

Imperial College Healthcare NHS Trust St Mary's Hospital

Quality Report

St Mary's Hospital
Praed Street
London
W2 1NY

Tel: 020 3312 6666

Website: [https://www.imperial.nhs.uk/
our-locations/st-marys-hospital](https://www.imperial.nhs.uk/our-locations/st-marys-hospital)

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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

St Mary's Hospital is an acute general teaching hospital located in hospital in Paddington, London. The hospital was founded in 1845 and has been operated by Imperial College Healthcare NHS Trust since 2008. 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 St Mary's 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 St Mary's Hospital as good overall.

Our key findings were as follows:

- Staff felt there was a positive incident reporting culture that promoted honesty within a 'no blame' culture. Staff at all levels told us they felt supported when they submitted incident reports and felt the level of feedback was appropriate.
- All areas met or exceeded the trust's 90% compliance target with hand hygiene and 'bare below the elbow' policies.
- Staff followed appropriate medicine management procedures that reduced the risk of incorrect doses and administration. Medicines were stored according to manufacturer instructions and mistakes were acted upon to reduce the risk they could happen again.
- The number of patients seen in outpatients with temporary notes as a result of their case records being unavailable was better than the national benchmark maximum of 4% of patients.
- Safeguarding processes were well established and staff demonstrated appropriate knowledge of them. All staff had access to trust safeguarding policies. Clinical staff in sexual health and HIV services had a higher level of safeguarding training that enabled them to safely care for vulnerable and at-risk patients, including those complex needs and challenging social circumstances.
- Processes were in place to ensure children and young people seen outside of paediatric services were cared for using appropriate safeguarding policies. Staff used monthly multidisciplinary safeguarding meetings to review such instances.
- Staff in diagnostic imaging used the World Health Organisation (WHO) surgical safety checklist for radiological interventions and the Society of Radiographer's 'pause and check' process as part of a robust risk management process.
- Consultant and nursing cover was generally adequate to meet demand. Where staff sickness might impact the ability to run a clinic, specialist registrars were able to provide some cover. Staffing levels were determined by the length of clinics and number of patients and according to consultant job plans.
- Staff in each service provided care and treatment that was benchmarked against the guidance of national bodies of practice, including the Medicines and Healthcare Products Regulatory Agency, National Institute of Health and Care Excellence, the Faculty of Sexual and Reproductive Health and the British HIV Association.
- Between January 2016 and December 2016, the hospital met the two week wait target for cancer referrals in every month.
- Waiting times in diagnostic imaging were better than the national target of six weeks for the five core diagnostic services between April 2016 and December 2016.
- Dedicated radiation protection advisers and radiation protection supervisors were in post and provided oversight for diagnostic imaging services to comply with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2006 and the IR(ME) Amendment Regulations 2011 safety guidance.

Summary of findings

- Staff spoke positively about the annual appraisal and professional development record process and said they had been able to secure training and development activities as a result.
- There was evidence of multidisciplinary working, including with safeguarding and infection control teams and between specialties. Weekly and fortnightly cross-site multidisciplinary meetings took place in diagnostic imaging that enabled clinicians to support each other and strategise complex cases.
- Staff treated patients with kindness and a friendly manner during all of our observations, including in clinical and non-clinical settings.
- Reception staff demonstrated understanding and patience when dealing with anxious or flustered patients and we saw reception staff in the Jefferiss Wing treat people who were waiting outside with particular compassion while they waited.
- Patients consistently told us they felt welcomed and valued in the service and they found staff attitudes to be memorable because of their warmth and positivity.
- When clinics were delayed or disrupted staff maintained communication with patients every 30 minutes and offered them water and advice about the delay and options for rebooking. .
- The volunteer service had started a pilot programme in main outpatients to scope the potential benefits and impact on patient experience of having a team based there permanently.
- An outpatient improvement programme was in place to reduce waiting times and delays to clinics. A new standard operating procedure enabled senior staff in main outpatients to escalate to the management team if a doctor was late for a clinic that resulted in delays to patients. We saw this worked well during our observations.
- In November 2016, main outpatients had achieved a turnaround time of 10 days for 95% of referrals, which was the trust target.
- A new complaints and concerns policy enabled complaints to be recorded, investigated and resolved within the trust's 40 day maximum target. The new system also enabled services to identify trends in complaints to drive improvements.
- A new general manager and seniornursein main outpatients had conducted a significant nursing and leadership review of the service and restructured it to deliver results in the outpatient improvement programme.
- All of the staff we spoke with were positive about the overall vision and future strategy for the trust. Most staff also felt empowered to promote positive change and provide suggestions for improvement in their own local services.
- Clinical governance structures helped staff to manage risks to services and involved an appropriate range of staff in most cases. Risk registers were updated regularly and staff with appropriate experience and knowledge managed these.
- The majority of staff we spoke with felt positively about the leadership in their service and described a work culture that facilitated development and innovation. This was particularly the case in cardiac, sexual health and HIV services.
- Feedback from patient engagement was used to improve services, particularly with regards to staff communication in main outpatients and the role of trust volunteers.
- Individual services engaged with their staff teams to improve working conditions and deliver better patient services. This included through consultation on working patterns and the implementation of a working group in diagnostic imaging to identify solutions to some of the challenges the team faced.
- Staff felt recognised and rewarded for their work through trust and local initiatives and spoke positively of opportunities to work with colleagues in other areas to gain a better understanding of how they worked.

We saw several areas of outstanding practice including:

- The senior team in the Jefferiss Wing, including sexual health and HIV services, demonstrated a sustained track record of building staff skill mix and service sustainability through promoting specialist training, practice education and rewarding performance. This resulted in positive impact on the local population because it meant people who were vulnerable or at-risk received timely support and treatment.

Summary of findings

- The outpatient improvement programme had begun to deliver results in a relatively short space of time and the process, involving staff consultation and a restructured leadership and governance team, meant clinic delays had been reduced and communication with patients improved.

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

- The hospital should ensure all staff working in clinical areas have appropriate fire safety training and an understanding of local evacuation procedures.
- The hospital should ensure incidents are fully investigated within a reasonable timescale in such a way that allows trends to be identified so as to ensure the service remains safe.
- The hospital should ensure contractors providing services are able to respond within a reasonable time to complaints made by patients against the trust in cases that involved both providers.
- The hospital should ensure doctors in training have up to date mandatory training in all required areas.
- The hospital should ensure pre-qualification allied health professionals have up to date mandatory training in all areas.
- The hospital should ensure each radiology practitioner has a documented local induction for checked competency in working under IR(ME)R guidelines.

Professor Sir Mike Richards
Chief Inspector of Hospitals

St Mary's Hospital

Detailed findings

Services we looked at

Outpatients and diagnostic imaging;

Detailed findings

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Background to St Mary's Hospital

Outpatients and diagnostic imaging services at St Mary's Hospital consists of a main outpatients department that includes six clinical treatment and assessment areas with 36 consulting rooms over three floors. Outpatient clinics are offered in 12 specialties: dermatology, hepatology, respiratory medicine, ear, nose and throat, rheumatology, neurology, gastroenterology, vascular surgery, allergy, cardiology, clinical haematology, neurosurgery, bariatrics, physiotherapy, general medicine, elderly medicine and stroke.

The main outpatient building includes a phlebotomy clinic, a private pharmacy and a volunteer-led coffee shop.

A range of outpatient day case specialties are provided in multiple areas across the hospital site, including a chest clinic, fracture clinic, dermatology day treatment unit, diabetes and endocrine clinic and electrophysiology.

Diagnostic imaging services offer a range of diagnostic and interventional procedures to support all aspects of clinical management. This includes angiography,

computed tomography (CT), interventional procedures, IVU, fluoroscopy, MRI, Nuclear Medicine, plain films (walk-in service with GP referral, no appointment necessary) and ultrasound. There are six ultrasound rooms with a seventh dedicated to recurrent miscarriages and a dedicated paediatric waiting area. Five MRI scanners are available in four locations. Three plain film radiographic rooms are available and the service offers single-photon emission computed tomography (SPECT) and dual-energy x-ray absorptiometry (DXA) to measure bone mineral density. One gamma camera is available. Resources also include an acute imaging centre with three-bay recovery area and anaesthetic capability and a fully equipped CT scanning unit.

The Jefferiss Wing offers dedicated Sexual Health, HIV and HTLV services on an outpatient basis. The Wharfside clinic is a dedicated HIV outpatient and day case unit with negative pressure facilities enabling respiratory isolation and delivery of nebulised pentamidine and other therapies.

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

Detailed findings

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 visit 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 St Mary's Hospital.

Facts and data about St Mary's Hospital

There were 554,321 outpatient appointments across St Mary's Hospital between April 2015 to March 2016.







Between January 2016 and December 2016 64,000 outpatient appointments took place at the main/central outpatient department. This accounts for 38% of all outpatient appointments in the trust. The most common outpatient speciality was dermatology.

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

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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The main outpatient building includes a phlebotomy clinic, a private pharmacy and a volunteer-led coffee shop.

A range of outpatient day case specialties are provided in multiple areas across the hospital site, including a chest clinic, fracture clinic, dermatology day treatment unit, diabetes and endocrine clinic and electrophysiology.

Diagnostic imaging services offer a range of diagnostic and interventional procedures to support all aspects of clinical management. This includes angiography, computed tomography (CT), interventional procedures, IVU, fluoroscopy, MRI, Nuclear Medicine, plain films (walk-in

service with GP referral, no appointment necessary) and ultrasound. There are six ultrasound rooms with a seventh dedicated to recurrent miscarriages and a dedicated paediatric waiting area. Five MRI scanners are available in four locations. Three plain film radiographic rooms are available and the service offers single-photon emission computed tomography (SPECT) and dual-energy x-ray absorptiometry (DXA) to measure bone mineral density. One gamma camera is available. Resources also include an acute imaging centre with three-bay recovery area and anaesthetic capability and a fully equipped CT scanning unit.

The Jefferiss Wing offers dedicated Sexual Health, HIV and HTLV services on an outpatient basis. The Wharfside clinic is a dedicated HIV outpatient and day case unit with negative pressure facilities enabling respiratory isolation and delivery of nebulised pentamidine and other therapies.

We last inspected this service in November 2014 and rated it to be inadequate. This reflected delays of up to six weeks in sending out appointment letters following a GP referral and a failure to consistently meet demand. We found doctors often turned up late to clinics and there was little structure in place to monitor performance.

As part of this inspection we observed care and treatment and interviewed staff in main outpatients, the Jefferiss Wing, all areas of diagnostic imaging and seven specialist outpatient or day case units. To arrive at our ratings we spoke with 20 clinicians, 14 nurses, nine nursing and healthcare assistants, seven administrative staff, eighteen

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staff at senior or management level, two volunteers, nine patients and six relatives. We looked at the records of 29 patients across services and took into account 61 other individual items of evidence.

Summary of findings

We rated this service as good overall because:

- Staff felt there was a positive incident reporting culture that promoted honesty within a 'no blame' culture. Staff at all levels told us they felt supported when they submitted incident reports and felt the level of feedback was appropriate.
- All areas met or exceeded the trust's 90% compliance target with hand hygiene and 'bare below the elbow' policies.
- Staff followed appropriate medicine management procedures that reduced the risk of incorrect doses and administration. Medicines were stored according to manufacturer instructions and mistakes were acted upon to reduce the risk they could happen again.
- The number of patients seen in outpatients with temporary notes as a result of their case records being unavailable was better than the national benchmark maximum of 4% of patients.
- Safeguarding processes were well established and staff demonstrated appropriate knowledge of them. All staff had access to trust safeguarding policies. Clinical staff in sexual health and HIV services had a higher level of safeguarding training that enabled them to safely care for vulnerable and at-risk patients, including those complex needs and challenging social circumstances.
- Processes were in place to ensure children and young people seen outside of paediatric services were cared for using appropriate safeguarding policies. Staff used monthly multidisciplinary safeguarding meetings to review such instances.
- Staff in diagnostic imaging used the World Health Organisation (WHO) surgical safety checklist for radiological interventions and the Society of Radiographer's 'pause and check' process as part of a robust risk management process.
- Consultant and nursing cover was generally adequate to meet demand. Where staff sickness might impact the ability to run a clinic, specialist

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registrars were able to provide some cover. Staffing levels were determined by the length of clinics and number of patients and according to consultant job plans.

