability and transformation plan, expanded academic health sciences centre and new integrated health programme.
- Two patients we spoke with in diagnostic imaging told us they were concerned about car parking. They were waiting to be seen and worried their car park tickets had expired. They said it was stressful worrying about car parking.
- The July 2016 performance report showed the Trust underperformed against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and underperformed against the 62-day GP referral to first treatment standard.

Access and flow

- Specialist nurses provided a 'walk in' clinic for patients on a Monday for patients where there was a suspicion of skin cancer. Patients were referred to the service by their GP and were often seen on the following Monday.
- A patient told us their appointment had been cancelled and re-booked twice because they required a CT scan before seeing the consultant again. They said they contacted the consultant's secretary because they did not understand why their appointments were cancelled, they had not understood they needed a CT scan. The consultant organised the scan and they were seen by

the consultant the following day. They were frustrated when their appointments were cancelled but pleased the problem had been sorted out and they saw the consultant so quickly.

- Another patient told us they had been waiting for an hour and 10 minutes. They said they attended clinic regularly and had always waited at least an hour to be seen.
- Another patient said they had once attended for their appointment and found the clinic was cancelled. They had travelled a long way and staff arranged for them to be seen. They said they accepted things went wrong: they were glad to be seen by medical staff.
- We spoke with 11 patients and asked them how long they had been waiting in clinic to be seen. The clinic was running thirty minutes late. Staff updated the whiteboard at the front of the clinic to display how late the clinic was running. Two patients had waited less than ten minutes, most waited 30 minutes, one waited for 45 minutes. Patients told us they appreciated being kept informed about delays.
- The trust had implemented a system which monitored when patients arrived and when they were seen. Patients checked in in by confirming their arrival on a computer screen located in the entrance to the department. Medical staff could see the patient had arrived and could call the patient into the clinic room using their computer. This enabled the service to monitor waiting times. However, not all medical staff were using the system and not all patients were checking in.
- Patients took a completed outcome form to the reception desk following their consultation. The doctor or nurse recorded when the patient required to be seen again and reception staff offered patients their appointment before they left clinic.
- The clinic fitted one patient into clinic from a ward because staff had concerns about their condition and knew medical staff from that specialty were in clinic.
- One patient we spoke with told us they had a number of very significant medical problems. They were attending the dermatology clinic with their partner. They had been discharged from another hospital in the trust and missed an appointment a few weeks later because they did not receive their appointment letter. They had not realised they had missed their appointment until they received a further appointment informing them about the missed appointment offering the appointment that day. They said apart from the administrative issues they were very happy with the medical care they had received.
- Outpatient department assistants carrying out the 'floor walker' role made sure patients knew where to go. They greeted and directed patients to the electronic check in or answered patients questions.
- We observed staff update a whiteboard showing if the clinics were running late. Staff also verbally informed patients in the waiting area how long they were likely to wait. We saw staff do this on several occasions during our inspection. This meant patients were kept informed about delays. Staff also apologised for the delay.
- Staff told us delays in waiting times to be seen in clinic were caused by complex patients needing longer than their allocated time; or overbooking the clinic by the clinician. Problems with waiting times in dermatology which had been addressed through additional ad hoc clinics and in endocrinology by bringing in additional medical staff.
- Nursing staff in the outpatient department had introduced a new system to inform patients about delays while waiting to be seen. Staff told us the longest delays could be up to two hours, in some specialist clinics. However, there have not been any complaints about waiting times since staff had started updating patients about delays.
- The matron told us they had recently introduced a process for doctors who had not arrived in clinic within 10 minutes of their first patient appointment. Staff contacted the doctor by telephone by senior nursing staff. Any further delay was escalated to a more senior level. An audit of clinic start times reported to the outpatient quality and safety committee found 33% of clinics started 10 minutes late with 6 clinics running 2.5 hours late.
- At our previous inspection we found clinics often started late but the trust were not monitoring this. As part of the trust's outpatient improvement programme a pilot audit to record doctor arrival times was undertaken in June 2016. The results for July 2016 showed 73% of doctors arrived on time to start their clinic and another 10% arrived within 10 minutes. 5% arrived 30 minutes after the clinic was due to start. The trust were monitoring when clinics started.
- There was a phlebotomy clinic with four cubicles next to general outpatient department. The phlebotomy clinic

started at 0800 to allow patients to have a blood test before the clinic began and the maximum wait was 20 minutes on the day we inspected. The phlebotomy clinic saw between 180 and 200 patients a day. Patients we spoke with told us they found the phlebotomy service very efficient.