- Staff in each service provided care and treatment that was benchmarked against the guidance of national bodies of practice, including the Medicines and Healthcare Products Regulatory Agency, National Institute of Health and Care Excellence, the Faculty of Sexual and Reproductive Health and the British HIV Association.
- Between January 2016 and December 2016, the hospital met the two week wait target for cancer referrals in every month.
- Waiting times in diagnostic imaging were better than the national target of six weeks for the five core diagnostic services between April 2016 and December 2016.
- Dedicated radiation protection advisers and radiation protection supervisors were in post and provided oversight for diagnostic imaging services to comply with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2006 and the IR(ME) Amendment Regulations 2011 safety guidance.
- Staff spoke positively about the annual appraisal and professional development record process and said they had been able to secure training and development activities as a result.
- There was evidence of multidisciplinary working, including with safeguarding and infection control teams and between specialties. Weekly and fortnightly cross-site multidisciplinary meetings took place in diagnostic imaging that enabled clinicians to support each other and strategise complex cases.
- Staff treated patients with kindness and a friendly manner during all of our observations, including in clinical and non-clinical settings.
- Reception staff demonstrated understanding and patience when dealing with anxious or flustered patients and we saw reception staff in the Jefferiss Wing treat people who were waiting outside with particular compassion while they waited.

- Patients consistently told us they felt welcomed and valued in the service and they found staff attitudes to be memorable because of their warmth and positivity.
- When clinics were delayed or disrupted staff maintained communication with patients every 30 minutes and offered them water and advice about the delay and options for rebooking. .
- The volunteer service had started a pilot programme in main outpatients to scope the potential benefits and impact on patient experience of having a team based there permanently.
- An outpatient improvement programme was in place to reduce waiting times and delays to clinics. A new standard operating procedure enabled senior staff in main outpatients to escalate to the management team if a doctor was late for a clinic that resulted in delays to patients. We saw this worked well during our observations.
- In November 2016, main outpatients had achieved a turnaround time of 10 days for 95% of referrals, which was the trust target.
- A new complaints and concerns policy enabled complaints to be recorded, investigated and resolved within the trust's 40 day maximum target. The new system also enabled services to identify trends in complaints to drive improvements.
- A new general manager and senior nurse in main outpatients had conducted a significant nursing and leadership review of the service and restructured it to deliver results in the outpatient improvement programme.
- All of the staff we spoke with were positive about the overall vision and future strategy for the trust. Most staff also felt empowered to promote positive change and provide suggestions for improvement in their own local services.
- Clinical governance structures helped staff to manage risks to services and involved an appropriate range of staff in most cases. Risk registers were updated regularly and staff with appropriate experience and knowledge managed these.

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- The majority of staff we spoke with felt positively about the leadership in their service and described a work culture that facilitated development and innovation. This was particularly the case in cardiac, sexual health and HIV services.
- Feedback from patient engagement was used to improve services, particularly with regards to staff communication in main outpatients and the role of trust volunteers.
- Individual services engaged with their staff teams to improve working conditions and deliver better patient services. This included through consultation on working patterns and the implementation of a working group in diagnostic imaging to identify solutions to some of the challenges the team faced.
- Staff felt recognised and rewarded for their work through trust and local initiatives and spoke positively of opportunities to work with colleagues in other areas to gain a better understanding of how they worked.

However, we also found:

- Fire risk assessments had highlighted a significant number of failings in fire safety and breaches of regulatory compliance. This meant buildings, treatment and waiting environments were not safe for patients, staff and visitors.
- There was not always evidence that showed trends in incidents were identified or acted upon in a timely manner.
- Mandatory training completion rates were variable across staff groups and subjects. In diagnostic imaging, doctors in training and pre-qualification allied health professionals (AHPs) did not meet the trust's minimum 90% compliance target in any subject area. Doctors in training in diagnostic imaging did not meet the trust's target training rate in any of the mandatory training topics and only 52% of this team had up to date resuscitation training to the required level.
- There was a significant lack of up to date training evidence for allied health professionals who worked in diagnostic imaging.

- Local audits in January 2016 identified a lack of space for waiting patients in the urology-gynaecology and fracture clinics as an area for improvement but no action had been taken to date to improve this.
- Although induction processes for diagnostic imaging staff were robust and designed to test competency, there was room for improvement in the documentation of inductions.
- Not all staff in diagnostic imaging had nationally recognised intravenous cannulation training, which they routinely needed in the course of their work. Senior staff were in the process of resolving this by trying to source appropriate training within their budget.
- 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.
- Waiting times in clinic for some services differed significantly between sites in the trust. This included ultrasound where the average wait for an appointment at St Mary's Hospital was 30 days from referral. This is within the national target of six weeks.
- There was limited space in many of the specialist clinical areas that impacted patient comfort and safety whilst waiting for appointments. This included overcrowded waiting areas such as in the diabetes

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and endocrine unit and ear, nose and throat (ENT) clinic. A trust action plan to identify better use of space in ENT had not been updated since February 2016.

- Navigation between services was problematic due to a lack of or confusing signage. Staff provided maps for patients and volunteers worked in some areas to help guide patients but staff in areas such as electrophysiology reported on-going concerns about this.
- Some patient waiting areas were cramped and not large enough to meet demand.
- There were limited resources to support patients with a learning disability and not all staff knew who to contact for support.
- Although clinical governance meetings in diagnostic imaging were well attended and led to demonstrable outcomes, there was a lack of representation from some specialties.
- Some staff said there was a lack of development opportunities, leadership support and innovation in their area of work.
- The senior team recognised staffing shortages in diagnostic imaging placed additional pressure on staff. However it was not clear that recruitment and training plans were understood by existing staff or that they had confidence in this process. This impacted their morale and exacerbated concerns around what they perceived to be inconsistent pay and conditions in some areas.

Are outpatient and diagnostic imaging services safe?

Good



We rated safe as good because:

- Staff felt there was a positive incident reporting culture that promoted honesty within a 'no blame' culture. Staff at all levels told us they felt supported when they submitted incident reports and felt the level of feedback was appropriate.
- All areas met or exceeded the trust's 90% compliance target with hand hygiene and 'bare below the elbow' policies.
- Infection control rooms were available for patients who presented with an infectious condition and processes were in place to contain the risk.
- Staff followed appropriate medicine management procedures that reduced the risk of incorrect doses and administration. Medicines were stored according to manufacturer instructions and mistakes were acted upon to reduce the risk they could happen again.
- The number of patients seen in outpatients with temporary notes as a result of their case records being unavailable was better than the national benchmark maximum of 4% of patients.
- Safeguarding processes were well established and staff demonstrated appropriate knowledge of them. All staff had access to trust safeguarding policies. Clinical staff in sexual health and HIV services had a higher level of safeguarding training that enabled them to safely care for vulnerable and at-risk patients, including those complex needs and challenging social circumstances.
- Processes were in place to ensure children and young people seen outside of paediatric services were cared for using appropriate safeguarding policies. Staff used monthly multidisciplinary safeguarding meetings to review such instances.

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- Staff in diagnostic imaging used the World Health Organisation (WHO) surgical safety checklist for radiological interventions and the Society of Radiographer's 'pause and check' process as part of a robust risk management process.
- Consultant and nursing cover was generally adequate to meet demand. Where staff sickness might impact the ability to run a clinic, specialist registrars were able to provide some cover. Staffing levels were determined by the length of clinics and number of patients and according to consultant job plans.

However, we also found:

- There was not always evidence that showed trends in incidents were identified or acted upon in a timely manner. For example, incidents had been reported in diagnostic imaging that included delays in conducting emergency scans and patient dissatisfaction with a third party provider used to increase capacity in the magnetic resonance imaging (MRI) service. However, incident records did not indicate the causes of the incidents had been identified or appropriate action taken to prevent them happening again.
- Mandatory training completion rates were variable across staff groups and subjects. In diagnostic imaging, doctors in training and pre-qualification allied health professionals (AHPs) did not meet the trust's minimum 90% compliance target in any subject area. Doctors in training in diagnostic imaging did not meet the trust's target training rate in any of the mandatory training topics and only 52% of this team had up to date resuscitation training to the required level. There was a significant lack of up to date training evidence for allied health professionals who worked in diagnostic imaging.
- There was room for improvement in evacuation and fire safety processes and training in most areas. This included low levels of mandatory fire training amongst doctors in training and pre-qualification AHPs and a lack of safe evacuation routes for patients in wheelchairs or beds from the upper floors of the main outpatient building and the Jefferiss Wing.

Incidents

- Between August 2015 and August 2016, staff in diagnostic imaging services reported 299 incidents. One

incident resulted in major harm and involved the trauma imaging unit and a delay of 47 hours in conducting abdominal x-rays for a patient admitted through the emergency department. The clinical service manager had reported that immediate action had been taken to ensure urgent scans could be provided immediately as a result. This incident was reported in September 2015 but had not been closed by November 2016. We were told that the delay in closing the incident was caused by actions required of another division. Three incidents resulted in moderate harm, including one incident of a delay in emergency scanning, a delay in processing the patient's diagnostic tests and a procedure undertaken in an unsafe environment. Immediate action was taken in each case to ensure the patient received appropriate care and staff initiated multidisciplinary contact to investigate the causes of each incident.

- Between July 2015 and July 2016, staff in outpatient services reported 72 incidents, all of which resulted in low or no harm. Fifteen incidents were reported due to patient notes or referral letters being unavailable to medical staff. This was a key focus of the trust's outpatient improvement programme and action had been taken since the incidents were reported.
- Staff had varying experiences of the incident reporting process, including learning. For example, radiation safety meetings were used to review incidents in diagnostic imaging but the meetings did not have permanent representation from radiology managers or medical physics experts. This was because the meetings were part of a more generic divisional safety meeting, which reduced the influence of operational level staff. Staff received feedback from the meetings via e-mail and team meetings and said they felt the level of feedback was appropriate. Key points from incident investigations were also displayed on each computer as a screensaver.
- Staff told us they felt able to submit incidents reports as part of a 'no blame' culture that enabled investigations to be transparent and involve everyone involved. A doctor told us they felt the senior team investigated incidents fairly and as a result staff were happy to be involved.
- The nurse manager and senior nurse in sexual health and HIV reviewed incident reports on a weekly basis and

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assigned a member of staff with appropriate experience and knowledge to investigate each one. This service demonstrated responsiveness to learning from incidents. For example, electronic test ordering had been introduced following previous labelling errors and missing samples. Staff in this service had undertaken sharps injury training as a result of an incident, which also resulted in new needles being introduced with a safety lock.

- Between October 2015 and October 2016 outpatient services reported one serious incident. This occurred in April 2016 when 150 patient outcome forms dated from February 2016 were found without follow-up action. This meant the patients involved had not received follow-up care or appointments.

Cleanliness, infection control and hygiene

- Staff in each area carried out monthly hand hygiene and 'bare below the elbow' audits. Between April 2016 and July 2016, all areas of outpatients, diagnostic imaging and sexual health achieved or exceeded the trust 90% target for compliance.
- Amongst outpatient nurses, 89% had up to date training in infection control and 85% of healthcare assistants were up to date. In diagnostic imaging, only scientific and technical staff met the trust's minimum requirement of 90% compliance with up to date infection control training. This included pre-qualification allied health professionals, amongst whom only 43% had up to date training. The consultant group in diagnostic imaging had 85% compliance and doctors in training had 75%.
- Antibacterial hand gel was readily available in all OPD areas, including in treatment rooms and at the entrances and exits to waiting areas. Signs encouraged patients and visitors to use the gel and we saw staff use it routinely. All of the patients we spoke with said they noticed staff wash their hands before examining them and said they felt hygiene standards were high.
- Staff used green 'I'm clean' stickers to indicate when an item of equipment had been cleaned, disinfected and was ready for use. We saw consistent use of this process.

- Infection control and traceability processes in ear, nose and throat (ENT) were robust and included a two-hour decontamination turnaround time for nasendoscopes.
- Antibacterial wipes were available in paediatric outpatients and notices invited parents to use them before and after their child played with toys. A daily cleaning schedule for toys was on display and staff had completed this consistently.
- A protocol was in place in paediatric outpatients to reduce the risk of infection if a child attended with chicken pox or measles in the active stage. This included contact with the trust infection control lead and contact with each patient who had attended that session.
- Weekly nurse-led cleaning checks took place in the Jefferiss Wing, including workarounds with the cleaning contractor manager.
- Angiography x-ray, the ENT clinic and general x-ray participated in the patient-led assessments of the care environment (PLACE) national scoring system. This system benchmarks environmental condition and cleanliness as assessed by patients. The latest 2016 scores indicated both x-ray areas scored 100% for cleanliness and an average of 90% for condition and appearance. The ENT clinic scored 92% for cleanliness and 72% for condition and appearance.

Environment and equipment

- Personal protective equipment was available in all areas and we saw staff consistently and safely use this.
- The trust was registered with the Health and Safety Executive for ionising radiation and was compliant with safety requirements following the most recent inspection.
- Diagnostic imaging services had a confinement room available for patients who presented with a high level of infection risk.
- Waste management was in accordance with national guidance in all areas, including in the separation and secure storage and disposal of hazardous waste.
- The service level agreement between the estates team and clinical departments was for an assessment of a problem to take place within 48 hours of a logged call. Staff told us this was rarely adhered to and that multiple calls were usually needed to have an estates issue

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resolved. Staff in the Jefferiss Wing had established a new escalation process whereby if a reported estates problem had not been attended to after three days; they could speak with an estates manager directly. Senior staff told us the lack of estates oversight had presented significant challenges. For example, a broken door to a liquid nitrogen storage area had taken 18 months to resolve and staff said the tracing of faults was not consistent as they were often reported as resolved when they were not. The estates function had been restructured with the head of nursing lead it, which was intended to deliver improvements.

- A central reporting area was available in diagnostic imaging, including a 'hot reporting area' with soundproofed doors for urgent and confidential discussions. This included capability for cross-site conferencing between clinicians.
- A negative pressure isolation room was available in the Wharfside clinic and could be used for nebulised therapies.
- The road outside of the Jefferiss Wing presented a risk to patient, visitor and staff safety. The unit exited directly onto a through public road that had limited clearance. During our inspection we observed a near miss when a person in a mobility scooter narrowly missed being hit by a car. There were limited warning signs or direction signs posted in the area. This was highlighted on the hospital risk register but no resolution had been found.
- Designated staff were responsible for safety checks on the equipment in their respective areas. For example, a senior nurse in the dermatology day treatment unit completed a safety check of ultraviolet UVB and UVA+B machines every morning using St John's Phototherapy Guidelines.
- Clinical space in specialist areas was clean, tidy, well equipped and fit for purpose. This included three echocardiogram rooms, an exercise room and two EG rooms in the cardiac diagnostics department and eight consulting rooms in the chest clinic. However, staff in every area described one of their key challenges as a lack of space for storage and patients who were waiting. For example, the waiting area in the cardiac diagnostics department was small and cramped and had no toilet facilities. Seating in the diabetes and endocrine unit was very limited and staff told us when four clinics were run

concurrently on a Monday morning, some patients had to stand while waiting. This was further exacerbated when patients in wheelchairs or on stretchers were waiting.

Medicines

- Medicines 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. Contrast media was stored in a locked room with restricted access.
- 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 of a 'Back to the floor Friday' audit which had recently been introduced by the trust, partly to ensure effective medicines management. This had been completed on a weekly basis for most clinics, although in clinic E this was missing for two weeks.
- Medicines used for resuscitation and other medical emergencies, including anaphylaxis, were available and tamperproof. However, we spoke to a member of staff who said they were not always accessible for immediate use, as the resuscitation trolley was situated in clinic D on the second floor of the outpatients building. This trolley served all three floors, which meant there was a risk that it would take a length of time to serve patients on the ground floor should it be required. We saw evidence of daily checks to ensure the appropriate medicines were stocked and had not expired.
- Appropriate arrangements for the supply of medicines were in place. A private pharmacy contractor served all outpatient prescriptions on the ground floor. They were open between 9am and 6.30pm Monday to Friday, and between 9am and 1.30pm on Saturday and Sunday. The latest figures available 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 and also via paper based prescriptions. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Staff had access to the trust pharmacy department for medicines information advice and medicines supply.

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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.

- 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.
- The nurse in charge completed a daily compliance checklist for medicines management to ensure storage and administration was compliant with trust policy. A medicines safety review group supported this process and provided additional medicines management training to help improve safety. New guidance had been issued to staff in ear, nose and throat clinics so they could administer topical medicines safely and appropriately.
- Staff gave printed instructions to patients in the use of contrast media and potential side effects.
- Nurses in sexual health and HIV services issued emergency contraception using patient group directions, which were monitored and updated regularly.
- There are three dedicated pharmacists aligned to the directorate who attended nurse and governance meetings, provided one-to-one staff support and maintained patient group directions in sexual health services.
- Appropriate action had been taken following a prescribing error in the Wharfside clinic. In this instance, a vaccine had been prescribed but another type was administered. In response, a mobile computer was provided that meant staff could take it with them into treatment bays and complete documentation alongside administering drugs or vaccines.

Records

- Outpatient services were transitioning from paper records to electronic records. The latest available data from July 2016 indicated an average of 2% of patients were seen in clinics with temporary records as a result of

case notes being unavailable. This was better than the national benchmark maximum of 4%. Where clinical records were unavailable, a decision was made by the lead doctor for the clinic on a case-by-case basis.

- We looked at 29 patient records across the areas we inspected. All of the records were signed by a named clinician who was readily identifiable and entries were legible.
- Electronic patient records (EPR) have been introduced in the HIV outpatient service in November 2015 and in the asymptomatic patient pathway in sexual health in 2016. EPR is planned for all other clinics and pathways during 2017/18”
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Safeguarding

- In diagnostic imaging, the qualified allied health professional (AHP), scientific and technical and consultant staff groups met or exceeded the minimum trust requirement that 90% of staff had up to date safeguarding adults training. All other staff groups did not, including pre-qualification AHPs, whose compliance was 43%. In this division safeguarding children training was also variable. Consultants, scientific and technical staff and senior managers achieved the trust's target but other groups did not. Training rates in outpatients were generally better, where all staff groups met or exceeded the 90% target for adult safeguarding and child safeguarding level one. Administration staff exceeded the target for child safeguarding level two and 78% of nurses and 88% of healthcare assistants had completed this.
- A paediatric safeguarding protocol was in place in main outpatients in the event a clinician booked a child or young person into an adult clinic for medical reasons. For example, a private waiting room was arranged and a children's nurse could be present if needed. All staff had child safeguarding training.
- Staff in the Jefferiss Wing prioritised young people if they attended a walk-in session and ensured they were offered an appropriate waiting area. In this, unit, 97% of clinical staff had up to date training in safeguarding adults and children to a minimum of level two.
- We spoke with staff about safeguarding in each area or department we visited. In all cases both clinical and

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non-clinical staff demonstrated appropriate knowledge and understanding. An alert on electronic records systems highlighted to staff if a patient was known to have a safeguarding issue. This system worked well in sexual health services and paediatric outpatients, both of which regularly cared for vulnerable or at-risk patients.

- Staff only administered contrast media in radiology if at least two members of staff were present.
- All clinical staff in sexual health and HIV services had level three adult and child safeguarding training and non-clinical staff had basic safeguarding training. Safeguarding training for clinical staff was specialised and enabled them to care for patients with specific risks, such as those at risk of Hepatitis B, men who have sex with men and sex-drug users.
- The specialist sexual health information and protection (SHIP) team in the Jefferiss Wing met weekly with child protection teams for young people seen in the service and used a specialist pathway to care for young patients who presented with needs relating to drug or alcohol use and self-harm. This team had working links with community youth offending teams and community adolescent mental health services to provide integrated safeguarding support.
- Monthly meetings took place trust-wide with safeguarding and service leads in each area.
- One safeguarding incident had been reported in outpatients between July 2015 and July 2016. This involved a nursing home sending an incorrect patient for an appointment. Staff in outpatients took the appropriate action at the time and there was no harm as a result.

Mandatory training

- All staff were required to complete a mandatory training programme that included safeguarding, basic life support and resuscitation, infection control and moving and handling. Staff in all areas told us they were given time during working hours to complete mandatory training updates.
- Amongst diagnostic imaging staff, 84% were fully up to date with mandatory training and in outpatients, 93% were up to date. The trust's target for mandatory training was 90% and four of the 10 staff groups in both

divisions met or exceeded this, including administration staff and healthcare assistants in outpatients and consultants and scientific and technical staff in diagnostic imaging. Pre-qualification AHPs had 55% average compliance and administration staff in diagnostic imaging had 77% average compliance.

- Doctors in training in diagnostic imaging did not meet the trust's target training rate in any of the mandatory training topics. Overall this group had an average 71% compliance, which included 37% in fire safety, 52% in resuscitation level two and 55% in information and governance. Of the seven staff groups in this division, only consultants and scientific and technical staff, who represented 31% of total staff, met or exceeded the 90% training target.
- Overall in the Jefferiss Wing, 91% of staff had up to date mandatory training. This included 89% compliance amongst sexual health nurses, 100% compliance amongst HIV management staff, 92% amongst non-clinical staff, 85% of HIV nursing staff and 89% of doctors.

Assessing and responding to patient risk

- An imaging trauma service was available and staffed to provide emergency scans within 30 minutes of a request being made, although previous incidents indicated this target was not always achieved.
- Reception staff shifts in diagnostic imaging did not always match the running times of clinics. This meant clinical staff also performed reception duties at times, which they felt was unsafe. From the minutes of team meetings we saw the senior team were aware of this issue and were undertaking a staff consultation to address it by proposing revised working hours. In the meantime, reception desks could be staff outside of core working hours only if individuals accepted overtime.
- Staff in radiology used a three-point identity check for each patient before conducting a procedure that involved radiation exposure. This team also used a World Health Organisation (WHO) surgical safety checklist for radiological interventions and the Society of Radiographer's 'pause and check' process. The risk management steering group audited use of the WHO checklist. The latest available data, for May 2016 and June 2016, indicated 98% compliance. In addition,

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two-person checks always took place before intravenous contrast media was administered. This meant staff ensured the correct patient was given the correct procedure every time.

- Staff in radiology routinely performed pregnancy checks and discussed recent sexual history with patients before completing a scan. If the results were inconclusive, they delayed the scan to protect the patient from potential harm.
- Staff in main outpatients followed an established policy in the event of a patient emergency that required the resuscitation team. This included outpatient staff waiting at the entrance to the unit to quickly direct the resuscitation team to the location of the patient. This had been tested in simulated exercises and as part of a live emergency.
- Treatment rooms were fitted with call bells, which staff could use to summon help in an emergency.
- Resuscitation equipment, including equipment for children, was available in all areas and staff consistently documented daily safety checks. In the main outpatients building, the resuscitation trolley was located on the second floor, with an emergency grab bag on the first floor. The trolley could only be safely moved between floors by use of a lift but staff did not have a manual override key for this, which meant they could not use the lift as a priority. We spoke with the general manager about this who said a second emergency grab bag would shortly be provided for the ground floor and the resuscitation team had approved this system.
- Evacuation procedures in the Jefferiss Wing did not meet the needs of all patients and staff. For example, a lift was available but this was a small passenger lift that could not fit patients who were cared for on a trolley or bed in the Wharfside clinic. A mobile 'medevac' chair had been provided to help staff evacuate people from the first floor but none of the staff we spoke with had been trained in its use. Staff said the risk of not being able to move patients on beds or stretchers to the ground floor was mitigated because this clinic was staffed by very experienced clinicians.
- All staff in the trust were required to undertake resuscitation level one training and some staff additionally required level two training as well as

appropriate updates. In diagnostic imaging, 74% of staff were up to date with their required level of training. This included 95% of consultants, 52% of doctors in training and 43% of pre-qualification AHPs. In outpatients, 84% of nurses and healthcare assistants had up to date training to the appropriate level. In the Jefferiss Wing, 89% of all staff had up to date resuscitation training.

Nursing staffing

- The trust had established the need for eight whole time equivalent (WTE) nurses in main outpatients to run this service safely and as planned. In October 2016, there were two WTE vacancies.
- 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.
- Nurse and healthcare assistant staffing levels per shift in main outpatients were established in advance based on the number of clinics running and the number of patients booked in.
- Specialist services planned staffing based on patient demand and the length of clinics running. For example, a senior sister, two nurses, three healthcare assistants and a plaster technician worked in the fracture clinic and ensured shifts were covered appropriately between them.
- Healthcare assistants worked across all outpatient clinics and had appropriate training for this. This meant the team could be deployed to the area that most needed support to meet patient needs. This was a recent initiative implemented as a result of patient feedback and ensured there was a staff presence at all times.
- Paediatric outpatients was staffed predominantly by healthcare assistants, with two registered children's nurses. A nurse manager led the unit and was based between two sites.
- Morning briefings were used to discuss complaints, feedback and incidents in main outpatients and paediatric outpatients. We attended one briefing in main outpatients and noted it was thorough, with all staff booked for the morning in attendance across multiple roles. The meeting was motivational and included a thorough discussion of the plans for the day and any concerns from the previous day.