- Consultant medical staff told us the imaging department provided an excellent service for urgent CT and PET CT scans.
- Staff told us last minute cancellations were rare and usually due to sickness. They said it was not always possible to inform them about clinic appointments that were cancelled at short notice
- The outpatient department operated a six week rule which meant no clinic should be cancelled with less than six weeks notice. The trust monitored this as part of their performance monitoring process. The performance report for July 2016 showed the number of hospital initiated cancellations was 8.1% compared with the trust's standard of 10%. This represented a reduction on previous months. 32% of the appointments cancelled were attributed to clinics being cancelled or the number of appointments reduced. Following our inspection the trust supplied us with additional information indicating the proportion of hospital initiated cancellations had reduced to 7.5%.
- During the period April 2015 to April 2016 the follow-up to new rate for Hammersmith Hospital was higher than the England average. Hammersmith Hospital is a specialist centre which meant many patients were referred for treatment from other hospitals resulting in higher rates of follow up attendances.
- Between April 2015 and March 2016 the 'did not attend rate' for the Hammersmith Hospital was higher than the England average. The performance report for July 2016 showed 12.1% patients did not attend for new or follow up appointments compared with the trust's target of 10.0%.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was worse than the England average. The latest figures for July 2016 showed 85.4% of patients were treated within 18 weeks.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services has been worse than the England overall performance and worse than the operational standard of 92%. The latest figures for July 2016 showed 84.6% of this group of patients were treated within 18 weeks.
- The England average was only just below the target, but this trust's performance is noticeably worse than the target and has the trend is getting worse.
- The trust was performing slightly worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral. Performance rose in Q2 2016/17 to 92.4% which was still below the England average of 94.2%.
- The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). Performance remained steady in Q2 2016/17 at 96.7% which was just below the England average of 97.6%.
- The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. Performance fell over 2 of the last 3 quarters but recovered in Q2 2016/17 to 80.1% still below the England average of 82.3%.
- The diagnostic imaging service sometimes outsourced image reporting when they had a backlog. There were no reporting radiographers.
- Information provided by the trust showed that between March and August 2016 patients waited between 16 and 25 weeks for an MRI appointment, 10-14 weeks for an ultrasound and 19-25 weeks for CT.

Meeting people's individual needs.

- We spoke with one patient who told us they had been attending the hospital for several years and received a diagnosis in December 2015 for a life limiting condition They said the consultant gave them the diagnosis but did not explain how this would affect them. The consultant gave them a leaflet developed by a charity and told them this included all the information they needed about their condition. They said they were told they would be referred to see a consultant who specialised in their condition and could ask any questions then. They received an appointment for February 2017. They felt this was too long to wait to find out how they would be affected by the condition.