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- Three ultrasound assistants supported the service in dedicated roles. For example, one assistant worked with a radiologist, one assistant worked with the clinician undertaking musculoskeletal injections and one assistant acted as a point of contact for patients.
- Two senior nurses, advanced nurse practitioners, staff nurses and nursing assistants led care in sexual health services. Following a skill mix review, all band seven nurses in sexual health and HIV services became nurse practitioners as a part of a new staff structure. In addition, all nursing assistants were trained as phlebotomists to help free up nurses to care for patients with more complex needs.
- Student nurses worked under direct supervision and were able to observe clinics and practice basic procedures. For example, a student nurse in the Wharfside clinic learned how to assist with a lumbar puncture and assisted with intramusculoskeletal injections.
- A team of four advanced nurse practitioners, three band six nurses and two band five nurses led the HIV service in the Wharfside clinic, with support from healthcare assistants. Individual shifts were staffed by an establishment of two nurses and one healthcare assistant.
- Community respiratory nurse specialists provided care and treatment in the chest clinic.
- Four nurse practitioner prescribers led the SHIP team and also provided a rotational training post for staff nurses from sexual health and HIV services.
- As at August 2015 and July 2016, the trust reported a vacancy rate of 13.6% in Outpatients trustwide; the vacancy rates ranged from 0% to 26.1% across reporting units.
- 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.
- Individual specialties were staffed according to consultant job plans and the number of patients seen per clinic. Each service had at least one dedicated consultant and a specialist registrar. For example, a consultant and a specialist registrar led the ENT service Monday to Friday and two specialist registrars and a middle career doctor led the gynaecology outpatient service.
- To address shortfalls in staffing in diagnostic imaging, a long-term action plan was in place. This aimed to develop existing staff into senior posts, extend recruitment to higher-level posts across a wider area of London and to begin international recruitment. The ratio of permanent sonographers to agency sonographers was 60:40 due to ongoing staff shortages. In radiology, staff told us clinics often ran with fewer staff rather than being cancelled, which they said was a safety concern.

The radiology service had a 13% vacancy rate, which would be reduced when six newly-recruited staff came into post.
- A radiologist was always present in the trauma unit.
- Two cardio-radiologists were available in the acute imaging centre.
- The chest clinic was staffed by pulmonary function physiologists, respiratory specialists and respiratory consultants.
- A consultant and two physiologists led the electrophysiology department.

A clinical director, two heads of specialty and a team of 14 consultants led care and treatment in sexual health and HIV services. There was one HIV consultant vacancy. There was always a supervising consultant or registrar who provided support on complex cases to other clinical staff including GP specialist training doctors. Usually this supervising senior doctor was supernumerary. Each consultant was paired with a nursing assistant per shift, which the nurse in charge allocated based on the nursing assistant's experience and skill base.
- Consultants in diagnostic imaging did not work to a shift-based system. Instead they used an individual job

Medical staffing

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plan in each specialty to structure clinic times and availability. Specialist registrars were assigned to each radiology sub-specialty and were rotated between these every four months.

- 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

- Major incident contingency plans were in place in all areas but had not been practised in simulation or rehearsal scenarios.
- Fire risk assessments had been carried out in 2016 and identified a total of 103 regulatory fire safety breaches, including 40 breaches that represented an immediate risk to the people in the buildings as well as to the infrastructure. A fire risk advisor (FRA) conducted an assessment of all three clinical floors of the main outpatients building as well as the basement in October 2016. The risk assessments found 61 areas of non-compliance with the Regulatory Reform (Fire Safety) Order 2005. Of which, 22 were considered to be of an immediate risk to the safety of people and/or the building and required immediate rectification. This included not enough fire extinguishers on the first floor, two obstructed emergency escape routes on the ground floor and faulty automatic fire doors throughout the building. An FRA conducted a fire risk assessment in the Jefferiss Wing in November 2016 and found 23 areas of non-compliance, including 10 that presented an immediate risk. This included missing ceiling tiles that meant fire could spread quickly, poor maintenance of firefighting equipment and blocked escape routes. This report identified significant safety concerns in this building and recommended that fire action plans be completely overhauled. A similar risk assessment in the diagnostic imaging unit situated in the basement of the main hospital found 19 areas of non-compliance, including eight that represented an immediate risk. This included fire-fighting equipment that was inaccessible, faulty equipment and an electrical fuse box that was damaged and open to the public.
- After our inspection we asked the trust for an update on the areas of non-compliance in fire safety. In response to the findings, the trust had entered into a six year improvement plan with the local fire authority and as of January 2017 23% of the recommendations had been addressed. Seventy percent of the remaining requirements improvements were due to be implemented by July 2017 and 7% did not have a planned completion date. Some urgent requirements had not been addressed quickly. This included no planned date for the installation of a suitable fire detection system and a delay of at least five months in acquiring additional fire extinguishers and evacuation signage.
- Each clinical area had a designated fire warden who would be responsible in the event of an evacuation. The fire warden for the shift was highlighted in daily briefings and the nurse in charge made sure any agency or locum staff were aware of this. However, staff demonstrated inconsistent knowledge of local fire procedures and none of the staff we spoke with had taken part in evacuation exercises. Fire training records indicated wide variance in completion rates despite it being part of mandatory training. For example, only 38% of doctors in training in diagnostic imaging and only 58% of administration staff in the same department had completed fire safety relevant to high-risk clinical areas. Although 100% of outpatient nurses had completed fire safety awareness training, only 67% had up to date training in fire safety for clinical areas. Other than administration staff and allied health professionals in diagnostic imaging, all staff groups in the directorates exceeded the 90% minimum target for fire awareness training. However, with the exception of scientific and technical staff in diagnostic imaging, no staff group met the 90% completion target for clinical fire safety in high-risk areas. In October 2016 an FRA documented a requirement that department leads ensure there are enough trained fire wardens for each area on shift and that staff must ensure they enrol on refresher training. In December 2016 an FRA made an immediate requirement that diagnostic imaging services on the basement level of the main hospital introduce enough fire marshals to be able to safely complete an evacuation. The requirements had not been implemented at the time of our inspection.
- Specialist staff demonstrated a proactive approach to working with emergency planning staff to address

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specific threats. For example, a HIV specialist nurse from the Wharfside Clinic worked with emergency planning and infection control staff to plan for infectious disease treatment provision in the event of an Ebola outbreak.

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:

- Staff in each service provided care and treatment that was benchmarked against the guidance of national bodies of practice, including the Medicines and Healthcare Products Regulatory Agency, National Institute of Health and Care Excellence, the Faculty of Sexual and Reproductive Health and the British HIV Association.
- Dedicated radiation protection advisers and radiation protection supervisors were in post and provided oversight for diagnostic imaging services to comply with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2006 and the IR(ME) Amendment Regulations 2011 safety guidance.
- Nurses, nursing assistants and healthcare assistants had opportunities to develop audits, particularly in sexual health services. This included completion of Public Health England audits to benchmark the standard of swab samples for certain infections.
- Improvements had been made in main outpatients that enabled patients to schedule a follow-up appointment before they left the department. In addition, clinicians recorded appointment outcomes no later than the following day to ensure accuracy and timeliness.
- Test results in sexual health and HIV services were provided within 72 hours by an on-site laboratory.
- Nurses, nursing assistants and healthcare assistants undertook a period of induction and supernumerary practice before being tested on their practical competencies to work alone.

- Staff in sexual health and HIV services were supported to undertake a range of specialist training, including accreditation from the British Association for Sexual Health and HIV STI Foundation Competencies, access to an academic development pathway and support to complete accredited diplomas and Masters programmes of study.
- Staff spoke positively about the annual appraisal and professional development record process and said they had been able to secure training and development activities as a result.
- There was evidence of multidisciplinary working, including with safeguarding and infection control teams and between specialties. Weekly and fortnightly cross-site multidisciplinary meetings took place in diagnostic imaging that enabled clinicians to support each other and strategise complex cases.
- Staff in the adolescent HIV transition clinic worked as a multidisciplinary team to support patients moving between young people and adult services.

However:

- Local audits in January 2016 identified a lack of space for waiting patients in the urology-gynaecology and fracture clinics as an area for improvement but no action had been taken to date to improve this.
- Although induction processes for diagnostic imaging staff were robust and designed to test competency, there was room for improvement in the documentation of inductions.

Evidence-based care and treatment

- Diagnostic imaging services complied with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2006 and the IR(ME) Amendment Regulations 2011. This included availability of three radiation protection advisers in the trust and three radiation protection supervisors at this site and well defined referrer, operator and practitioner roles and responsibilities.
- The trust was licensed by the Administration of Radioactive Substances Advisory Committee to provide radioactive medicinal products by certified staff.

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- Staff in diagnostic imaging used the National Diagnostic Reference Levels (NDRLs) in line with IR(ME)R guidance for computed tomography (CT) scans, general radiography and fluoroscopy.
- Care, treatment and staff training in sexual health services was delivered according to national best practice guidance issues by the Faculty of Sexual and Reproductive Health (FSRH) and the British Association of Sexual Health and HIV (BASHH). Staff in HIV services followed national (BHIVA) guidance.
- The head of specialty for genitourinary medicine prepared guidelines for BASHH and staff told us she was proactive in sharing this with the whole team, which contributed to on-going updates of expertise.
- Nursing assistants (NA) in sexual health and HIV services were supported to develop their skills and experience by leading or supporting local audits. For example, one NA worked with a nurse to audit the quality of swab samples submitted to the laboratory for gonorrhoea testing in line with Public Health England guidance. Nurses were also involved in auditing the care of patients who had experienced sexual assault and were designing an audit protocol to assess the effectiveness of a new hepatitis pathway. Nurses involved in audits were given two presentation slots per year in divisional meetings to present their work.
- An outpatient audit in January 2016 identified a lack of space and overbooked clinics in the urology-gynaecology clinic and a lack of clinical space in the fracture clinic as risks to the services. Although a review of capacity had been undertaken, there was no mitigating action taken.
- Pathology services utilised an annual audit plan for infection immunity that included two audits at St Mary's Hospital to benchmark services against national standards. One audit was ongoing in respiratory medicine to test the efficacy of new testing equipment for tuberculosis and another audit was to assess diagnostic compliance of syphilis testing with national guidelines.

Equipment

- Ultrasound equipment was ageing and staff told us this meant it produced substandard image quality. This was

noted on the service risk register in addition to the risk of chiller units failing. The trust was in the process of moving maintenance to a managed equipment service that would ensure more timely replacement.

- The imaging trauma unit was equipped with two scanners for the emergency department and could provide urgent ultrasounds, plain film, MRIs, CTs and x-rays. This unit was also able to see outpatients out of hours who required acute imaging.

Patient outcomes

- Staff used a trust IR(ME)R policy to ensure patient referrals for radiation treatment met established safety and medical criteria.
- The trust did not participate in the Imaging Services Accreditation Scheme and included this in a developmental strategy.
- Improvements had been made in how patients seen in main outpatients were followed-up. A new leadership team and strategy had implemented a standard operating procedure that meant patients could book a follow-up appointment before they left the department. In addition, staff recorded the final outcome of each appointment no later than the day after the appointment. This ensured notes were timely and accurate.
- Clinical nurse specialists across the trust used treatment pathways to ensure patients were seen at the most appropriate place. For example, if head or neck cancer was diagnosed at St Mary's Hospital, staff would refer the patient for treatment to another of the trust's sites.
- Staff in nuclear medicine rotated between three sites to take advantage of their experience during a period of staffing shortages and used common treatment protocols to ensure continuity of care.
- An electrocardiogram (ECG) technician was available in the cardiology clinic at all times and ensured each new patient received appropriate tests as well as their medical consultation.
- Test results in sexual health and HIV services were provided within 72 hours of testing by an on-site

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laboratory and were sent to the requesting clinician. Junior doctors had access to all test results and reviewed these as they arrived, with rapid escalation to a consultant if needed.

- Between April 2015 and March 2016, the ratio of follow up appointments to new appointment was lower than the national average, at an average of 2.3:1 compared with the national average of around 4:1.
- Between January 2016 and December 2016, 74% of patients with suspected cancer had an appointment scheduled within two days of receipt of the referral. This was lower than the hospital's 98% target. However, in this period the hospital met the two week wait target for cancer review appointments in every month, with an average wait of 1.5 weeks.
- The hospital monitored waiting times in diagnostic imaging against the national diagnostic target of six weeks. Between April 2016 and December 2016, waiting times in for the five core diagnostics offered were significantly better than the target in every week, with an overall average wait of 2.9 weeks.

Competent staff

- Main outpatients did not have a dedicated education and learning post but the senior sister and charge nurse organised mentorships and specialist training, including in dermatology and diabetes. This enabled staff to move between clinics in line with the needs of the service.
- New nurses, healthcare assistants and NAs undertook a period of induction and supernumerary practice before working alone. In sexual health, the NA supernumerary period lasted two weeks during which time they were 'buddied' with an experienced member of staff and given time to complete study modules.
- Staff in diagnostic imaging underwent a local induction in addition to the trust induction that included IR(ME)R practitioner induction for plain film. However, this was not documented in any local procedures or policies and so could not always be evidenced. Senior staff practitioners acting under IR(ME)R regulations vetted scans and used quality assurance checks to make sure they were carried out appropriately. Local induction for CT scans was comprehensive and included the trauma unit, with a requirement that a senior member of the team observe staff to establish their competency.
- All staff in the fracture clinic had undergone an appraisal in the 12 months prior to our inspection.
- We looked at a sample of seven anonymised appraisals for clinical and non-clinical staff. In each case staff were given the opportunity to identify their positive achievements in the previous year and work with their line manager to establish what they planned for the next 12 months. Each appraisal included evidence of professional development, including through leadership courses, specialist training and successful completion of clinical competency checks. The appraisal structure provided a supportive framework staff could use to progress their career and ensure their clinical practice met trust and national standards.
- Staff in sexual health and HIV services had access to an academic development pathway. The senior team used this to encourage staff to continue their education and seek professional development in the service.
- Radiology services had introduced a picture archiving and communication system (PACS). A radiographer manager working in the department had been involved in the development and rollout of the system, which helped ensure staff competencies developed alongside this.
- Not all staff in radiology had intravenous cannulation training and service managers were sourcing less costly training courses to improve this. Intravenous cannulation training was mandatory for all senior radiographic staff, although all staff had been trained internally, at the time of the inspection some staff were on the waiting list to be attend the external course to achieve a national certification.
- Junior staff in diagnostic imaging told us they were supported by the CT lead to rotate through different areas in the department, which they felt enhanced their competency and skills development.
- Nurse practitioners in sexual health and HIV services were trained in motivational interviewing for harm reduction. This meant they could effectively communicate with a diverse range of people about sensitive or safety critical subjects, such as sexual risk and drug use. This unit demonstrated a sustained and consistent approach to ensuring staff were highly skilled. For instance, NAs and nurses were trained in the aseptic non-touch technique, administering Hepatitis B

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vaccinations, microscopy and conducting intimate exams. Staff also completed partner notification workshops and British Association for Sexual Health and HIV (BASHH) training in caring for asymptomatic patients. The service provided training accreditation for all clinical staff from the BASHH STI Foundation Competencies (STIFF). All staff at band seven and above were accredited to the advanced STIFF level and all other clinical staff were accredited to STIFF level one.

- All band six nurses in sexual health and HIV had completed or were working towards a diploma from the FSRH in subdermal implants and band seven nurses were working towards a diploma in coil fitting. All staff in the SHIP team had completed training in sexual health advising.
- FSRH diplomas and BASHH accreditation was available to F2-grade doctors and a specialist trainee pathway was offered to registrars.
- Champions in domestic violence had been trained in sexual health and HIV services and were able to provide structured advice to any member of staff, including in urgent situations. The champions were supported by the SHIP team who could provide additional expertise and guidance.
- All staff in sexual health and HIV services were invited to submit an abstract to the annual BASHH conference. If this was accepted, the senior team supported their attendance as a development opportunity and they presented their experience back to the team.
- Qualified nurses in sexual health and HIV services had the opportunity to rotate between the two clinical areas after six months of experience. This enabled them to develop new skills, such as in cryotherapy and partner notification.
- Advanced nurse practitioners led staff training and skill development in the Wharfside clinic and a nurse consultant education lead fulfilled this role for sexual health services. Nurses in the Wharfside clinic undertook specialist training every two months, such as in caring for patients with complex comorbidities, including HIV and Hepatitis C.
- Staff completed an annual appraisal or professional development review (PDR) with support from their line manager. All of the staff we spoke with were positive

about this process and said it helped them to benchmark their practice and performance against the needs of their patients and expectations of their respective department. Appraisal rates were generally high. In the Jefferiss Wing, 100% of staff had a PDR update in the previous year.

- A specialist cardiac physiologist in the cardiac diagnostics department attended monthly medical devices meetings to ensure the service was up to date with the latest equipment usage advice.

Multidisciplinary working

- Outpatient services worked together to meet the needs of patients, including unplanned needs. This included audiology support for all clinics and speech and language therapists working in consultant-led ear, nose and throat clinics.
- Weekly and fortnightly cross-site multidisciplinary meetings took place in diagnostic imaging in a dedicated room with capacity for 100 people and videoconferencing capability.
- Internal multidisciplinary working between diagnostic imaging staff ensured patients received treatment in the most appropriate location. For example, patients who were prescribed beta blockers had their moves minimised and scans in the hospital conducted in the area nearest to them.
- Staff in the adolescent HIV transition clinic worked as a multidisciplinary team to support patients moving between young people and adult services. For example, this process was led by a paediatric HIV consultant, an adult HIV consultant and an advanced nurse practitioner. A paediatric nurse could also support this process if necessary.
- Sexual health and HIV services had embedded links with a broad multidisciplinary team of specialties. This included a psychosexual consultant, psychiatric liaison nurse, accident and emergency department liaison, HIV dietician, smoking cessation nurse and a neurology consultant to support patients with HIV and dementia. The service demonstrated a track record of positive patient outcomes as a result of multidisciplinary working. For example, by working with geriatricians,

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dementia specialist nurses and staff in accident and emergency (A&E), the service achieved a community placement for a patient living with HIV and dementia who attended A&E unnecessarily on a frequent basis.

- A professor in HIV ran a joint specialist clinic with a consultant neurologist for patients with neurocognitive impairment and other complex neurological conditions. A specialist eye clinic for HIV patients was also available every week.
- Weekly multidisciplinary lung cancer meetings were held with a consultant chest physician, respiratory physiologists and other clinicians from the chest unit. This unit ran as a multidisciplinary service. We spoke with a community respiratory nurse specialist who said they received “excellent” support from consultants and the lung function team.
- Cardiologists and echocardiogram physiologists attended weekly multidisciplinary meetings in the cardiac diagnostics department.
- Sexual health services had established agreements with the emergency gynaecology service to undertake urgent pelvic ultrasounds when needed. Staff could also refer patients for rapid testicular ultrasounds.

Seven-day services

- The trust planned to introduce bookable seven-day access to outpatient diagnostic imaging services in early 2017.
- At the time of our inspection, trauma imaging services were available 24-hours, seven days a week.
- A specialist registrar and interventional radiologists were available on-call 24-hours, seven days a week and consultants had remote access to the PACS.
- Individual specialties determined their own level of out of hours cover for emergencies. For example, a cardiologist and HIV consultant were always available on call.

Access to information

- As part of the outpatient improvement programme, a strategy had been implemented to improve the availability of case notes and reduce the risk patients would arrive for an appointment and the doctor did not have their records. The strategy included digitising

existing health records and the use of an electronic system for new patients. This would also reduce the reliance on temporary paper records. In October 2016 the trust was digitising records at a rate of 80,000 per month.

- All of the staff we spoke with told us there had been a sustained improvement in the quality, availability and tracking of patient notes in the previous year.
- Patient records for sexual health and HIV services were stored on-site in the Jefferiss Wing. Administration staff ensured clinicians had ready access to these, including for pre-booked appointments.
- Patients told us they had noticed an improvement in communication between the hospital and their GP. This included more detailed information sent to them and GPs better informed of what had happened in the hospital. The diagnostic imaging risk register included a risk that GPs would not receive imaging results because the IT system used by the trust was incompatible with the GP records system. To address this, the IT department monitored results transmissions daily and the imaging department sent failed transmissions by fax instead.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguard**
- Staff demonstrated knowledge of the Mental Capacity Act (2005) at levels appropriate to their job role and responsibilities. Protocols were in place to support staff when they had concerns about a person’s capacity to consent to treatment and staff showed us how they could access these.
- An appropriate clinician had documented consent in all of the records we looked at.
- Consent processes in diagnostic imaging were robust and ensured patient consent was documented by the referring clinician and by the radiographer before a procedure was carried out.
- Nurses in sexual health and HIV services were trained to complete initial mental capacity assessments and advanced nurse practitioners and doctors were able to complete full assessments under the MCA.

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- All clinical staff in sexual health and HIV services who could see patients independently had completed training in the Fraser guidelines and Gillick competencies. In these services 80% of clinical staff had up to date training in mental capacity.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because:

- Staff treated patients with kindness and a friendly manner during all of our observations, including in clinical and non-clinical settings.
- Reception staff demonstrated understanding and patience when dealing with anxious or flustered patients and we saw reception staff in the Jefferiss Wing treat people who were waiting outside with particular compassion while they waited.
- Patients consistently told us they felt welcomed and valued in the service and they found staff attitudes to be memorable because of their warmth and positivity.
- When clinics were delayed or disrupted staff maintained communication with patients every 30 minutes and offered them water and advice about the delay and options for rebooking.

Compassionate care

- We observed interactions between reception staff and patients on 17 occasions in 11 different areas. In every case the receptionist greeted the patient politely and with a friendly manner. Where patients had difficulty communicating, either because of a language barrier or a speech issue, receptionists were patient and kind.
- We observed a healthcare assistant in the fracture clinic speak gently and reassuringly with a patient who was confused and asking for analgesia. They made sure the patient was calm and orientated before seeking help from a nurse.
- Staff in the Jefferiss Wing treated patients with respect and kindness. For example, we saw a doctor gently and discreetly wake a patient up who had fallen asleep in the waiting room, offering them reassurance and

humour afterwards. During another observation we saw a doctor recognised a waiting patient and greeted them with a manner that demonstrably pleased the individual.

- Patients told us staff were kind and friendly towards them. One patient in main outpatients said, “The care couldn’t be better.” One patient in the dermatology clinic said, “Everyone here is really nice, they always are” and one patient in the diabetic clinic described the consultant care and approach of the healthcare assistants as “first class.”
- Results from the patient survey in the Jefferiss Wing were consistently positive. Between November 2015 and December 2016 88% of patients said they would recommend the Wharfside clinic, 94% of patients would recommend the walk-in clinic and 98% of patients would recommend the sexual health service.

Understanding and involvement of patients and those close to them

- When a large queue formed for access to the sexual health drop-in clinic, we saw a receptionist spoke with patients one by one and gave them a registration form as well as information about the waiting time. Where someone had anxiety about the length of the wait or process, the member of staff offered calm reassurance as well as information about when the clinic usually had quieter periods.
- Patients we spoke with said they felt services tried to accommodate their needs. For example, one patient who was due to have a biopsy asked staff if they could move the appointment to later in the day, when a relative would be available to accompany them. They said this was changed without a problem. Another patient said staff were helpful and accommodating when they had asked to make changes.
- Patients told us they felt involved in their care and treatment. One patient said, “The doctor always shares his treatment plan with me.”
- A new standard operating procedure in main outpatients meant staff were more actively involved in communication with patients during periods of delay or disruption. In such circumstances staff provided an update to patients every 30 minutes.

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- Nurses and healthcare assistants in main outpatients demonstrated an understanding of patient frustration and helped to improve their experience. For example, we observed staff routinely apologise to patients and explain what had caused the delay. Staff also offered patients a glass of water.

Emotional support

- Chaplaincy, emotional support and counselling services were available to patients in the hospital and these services were signposted in waiting areas.
- Staff routinely provided printed and/or electronic information to patients with more information about their condition.
- Staff in the Wharfside clinic along with the specialist sexual health information and protection team were trained to provide emotional support to patients to help them adjust to an HIV diagnosis.
- The hospital had established provision to support patients who experience domestic violence to access crisis and mental health services.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated responsive as requires 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.

- Waiting times in clinic for some services differed significantly between sites in the trust. This included ultrasound where the average wait for an appointment at St Mary's Hospital was 30 days from referral. This is within the national target of six weeks.
- There was limited space in many of the specialist clinical areas that impacted patient comfort and safety whilst waiting for appointments. This included overcrowded waiting areas such as in the diabetes and endocrine unit and ear, nose and throat (ENT) clinic. A trust action plan to identify better use of space in ENT had not been updated since February 2016.
- Navigation between services was problematic due to a lack of or confusing signage. Staff provided maps for patients and volunteers worked in some areas to help guide patients but staff in areas such as electrophysiology reported on-going concerns about this.
- Some patient waiting areas were cramped and not large enough to meet demand.
- There were limited resources to support patients with a learning disability and not all staff knew who to contact for support.