Outpatients and diagnostic imaging

- Information leaflets in diagnostic imaging were available in several different languages and easy to read versions for people with a visual impairment. The service had access to interpreters if required, which could be booked in advance.
- We saw a complaints leaflet written in an easy to read format for patient with a learning disability. The leaflet described how patients could access advocacy advice and help if they were unhappy with their care.
- Staff told us patients who became unwell while waiting to be seen were brought to the attention of medical staff.
- Staff in the outpatient department told us they had all completed mandatory training in dementia. They said the department had a few patients with dementia every week and they felt able to provide appropriate support for patients who needed it.
- Paediatric referrals were all screened and referred on to paediatric clinics where appropriate. Very few young people were seen in the general outpatient department.
- There was a drop in service in the dermatology clinic every Monday. A specialist nurse would see patients referred by their GP because of unusual pigmentation or a suspicious mole.
- There were chairs in the clinic waiting areas for bariatric patients.
- When we reviewed patients' records we saw one patient had not attended their scheduled clinic appointment. The doctor had written to the GP and the patient requesting they re-arrange their appointment because they were concerned the patient's symptoms might suggest a potentially serious condition.
- We spoke with eight patients waiting in clinic to be seen. One patient told us things were improving. They said they attended approximately every three months and sometimes waited up to an hour to be seen but on the last few occasions they had attended the waiting time had improved. They said they thought nurses announcing how long patients had to wait was a good idea.
- Diagnostic imaging staff told us if a patient did not attend for an urgent appointment they would contact the referring doctor by phone or write to the referring doctor if the missed appointment was for a routine investigation. They described how text messaging was introduced which had resulted in the DNA rate reducing. They said patient had sometimes not attended because they had not received a letter but the text messaging meant patients were informed,
- The check in kiosks provided an extensive choice of languages. Interpreters were available either through a telephone link or by a translator by appointment.

Learning from complaints and concerns

- The trust responded to complaints based on the risk grade of the complaint. Low risk was 25 working days, medium risk was 45 days and high risk was 65 days, the trust allowed themselves one extension per complaint. All complaints were read by the associate director of complaints for the trust. Sign off on a complaint depended on the risk grade, low grade complaints were signed off by a complaints officer, medium risk were signed off by the associate director and high risk ones by the chief executive.
- In the reporting period between August 2015 and July 2016 there were 53 formal complaints about Outpatients services at this trust. The trust took an average of 32 days to investigate and close complaints; this is in line with their complaints policy, which states that the trust has a target to resolve each complaint within an average of 40 working days.
- Staff informed patients about waiting times in clinic in response to complaints they had received.
- Staff in diagnostic imaging told us they reviewed the complaints they received monthly. They told us patients raised concerns about dignity during examinations, the gowns patients were provided with, car parking and signage.
- Key themes were extracted from complaints about outpatient services to inform service improvement plans. The outpatient improvement programme identified that 106 complaints were received by July 2016 were relating to outpatients. 14 of the complaints were formal, the remaining 92 were made through PALS
- The problems included patients booked into the wrong clinic, not being given a follow up appointment not receiving cancellation letters, being cancelled multiple times including one occasion of on the day and the length of time waiting for a first appointment.

Are outpatient and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Good

We rated well-led as good because:

- A strategy had been developed for diagnostic imaging setting out a five year plan which included amongst other things, a plan to extend the service during weekdays and introduce weekend working.
- The outpatient improvement programme was beginning to have traction and bring about change. Staff involved with the outpatient improvement programme spoke positively about the changes
- An outpatient service level agreement had been developed which set out how the central outpatient service and specialist teams would work together to meet the targets in a new performance framework.
- Staff described the culture within the service as open and transparent. Staff were able to raise concerns and felt listened to. Staff felt local leaders were visible and approachable.

However

- We found that governance and leadership was still shared between managers in the main outpatient department and within the different specialties and divisions. Staff told us that this could sometimes delay new systems from the development plan being implemented.
- Waiting times for patients in clinic were still a problem with some clinics being overbooked or cancelled.
- The results of the trust's staff opinion survey showed only 36% of diagnostic imaging staff felt connected to the vision of the Trust.
- Only 32% of staff in diagnostic imaging felt that poor behaviour and performance was addressed effectively.

Vision and strategy for this service

- A strategy for diagnostic imaging was developed in September 2014 which included a five year plan to extend the service during weekdays and introduce weekend working, achieve ISAS accreditation within 3 years, participate in benchmarking, achieve and sustain <15 days waiting time target for all imaging examinations for outpatient and GP referrals.
- An outpatient improvement programme had been developed to address concerns identified in the 2014 CQC inspection and improve the quality of service provided for patients. The programme update of August 2016 showed there were 14 projects underway including reducing the rate of patients who do not attend their outpatient appointment; address problems with the administration of appointments which was leading to unnecessary delays and inconvenience to patients
- Staff received a newsletter from the divisional director containing information and updates about the trusts outpatient improvement programme.
- The results of the staff opinion survey showed 91% of outpatient staff felt they understood the trust's vision. 74% of staff reported they felt connected to the trust's vision. 79% of staff said the executive team provided clear direction about the trust's priorities. However, results demonstrated only 36% of diagnostic imaging staff felt connected to the vision of the Trust.

Governance, risk management and quality measurement

- There were meetings every Friday where outpatient staff met with operations staff and development managers from the clinical divisions to discuss the organisation and performance of the outpatient clinics.
- The outpatient department maintained a risk register. The highest risks related to the temperature within the outpatient department which reached 30-35 degrees. We saw the risks were reviewed by the central outpatient directorate quality and safety committee. The committee raised the risk score to 16 due to the increased likelihood of the risk occurring over the summer months.
- An outpatient improvement plan had been developed which addressed many of the issues identified in the outpatient departments at the previous inspection in September 2014.
- A Risk Management Steering Group reviewed risks in diagnostic imaging. The minutes of the meetings showed infection control, incidents and risks within the imaging department were some of the topics discussed.
- An integrated performance report provided managers with monthly information on a range of quality measures for outpatients and diagnostic imaging. These included incidents, mandatory training, national clinical audits, referral to treatment times, cancelled clinics and reporting times for diagnostics. The performance report

charted improvements and reductions in performance. The information was discussed by local management teams, directorate, divisional and executive management teams.

- The Executive Quality Committee monitored the number of IR(ME)R incidents and discussed how the number of incidents could be reduced. The committee had commissioned an audit of the trust's management of ionising radiation. The risk of IR(ME)R incidents occurring was reviewed regularly at the departmental Risk Management Steering Group meeting and rescored appropriately in accordance with the number of reported incidents. All IR(ME)R incidents were also reported to the Radiation Protection Advisor who assesses the radiation dose to the patient. The service had set a target of reducing reportable IR(ME)R incidents by 25% by March 2017.

Leadership of service

- The outpatient service was overseen by a leadership team of three managers – the Senior Nurse, Clinical Director and General Manager. The team was supported by clinical and administrative staff. The team had been strengthened since our previous inspection and there was more of an emphasis on local site management.
- The outpatient and imaging departments were managed within the division of women and childrens' and clinical support services.
- However, governance and leadership was still shared between managers in the main outpatient department, different specialties and divisions. Staff were working more closely together on improvements but the structures were still relatively new and some posts had still to be appointed to. Some staff described their frustration in moving the outpatient improvement programme forward. They told us they felt the change and new systems being introduced were all positive but not all staff working in specialties were using the systems. An outpatient service level agreement had been developed which set out how the central outpatient service and specialist teams would work together to meet the targets in a new performance framework.
- The minutes of departmental staff meetings showed incidents and risks were discussed. We saw for example delays in clinics, heat in the department and other environmental issues had been discussed.
- Sisters from the three outpatient departments in the trust met weekly to share information and share good practice.
- Senior sisters met managers monthly to discuss the management of outpatient departments in all three hospitals. Information from these discussions was shared with staff in the outpatient department through the newsletter produced by the senior sister.
- A service support manager provided operational management support to the department dealing with complaints and IT issues.
- Staff told us a lot of effort was being invested in improving clinics with the longest waiting times and the most overbooked. Staff told us improvements were being made but there was still a lot of work required for example to review the clinic booking templates with each specialty.
- Some managers in the diagnostic imaging service were not aware of the IR(ME)R annual report
- Staff within the outpatient department spoke positively about their local leadership and told us they felt that valued.

Culture within the service

- Staff told us they were able to raise concerns and discuss issues openly within the department.
- One member of staff who had worked at the service for several years told us team working within the department had improved over the last year.
- The results of the trust's staff opinion survey showed 96% of staff were of the view that their immediate team worked well together. However, only 32% of staff in diagnostic imaging felt that poor behaviour and performance was addressed effectively. 63% of staff in outpatients felt poor performance and behaviour was effectively addressed. 94% of staff indicated their working environment was friendly and welcoming and 56% of staff, feel a sense of personal achievement in their work. However, 38% felt they were put under pressure to work outside their working hours
- 98% of staff working in outpatients felt they understood what behaviour and performance was expected at work. 98% of staff working in outpatients felt they were clear about their objectives and responsibilities.
- Staff in the outpatient department told us there was a strong team feeling it almost felt like a 'family' atmosphere.