However:

- A wide range of services were available in response to the needs of the local population, including audiology support, specialist orthopaedic clinics, facilities for forensic examination of young people and rapid-result laboratory facilities in sexual health and HIV services. The chest clinic offered five core areas of treatment and four specialist consultant-led clinics.
- Sexual health and HIV services offered nine specialist clinics and a sexual health information and protection team (SHIP) provided targeted clinical care and treatment for vulnerable and at-risk patients.
- The volunteer service had started a pilot programme in main outpatients to scope the potential benefits and impact on patient experience of having a team based there permanently.
- An outpatient improvement programme was in place to reduce waiting times and delays to clinics. This information was monitored and between June 2016 and November 2016, an average of 73% of doctors were on

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time for clinics and 24% of doctors were up to 30 minutes late. The improvement plan had led to a number of actions to reduce wasted appointments by patients who did not attend, including a restructured appointment communication process.

- A new standard operating procedure enabled senior staff in main outpatients to escalate to the management team if a doctor was late for a clinic that resulted in delays to patients. We saw this worked well during our observations.
- Staff audited clinic delays through a new electronic appointments system. This was in the implementation phase but all of the clinics that used it were able to submit data so staff could identify when delays occurred and why.
- In November 2016, main outpatients had achieved a turnaround time of 10 days for 95% of referrals, which was the trust target.
- A range of access pathways for sexual health and HIV services meant patients were quickly directed to the most appropriate service and clinician. A pilot was underway to establish the usefulness of offering pre bookable appointments for asymptomatic patients 48 hours in advance.
- A new complaints and concerns policy enabled complaints to be recorded, investigated and resolved within the trust's 40 day maximum target. The new system also enabled services to identify trends in complaints to drive improvements.
- Although imaging staff were rotated between sites to reduce the impact of short staffing, waiting times different significantly. For example, the standard wait for an ultrasound at St Mary's Hospital was 30 days but the wait for the same procedure at Hammersmith Hospital was only 10 days.
- Navigation at the St Mary's site could be problematic due to service areas located in multiple areas with considerable distances between them. For example, although a phlebotomy unit was located in main outpatients; all other areas for tests such as x-rays and lung function were located elsewhere. This could not be fully mitigated until a new department was built, which was planned for 2020. As an interim measure, staff had replaced signage around outpatients and in the main hospital building and had produced easy-read and colour-coded maps to help people navigate. A pilot scheme had enabled volunteers to be based in the department and this team were also able to help patients navigate the site, including escorting them if needed. Staff in the electrophysiology department told us patients often arrived confused or anxious because it was so difficult to find. Staff told us they had not been able to secure improvements to signage in the building despite escalating the issue.
- Staff in main outpatients, sexual health and HIV services could deliver the flu vaccine at the time of a routine or walk-in appointment.
- Sexual health and HIV services offered nine specialist clinics, including sexual health for young people, a sexual function clinic, an emergency HIV clinic, gender-specific clinics and a sex worker support service.
- The sexual health information and protection (SHIP) team was formed to provide a dedicated service for those most at risk of sexually transmitted infections including vulnerable patients. A team of experienced nurse practitioners led this team and could provide microscopy, differential diagnosis, health promotion and treatment for sexually transmitted infections. This meant patients had one point of contact and did not need to see multiple clinicians, which could increase stress and anxiety. In addition the SHIP team provided care for patients who experienced domestic and sexual

Service planning and delivery to meet the needs of local people

- A dedicated audiology clinic provided service to ear, nose and throat (ENT) patients during new and review appointments. The service also provided direct access clinics for age-related hearing loss.
- A fracture clinic operated daily Monday to Friday and specialised orthopaedic clinics were available.
- The Jefferiss Wing had an on-site laboratory that provided immediate medical support to staff taking tests in sexual health and HIV services.
- A specific room to care for young people who needed forensic examination was available in paediatric outpatients.

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violence and for all patients with complex sociosexual and/or safeguarding needs. Sub-specialty services included vulval dermatology, biopsies and chronic pelvic pain.

- The SHIP team participated in a healthy school relationship education network that enabled them to provide sex education and advice to young people.
- A dedicated adolescent HIV transition clinic was led by an advanced nurse practitioner and consultant. This service helped support young people in moving between young people's services and adult services for treatment management.
- The chest clinic offered capillary and arterial blood gas testing, pulmonary function tests (PFTs), follow-ups to patients who had been treated with continuous positive airway pressure and long term oxygen therapy for patients with chronic obstructive pulmonary disease. Consultant-led clinics were also available for tuberculosis, lung cancer, asthma and bronchitis.
- A team of 150 volunteers provided welcome and meet and greet services across the trust and had started a trial in main outpatients to identify if the team could have a positive impact on patient experience. As part of the trial the team wore new uniforms that were designed to make them easily identifiable by patients.
- Specialist outreach workers from non-profit agencies held sessions in sexual health and HIV services to provide additional capacity for harm and risk reduction with specific patient groups.

Access and flow

- 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. The trust are showing a downward trend which is in line with the trend in the England average which is also getting worse.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services was 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 is 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 cancer waiting times: 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 cancer waiting times: 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 cancer waiting times: patients receiving their first treatment within 62 days of an urgent GP referral. Performance fell over two of the last three quarters but recovered in Q2 2016/17 to 80.1% which was still below the England average of 82.3%.
- Between August 2015 and July 2016 the percentage of patients waiting more than six weeks to see a clinician was lower than the England average.
- Staff monitored the punctuality of doctors in outpatient clinics as part of an overall improvement strategy to reduce waiting times and delays. Between June 2016 and November 2016, an average of 73% of doctors were on time for clinics, 24% of doctors were up to 30 minutes late and 3% were over 30 minutes late.
- Between April 2015 and March 2016 the 'did not attend' (DNA) rate for outpatients was between 8% and 10%, which was higher than the national average rate of 7%. This aspect of access and flow was a key focus of the trust's outpatient improvement programme. As a strategy to reduce the DNA rate, the trust introduced tracking of appointment letters from print to dispatch, introduced a voice reminder service as well as text, voicemail and e-mail options and improved the clarity of information sent out in letters. This reduced the trust-wide figure of outpatient DNAs from 17% in September 2014 to 11.3% in October 2016.
- Between December 2015 and December 2016, outpatient services cancelled 5856 appointments due to

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administrative errors, patient error in booking or clinic cancellations within six weeks of the appointment. This equated to 7.9% of appointments, which was better than the maximum appointment cancellation target of 8.5%.

- Routine magnetic resonance imaging (MRI) scans were available from 8am to 8pm Monday to Friday and from 9am to 5pm on Saturdays. Emergency MRIs were available in the imaging trauma unit 24-hours, seven days a week.
- A new senior nursing team in main outpatients implemented changes in flow management and introduced a new standard operating procedure (SOP) to reduce delays and improve the service. For example, if a doctor was not present 15 minutes later than the planned start time of a clinic, the senior sister would escalate this to a manager. Staff told us this meant punctuality had improved and doctors routinely told the nurse in charge when they had arrived. We saw the escalation process worked well in practice. For example we saw a consultant had not arrived in the vascular clinic 15 minutes after its start time. The specialist registrar escalated this and obtained a second registrar to assist with consultations and the senior sister escalated it to the senior medical team, who found the consultant was in theatres. The senior sister spoke with waiting patients to explain the situation. It was not clear why there had not been communication between departments in advance to prevent the situation.
- As part of the new SOP, a clinic monitoring form was introduced as an auditable tool to help staff monitor where delays most often occurred. Staff running each clinic added feedback to the forms so that the senior team could establish how best to improve waiting times. The outpatient senior sister met with clinical leads to discuss tracked performance of each clinic, which was organised responsively depending on the performance of the clinic. For example, meeting with the hepatology lead took place every six weeks and with the neurology team every month.
- We looked at 12 completed clinic monitoring forms and noted they did not include the time patients were actually seen. We spoke with the general manager and senior sister about this. Patients who used the self-check-in system were called to their appointment room through the electronic system, which recorded the time they were seen. This system was in the implementation stage and 50% of clinics used it, which meant the time difference between the booked appointments and being seen was available for these patients.
- At the time of our inspection the trust was reporting 44% patients waiting over 30 minutes to see a clinician (this is the proportion of clinics which overrun by more than 30 minutes, so the trust has assumed the worst case scenario and that all patients are impacted by the delay).
- Between February 2016 and December 2016, 61% of patients were seen on time and 29% were seen within 20 minutes of their booked time. Once the electronic system was fully functional in all clinics, waiting times would be audited fully. The senior sister identified clinics with good levels of compliance with the new process during daily briefings. In one briefing we observed the neurology clinic had achieved 98% compliance on the previous day.
- Cardiology clinic bookings did not include pre-booked tests, which staff said meant they often ran late. For example, new patients always underwent an electrocardiogram (ECG) and echocardiogram (ECHO), which meant they then had to return to the doctor to be reviewed. This was mitigated to some extent by having a dedicated ECG technician in the clinic at all times it was open. On one day of our inspection the average delay was 45 minutes for this reason. Staff in this clinic told us this was a common occurrence as up to 18 new patients per day were seen.
- ENT services were available Monday to Friday with an emergency referral service available on a Wednesday afternoon.
- Waiting times to have a hearing aid fitted in the audiology department depended on the type of equipment needed. For example, an open fit model could be inserted one week after an initial assessment but moulded fit models could take up to five weeks.
- Patients gave us varying feedback of their experiences of waiting times. Six patients told us they had noticed a reduction in late clinics in the previous year and said they rarely waited more than 20 minutes past their appointment time. Another patient said there were often lengthy waits in phlebotomy and appointments in

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the vascular clinic were often changed by the service several times. We spoke with nurses about this who told us delays in the phlebotomy unit were common but phlebotomy staff would advise people when their quieter times were so they had the option of coming back then. In addition, the haematology service provided staff to help in phlebotomy for two sessions each week.

- A new centralised booking system had been implemented to make appointment management more responsive to patient need. Individual outpatient specialties could decide if they wanted patients to book follow-up appointments through central booking or on-site at the time of their appointment.
- Staff identified cardiology, rheumatology and neurology as the clinics that most often ran late. This was because appointment slots were for 10 minutes but some patients needed up to 30 minutes. We spoke with the senior sister and two consultants about this who told us the templates for each clinic, which was used to structure appointment length, were under review by each specialty to identify how they could be more flexible or allocate extra time for each patient. This had resulted in early improvements, such as the removal of the ability to double-book appointments and a new template for the hepatology clinic that would allow staff to more accurately record waiting, treatment and departure times. This clinic had also introduced longer appointment times as a trial to reduce delays.
- If a patient did not attend for an urgent cancer referral, they were always offered a new appointment within two weeks.
- The Jefferiss Wing offered a range of clinics and access times that had been developed to meet the needs of patients. This included a rapid 'check and go' service for sexual health from 9am to 6.30pm Monday to Thursday and 9am to 4pm on Fridays. Early clinics were offered two days per week and sexual health checks and testing services were available five days a week. In response to patient feedback, the sexual health service had introduced a new asymptomatic care pathway that included pre bookable appointments online. The appointments were released 48 hours in advance and gave patients a time slot to attend that meant they could better plan their time in the clinic. Staff aimed towards a one hour assessment and treatment target for

patients who were asymptomatic and attended the walk-in clinic. In October 2016 76% of patients were seen within this target. The HIV service operated an emergency clinic for patients who had run out of medication or who had symptoms that needed urgent attention.

- Treatment pathways in the sexual health unit were divided into symptomatic and asymptomatic streams, which helped staff to see patients more efficiently by using the most appropriate staff. For example, symptomatic patients would be seen by a nurse and doctor and asymptomatic patients would be seen by staff trained in contraception and sexual health testing.
- A policy was in place in the Jefferiss Wing for times of exceptional demand on the walk-in service. The nurse in charge would triage patients in the waiting areas to prioritise those with the highest level of need. The nurse in charge would then meet with the consultant in charge to expedite patient pathways and in exceptional circumstances allocate slots for patients to return the next day.
- The chest clinic was equipped to offer respiratory consultant review and pulmonary function tests, led by specialist physiologists. Emergency PFTs and appointments for cases of suspected TB were available within two weeks of referral and in this clinic we saw low waiting times with few delays.
- The booking and appointment system in the dermatology day treatment unit meant there were no delays. This system included separate appointments for each patient symptom or complaint and one hour review slots for new patients. Routine referrals were given an appointment in four to six weeks and urgent referrals were seen in two to four weeks. This information was provided by senior staff in the department although no audit data were available.
- Routine ECHO appointments in the cardiac diagnostics department were available with two to six weeks' notice. Urgent ECHO appointments were available for same-day referral.
- Staff in the diabetes and endocrine unit were able to facilitate urgent appointments for patients who turned up without an appointment if clinically appropriate. Routine referrals in this clinic were seen within 13 weeks and doctors operated extra clinics if waiting lists were

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about to exceed this. Referrals to the weekly lipid clinic were also seen within 13 weeks. One patient we spoke with during the inspection said service in the clinic was variable. For example, they had visited in June 2016 and experienced a delay of 94 minutes with no information about the delay on the information board. Staff told us this was a rare occurrence and would only occur if a member of staff was off sick or if an emergency meant they needed to see patients urgently.

- Referrals to the electrophysiology department were seen within three weeks and the administrator told us they could accommodate urgent requests. This service had a track record of meeting the five week target for time from referral to appointment.
- Main outpatients monitored the turnaround time of referrals received with appointments. In November 2016, the department had achieved a turnaround time of 10 days for 95% of referrals, which was the trust target. In addition the department completed a consultation with a specialist organisation that helped to redesign printing and posting systems to ensure patients received letters in a timely manner. This involved a review of the patient database against Royal Mail records and digitisation of the letter dispatch process. An e-mail service was implemented in September 2016 and patients were routinely offered this.
- During our inspection we reviewed clinic waiting times in main outpatients at three points in time. This included a total of 19 clinics and 24 doctors. Overall 13 clinics were on time. Delays were found on two occasions in the ENT clinic and the vascular clinic. Most delays were less than 30 minutes, with the exception of cardiology where one doctor was running 55 minutes late. Where clinics were running late staff had written up to date information on a display board, apologised to patients and explained the situation.
- At the time of our inspection the trust was reporting that less than 2% of patients were being seen in Outpatients without the full medical record being available.

Meeting people's individual needs

- Waiting times were displayed on boards in each clinic area and staff updated these whenever there was a change, or at hourly intervals. In addition staff in each clinic carried an egg timer with them to remind them to

update patients every 30 minutes during a delay. Staff advised patients of the waiting times on arrival in main outpatients and in sexual health walk-in services they were given an estimate of visit time.

- Separate waiting areas for men and women were provided in the sexual health unit and each had gender and condition-specific printed information available for patients. In addition, staff had created an electronic access option as an alternative to printed information from a sexual health charity. For example, QR codes linked to specific subjects were on display in waiting areas and patients could use their smartphone to access the information.
- Self-check-in machines were available in main outpatients and the Wharfside clinic and included instructions in 23 different languages the trust had identified as spoken locally. Managers monitored the most used languages and ensured they were prominently displayed on the welcome screen for easy access. The machines directed patients to the appropriate waiting areas and signage in the building matched the exact words used in on-screen information. Receptionists were available to provide one-to-one check-in and directions at all times when the department was open and a pilot volunteer scheme in main outpatients meant at busy times volunteers could also help direct patients.
- Reception areas were fitted with hearing loops, which were advertised to patients and visitors.
- Waiting areas in the main outpatients department had a range of seating available, including with and without arms and bariatric chairs.
- Signs in main outpatients advertised an e-mail appointment service to patients who wanted it.
- The audiology department had limited access space and we saw it became overcrowded due to having only two testing booths.
- Information on display in paediatric outpatients included a television screen that encouraged patients and parents to let staff know how they preferred to be addressed. Information for young people on the dates of various religious festivals was also on display, such as Diwali and Christmas.

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- Waiting areas had television screens that displayed information on the services provided, key members of staff and contact information, including social media.
- Staff in paediatric outpatients were not informed in advance if a patient had a learning disability but were able to adapt the service as they became accustomed to the individual's needs. For example, they could arrange appointments in the first or last slots of the day to avoid the anxiety arriving into a busy waiting room could cause.
- All departments had access to telephone or in-person interpreters.
- Most patient waiting areas were equipped with wi-fi.
- Posters were on display to advise patients that private areas were available if they wanted to speak with staff.
- Appointment reminders from main outpatients were sent out by text, e-mail or letter according to each patient's preference.
- Specialist sexual health clinics had adapted to the needs of individual people. For example a sexual function clinic included psychologist input and offered a consultant led sexual dysfunction service.
- A specialist trainee led the HIV emergency clinic under direct consultant supervision patients had direct line access to them and were able to attend the clinic at short notice. This member of staff also provided on-call advice to staff in the accident and emergency department.
- There were limited resources for patients with a learning disability and not all staff we spoke with knew if the trust had a learning disability lead. In sexual health, staff said they would refer to the SHIP team, who we confirmed were resourced to support patients with a learning disability.
- A psychosexual consultant was available in the Jefferiss Wing and a psychiatric liaison nurse ran three clinics per week and supported patients with issues such as alcohol dependency and depression.
- Although space was very limited in most areas for patients, the Coulter Suite, which provided dynamic endocrine testing, was spacious and comfortable with large chairs for patients whilst they underwent blood and endocrine tests.

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.
- A new complaints and concerns policy had been established following the centralisation of the complaints process, which included responsibility for complaints moved to the corporate nursing directorate. The complaints and service improvement manager implemented a 'change register' to identify and monitor all of the changes made as a result of complaints. This process helped to identify how divisional services were improving as a result of patient complaints.
- Between October 2015 and August 2016, outpatient services received six formal complaints and diagnostic imaging received 20 formal complaints. Five of the outpatient complaints and three imaging complaints related to poor communication about clinic running times or clinic delays. In each case, staff had recorded an apology to the patient as well as corrective action taken. For example, when a patient had been incorrectly booked into a clinic, the team responsible had been given additional training. The new centralised booking system would also prevent future recurrences. All of the complaints looked at this in this period had been resolved within the 40 day target established by the trust. However, there were not procedures in place to ensure third party contractors who provided services on behalf of the directorate were equipped to resolve complaints. For example, a mobile MRI scanner was available on site and was used to increase capacity. This was provided by an external agency. When a patient

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submitted a formal complaint about this, the complaint coordinator was not able to obtain a timely response from the operator. The recorded complaint outcome stated that staff would continue to “chase up” the company responsible. One outpatient complaint related to the attitude of an agency nurse but there was no documented follow-up to this.

- Between January 2016 and November 2016, Jefferiss Wing services received four formal complaints. Three complaints related to patient experience in the walk-in clinic, including two complaints about delays to results. One complaint related to a reaction a patient experienced during a clinical trial. In each case the general manager contacted the patient and there was evidence they were kept up to date during the investigation. Changes were put in place as a result of complaints, including more detailed training for doctors with regards to information governance and training for reception staff to ensure they proactively offered patients a range of contact methods.
- ‘Let us know’ leaflets were widely available which detailed different methods of providing feedback. This was also a resource to signpost patients and visitors to appropriate bodies such as for complaints advocacy, Action against Medical Accidents and the Parliamentary and Health Service Ombudsman.
- All staff were able to handle verbal concerns or complaints in the first instance and each department had a clear escalation policy so that an appropriate senior person was made aware of the situation. Staff also referred patients to the patient advice and liaison service (PALS) if they wanted their complaint to be investigated by staff not directly involved in the department. Outpatient departments let the PALS team know when clinics were running late and what the reason was so they could be better prepared to discuss concerns with patients.
- Staff working in the trust’s improvement project took a lead in resolving patient complaints at the local level. A doctor told us this worked well because those in the improvement project were very interested in dealing with problems and were able to get to the bottom of issues quickly.

Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

- A new general manager and senior sister in main outpatients had conducted a significant nursing and leadership review of the service and restructured it to deliver results in the outpatient improvement programme. This was a collaborative project with a proactive programme manager that resulted in new operating practises to reduce clinic delays, improve patient outcomes and ensure the staff team was sustainable.
- All of the staff we spoke with were positive about the overall vision and future strategy for the trust. Most staff also felt empowered to promote positive change and provide suggestions for improvement in their own local services.
- Staff in diagnostic imaging, sexual health and HIV were research active and sought out projects that would help them develop their services.
- Clinical governance structures helped staff to manage risks to services and involved an appropriate range of staff in most cases. Risk registers were updated regularly and staff with appropriate experience and knowledge managed these.
- All services demonstrated high standards of information governance and patient confidentiality.
- The majority of staff we spoke with felt positively about the leadership in their service and described a work culture that facilitated development and innovation. This was particularly the case in cardiac, sexual health and HIV services.
- Feedback from patient engagement was used to improve services, particularly with regards to staff communication in main outpatients and the role of trust volunteers.
- Individual services engaged with their staff teams to improve working conditions and deliver better patient

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services. This included through consultation on working patterns and the implementation of a working group in diagnostic imaging to identify solutions to some of the challenges the team faced.

- Staff felt recognised and rewarded for their work through trust and local initiatives and spoke positively of opportunities to work with colleagues in other areas to gain a better understanding of how they worked.
- A therapies quality and safety committee maintained oversight of clinical governance in individual specialist therapies clinics to ensure incidents and complaints were monitored and ensure clinical practice met trust and national guidance.

However:

- Although clinical governance meetings in diagnostic imaging were well attended and led to demonstrable outcomes, there was a lack of representation from some specialties.
- Some staff said there was a lack of development opportunities, leadership support and innovation in their area of work.
- The senior team recognised staffing shortages in diagnostic imaging placed additional pressure on staff. However it was not clear that recruitment and training plans were understood by existing staff or that they had confidence in this process. This impacted their morale and exacerbated concerns around what they perceived to be inconsistent pay and conditions in some areas.

Leadership of service

- The main outpatient service and diagnostic imaging had been restructured at a divisional level and had moved from the division of investigative sciences and clinical support services to the division of women's, children and clinical support. New leadership posts were also created, including a senior sister. Most of the staff we spoke with were positive about this change and the impact it had on patient experience and safety. One member of staff said they felt the changes had placed staff under high levels of stress, which had resulted in sickness and staff leaving.
- The senior sister in main outpatients had implemented a daily morning briefing to improve staff cohesion and morale in addition to the efficient running of the service.

We attended one briefing, which included staff at all levels, including service and general managers. The meeting had a motivational tone and the nurse in charge asked each person how they were feeling and if there was anything everyone else needed to be aware of that meant they would benefit from extra help and support. Staff achievements were acknowledged, such as a healthcare assistant who had received positive feedback from a patient the previous day.

- Staff in diagnostic imaging spoke positively about their relationship with the clinical service manager and general manager and said they were both fair and approachable.
- There were clear lines of leadership support for staff at all levels and every individual we spoke with knew who to contact if they needed help or support. Staff in sexual health and HIV services spoke positively about the leadership team and said every member of the team was approachable and open to talking with them.
- Staff described varying experiences of the trust executive team. For example, staff in diagnostic imaging said the chief nurse and chief executive often came to the department and spoke with staff whereas some staff in the Jefferiss Wing said they had not met any members of the team.

Vision and strategy for this service

- The overarching plan for outpatients and diagnostic imaging services was to successfully move all services into a new purpose-built estate due to be completed in 2020. All of the staff we spoke with across departments and grades spoke positively about this. One person in sexual health services said, "I think the vision for redevelopment is very clear and detailed. We've all been involved in it and I think it's a very exciting goal for us."
- An outpatient improvement plan, launched in spring 2015, laid out five key areas of improvement including responsiveness to customer care, communication with patients and GPs and digitising outpatient services.
- Staff in diagnostic imaging were research active and proactively participated in studies that could improve patient treatment and outcomes. In 2015/16, three research projects were active that covered four clinical

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specialties. Staff in the acute imaging centre planned to take part in research to introduce focused ultrasound treatment for brain tumours following successful trials in outside of the UK.

- Sexual health and HIV staff were in a retendering process with local commissioners. As part of this they planned to complete the pilot of pre-bookable asymptomatic pathway appointments and develop a self-swabbing service to increase efficiency for walk-in patients. Services also planned to introduce more technology to aid efficient communication with patients, such as software that would allow patients to access test results online. In addition a 'click' clinic has been established. This allowed HIV positive patients who were stable on medication to be seen in the clinic every six months for routine blood tests and see their consultant annually. Software planned for this service would allow patients to manage this themselves online. The service had also entered into a pilot scheme with a non-profit sexual health agency to offer home testing for HIV.
- The volunteering team had recently transferred from being operated and funded directly by the trust to a charity. As part of this the head of volunteering had drafted a new strategy that identified the numbers of volunteers needed, how the roles would be developed and how they would impact the quality of patient experience. The trust improvement team supported the development of volunteering services, which included planning for more robust recruitment, selection and training processes.