Outpatients and diagnostic imaging

Public engagement

- Patient and GP representatives had been recruited to participate in the outpatient improvement programme.
- There was a noticeboard at the entrance to the department with photographs and names of the senior staff working in the department.
- Clinic appointment letters were changed recently to be more patient friendly' as a result of feedback from patients.

Staff engagement

- A clinical reference group provided advice and feedback on the outpatient service improvement plans.
- A staff recognition scheme was in place for staff. Staff were nominated for the award by their colleagues.
- Diagnostic imaging staff told us good practice was recognised through the 'Instant Recognition Awards' Staff received a card and a badge. Three groups of staff within the department had been recognised including the secretarial team.
- As a result of the staff opinion survey the diagnostic imaging service planned to complete and implement a workforce strategy in partnership with staff carry on with work to reduce vacancy rates and improve retention, consult with staff incorporate overtime hours into contracts for new staff.
- The staff opinion survey results for the outpatient department showed that 77% of staff would recommend working in the trust. The staff opinion survey results included staff working in all three outpatient departments. Separate results for Hammersmith hospital were not available. 77% of staff were satisfied with their job overall. 79% of staff would recommend the service as a place to receive care or treatment.
- 81% of staff working in outpatients felt they were able to contribute to innovation within their team or department 64% of outpatient staff felt they were empowered to make change happen in their area of work.

Innovation, improvement and sustainability.

- An outpatient improvement programme was in place. The programme was accountable to the trust's Executive Transformation Committee. The programme included contributing to the development of the trust wide Patient Service Centre as the first point of contact for patients, transforming the clinic environment, improving the quality and content of patient communication, increasing the availability of patient notes (paper and electronic, monitoring clinic start and end times.
- The outpatient team had won a 'Collaborating with our patient's award' for introducing the 30 minute updates for patients waiting to be seen in clinic. The number of complaints about waiting times had reduced since the updates had been introduced.
- The trust had developed and were implementing a digital strategy, including roll out of electronic patient records and electronic prescribing plus new website and Care Information Exchange pilots.
- The trust was developing a patient service centre to provide a single point of access for patients and referrers. The outpatient improvement team were incorporating outpatient appointment processes into the service centre. The centre was due to open in December 2016.
- An outpatient 'service level agreement' was being developed for specialist teams and agreed new performance framework. This included improved monitoring of booking processes, clear accountabilities and tracking of performance against trust targets.
- Staff told us they had participated a customer service training programme for outpatient teams.
- There were monthly team meetings in diagnostic imaging where incidents, staff and other organisational issues were discussed. Three members of the haematology department were engaged in a quality improvement team. The team holds regular monthly meetings where complaints and incidents are all reviewed and signed off by a lead clinician.

Outstanding practice and areas for improvement

Outstanding practice

The trust was transforming outpatient service across the trust through the outpatient improvement programme. A Patient Service Centre was being set up as the first point of contact for patients and plans had been developed for improvements to clinic environments, improving the quality and content of patient communication, increasing the availability of patient notes and monitoring clinic start and finish times.

Areas for improvement

Action the hospital SHOULD take to improve

- The trust should improve performance against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and the 62-day GP referral to first treatment standard.
- The trust should improve performance against referral to treatment time (RTT) for non-admitted pathways for outpatient services.
- The trust should improve performance against referral to treatment time (RTT) for non-admitted pathways for outpatient services.
- The diagnostic imaging service should ensure they comply with updated guidance; for example, the Royal College of Radiographers guidance on x-raying patients with longstanding lower back pain.
- The trust should reduce waiting times for patients in outpatient clinics.
- The trust should reduce the number of overbooked or cancelled clinics.
- The trust should ensure the temperature of the outpatients clinic department is a comfortable temperature for patients.