Governance, risk management and quality measurement

- HIV, sexual health and infectious disease services were a directorate within the medicine division led by a clinical director, lead nurse and general manager. Staff said the general manager and whole leadership team were visible, accessible and attended clinical meetings. Staff in this directorate used a series of four monthly meetings to ensure clinical governance was robust and the service was robustly managed. This included a genitourinary medicine meeting, a directorate meeting, a nurse meeting and a service development meeting.
- Outpatients and diagnostic imaging services were distinct directorates within the women's, children's and

clinical support division. A divisional director had oversight of all clinical services within the directorates and was supported by a divisional director of operations, an outpatient improvement programme manager, a head of nursing and a divisional director of nursing and midwifery. The outpatient services directorate was led by a clinical director, senior nurse and general manager. The diagnostic imaging directorate was led by a general manager, lead radiographer, clinical director and senior nurse.

- A multidisciplinary radiation safety committee managed the investigation of safety issues and incidents in diagnostic imaging through monthly risk meetings. Senior managers and clinicians attended the meetings and radiation protection supervisors and medical physics experts were invited although their attendance was not mandatory.
- There was a lack of consistency in staff governance in diagnostic imaging. For example, there were strict limits to the number of radiographers and ultrasound staff who could be off at one time but this did not apply to radiologists, which could cause blocked lists. In addition, trust medical exposures and radiation protection meetings took place monthly but did not include radiographer representation.
- The radiology clinical service manager invited new staff to a 'welcome interview' following successful recruitment. This helped them get to know the department and ask any questions before they started their substantive post. We received positive feedback about this process.
- Services monitored risks with the use of risk registers. This was a tool used to assign ownership of risks to a named senior person who could then document progress towards resolving or mitigating the problem. The directorate committee initially reviewed entries on the risk register and once signed off these were sent to the divisional committee and then to the trust executive team.
- The risk register for diagnostic imaging included 38 items, 12 of which were classified as major risks. The age of equipment was a significant risk in diagnostic imaging and was listed on the appropriate risk register. Staff had submitted a business case for the replacement

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of the gamma camera and were awaiting the outcome of this. Other major risks included inappropriate nurse skill mix, which led to an increase in sickness and turnover and lack of space in waiting areas.

- Staff in main outpatients attended a fortnightly meeting to discuss clinic operation, including trends in patients who missed appointments. We observed a meeting and found it well attended by a range of staff. The meeting was used to discuss incidents, complaints and updates to individual clinics. Staff also had the opportunity to give feedback and provide follow-up information from the last meeting.
- Risks associated with confidentiality were well managed. In all areas we saw patient notes were stored in locked cabinets or supervised by staff at all times. Information governance was part of the trust mandatory training programme and all of the staff we spoke with demonstrated this in practice, such as locking computers and removing IT access cards when they were not in use. All staff in outpatients, 93% of consultants in diagnostic imaging and scientific and technical staff had up to date information governance training. In diagnostic imaging, doctors in training (55% compliance), AHPs (73% compliance) and administration staff (79% compliance) did not meet the trust 90% target for up to date training in information governance.
- The risk register for main outpatients including eight items. The item with greatest severity involved the risk of overbooking appointments, resulting in cancellations and subsequent clinical risk. The new standard operating procedure for booking had begun to resolve the issue of overbooking, which now only took place with authority from a consultant under clinical need. This system also contributed to reducing clinic delays. In addition, a clinical reference group had been established to monitor progress. Other risks included patient notes being unavailable for clinics and delays of up to 3 hours in admitting patients to inpatient areas. Risks were clearly documented and evidenced and an assigned senior member of staff updated each risk monthly with mitigating actions and progress towards a firm resolution. There was appropriate input of clinical, non-clinical and managerial staff for each area of risk.
- Clinical governance and leadership in main outpatients had been restructured since summer 2015 and gave

outpatients a dedicated leadership structure. This included the appointment of a senior nurse with a change management background to provide 50% clinical leadership and 50% management function. This member of staff worked with the general manager and service support manager to improve the operation of the unit, including working relationships, implementing a performance framework and improving patient experience. Managers involved in this told us the trust recognised outpatients as an area of priority and a steering group, formed of multiple business areas, was driving forward positive change.

- A therapies quality and safety committee, led by a therapies executive lead, maintained clinical governance for day case and outpatient specialist therapies including the hand therapy clinic and lipid clinic. The committee held a monthly clinical governance meeting, which was attended by a representative of each specialist service and grade of staff. This ensured each clinical service adhered to a structured risk management process regardless of how often it operated or how many patients it saw.

Culture within the service

- We spoke with seven staff from the imaging department representing five different grades across clinical and non-clinical services. All staff told us they felt the department was a supportive place to work, with opportunities for development and leadership that valued them. For example, staff in radiology told us they appreciated the opportunity to work under supervision in the trauma unit when they were relatively junior as a strategy to increase confidence and skills. One member of staff said, "There is never a day that I am overwhelmed or under challenged."
- Staff we spoke with in other areas felt differently. For example, staff in audiology said they enjoyed working there but there was a lack of support for development. This included multiple cancellations of planned facilities work and a reliance on equipment manufacturers to fund conference attendances when the trust would not do so. One member of staff in paediatric outpatients told us they felt unsupported by the senior team and that they felt they could raise issues but this was not

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followed up with action or change. All of the staff we spoke with in the chest clinic told us their working culture was supportive, positive and pragmatic to deal with challenges such as a lack of space.

- Staff told us when their circumstances changed or they were not able to fulfil their contracted role, the leadership team worked with them to find an appropriate alternative. This included support to move between clinical and non-clinical roles and the training needed to complete this effectively.
- Some staff felt they were not always spoken to with respect. For example, one member of staff said a consultant had shouted at them when they asked for some clarification about a follow-up plan for a patient who had not understood them. They said although working relationships were mostly positive, there was room for improvement in how staff with different roles spoke to each other.
- Senior staff in each department were clear about their responsibilities under the duty of candour. In diagnostic imaging, the site leads were responsible for ensuring this was followed. In outpatient areas the senior nurse or doctor responsible for the clinic would ensure they met the requirements.
- Diagnostic imaging site leads and radiology managers felt practice at the trust was not up to date and did not reflect comparable trusts in London. They felt this was a driving factor in the relatively high turnover of staff and difficulty in recruiting as it also meant there was limited scope for staff, particularly radiographers, to develop into advanced practice. Some staff also felt a lack of support from the clinical director and senior radiology team meant the situation had not changed. Staff in other areas were more positive about the future of their service. For example, one member of staff from nuclear medicine said equipment had slowly started to be replaced and a five year plan as to direct this was being put in place. The trust had identified room for improvement in some of the areas of concern raised by staff and planned to introduce new roles according to the North West London radiography careers framework, including reporting radiographers, trainee, sonographers and clinical nurse specialists for neuroradiology.

- Seven radiology staff we spoke with said they felt they had the opportunity to take part in innovative practice and their work was varied, particularly with the opportunity to work in neuro-radiology, paediatrics and trauma.
- All of the staff we spoke with in sexual health and HIV services spoke positively about working relationships and culture. For example, a nursing assistant described “brilliant” relationships between the nursing team and doctors. They said, “All of the doctors are very approachable, very easy to speak to. They’ll step up and do examinations if no nurses are available.” A senior nurse said they appreciated the visibility of the leadership team. They said, “When we ask for training we get it and when we need something for our own wellbeing we get that too.”
- Non-clinical staff spoke positively of working relationships and culture. For example, a patient scheduler for the cardiac service said the support they received from the diagnostics support manager was of a high standard and a receptionist in the chest clinic described working relationships as “excellent.”
- Staff reported a working environment free from bullying and harassment in every area we visited, with the exception of one report in diagnostic imaging. Managers told us they were confident teams were stable and any minor concerns were handled appropriately. All staff also had knowledge of an employee relations advisory service, which gave them access to independent advice if they needed it.

Public engagement

- Reception staff and volunteers provided one-to-one education sessions to patients in the use of self check-in machines who otherwise felt anxious using them alone.
- As a strategy to increase patient feedback, staff in sexual health and HIV services had linked a patient survey with a QR code and text service. This enabled patients to use the QR scanner on their smartphone during the clinic visit to download the survey from a code on their registration form and submit it electronically. Patients who registered for the text message contact and results service received a survey link this way one week after their appointment. This helped staff to gain a clearer understanding of the individual experience as it had given them time to reflect.

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- As part of improvements to access and flow in main outpatients, the senior sister had spoken with patients and asked them what they would like to see changed in the department. Patients said they wanted a more 'personal touch' from staff and a more visual presence when waiting. Staff presented the findings in a poster to the trust executive team and implemented the changes as part of the wider improvement plan.
- New uniforms worn by volunteers had resulted from patient and visitor feedback that identified there was a lack of visibility of the team.

Staff engagement

- Senior staff in diagnostic imaging had consulted staff on using a shift rotation system between the three trust sites to reduce the impact of short staffing. Although staff told us they felt this was a positive approach, they said it was often difficult to reach the clinical director and they did not see him regularly.
- The radiology service operated staff partnership working groups with staff group representatives. This provided staff with a forum to discuss their work and to raise concerns and frustrations. The most common issues raised related to the age of equipment and the condition of the estate.
- The senior leadership team presented 'Make a difference' certificates to staff in recognition of good work. Staff demonstrated knowledge of this scheme and spoke positively about it. Staff in sexual health and HIV told us they felt the awards were motivational and generated a feeling of pride when anyone in their team achieved an award. Most recently a nursing assistant had been awarded this following positive feedback from a patient.
- Administration staff had raised concerns about the design and layout of the reception area in acute imaging. In response the area had been redesigned so they could see all waiting patients and panic alarms were installed with a direct link to the security team.
- Exit interviews with staff leaving diagnostic imaging services highlighted a trend that new people were recruited who did not expect to have to work weekends. To address this new contracts were offered that clearly outlined working hours and patterns to help people plan their work life balance more readily.
- As part of the changes implemented to working practices in main outpatients, the senior sister had met with each consultant to ask what they wanted to see in their clinics and how they could best be supported by the nursing team. Medical staff gave positive feedback about this process and it said it had led to collaborative changes. A consultant on shift patterns with nurses and HCAs had also taken place. As a result, some staff were trialling longer shifts over four days per week, instead of shorter shifts over five days. This was a voluntary trial and staff we spoke with told us the consultation process had been inclusive and made them feel valued.
- Results from the most recent staff survey showed 90% of staff in sexual health and HIV services would recommend it as a place to work and the team reported 86% job satisfaction. In outpatients, 93% of staff said they felt engaged by the trust, reported good job satisfaction and would recommend the hospital as a place to work.
- This team had participated in an 'In your shoes' programme that offered individuals the chance to work alongside colleagues to help understand each other's role. In addition, band six nurses met weekly to discuss their needs and support each other with any concerns or challenges.

Innovation, improvement and sustainability

- Staff in diagnostic imaging highlighted highly skilled imaging assistants and experienced reception staff as valuable assets to the department but raised concerns the roles were not sustainable because of disparities and inequalities in pay and skill base. As the department had on-going short staffing, the individuals we spoke with worried this could be worsened without recognition of the work their teams did. The trust had implemented a retention premium to help retain staff in the areas under most pressure.
- The radiology service predicted an increase in demand of 9.3% in the following year and was operating with 460 hours of overtime per week due to staff shortage. To ensure the service remained sustainable, a recruitment plan for 50 new staff over a two year period had been implemented.
- Staff in several different areas spoke to us about the development opportunities available within their role as a strategy to encourage building skills and their value to

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patients and the trust. For example, band five staff in radiology told us they were happy to be supported to develop as individual practitioners and two band seven staff had been supported to undertake radiographer reporting training.

- Staff in sexual health and HIV services were prepared for local changes to referral protocols in order to maintain access for patients and protect the sustainability of the service. For example, referrals to specialist services were being transitioned to GPs. In response staff conducted outreach and education sessions with local GPs to ensure they were able to provide appropriate referrals.
- The nurse consultant education lead and other staff in sexual health and HIV services offered external training courses as a way to raise funds to send their own staff on specialist training and to conferences. The

departmental approach to providing staff with highly specialised on-going training, including national accreditation and a diploma, also contributed to the sustainability of the service and staff retention.

- All band seven staff in sexual health and HIV had completed or were currently completing a Masters programme of study and the senior team supported them to complete their research in the department. Nurse research training was also available and nurses who had completed this took part in research projects as medication administrators. New band six nurses had to be prescribers as part of the service plan to ensure it remained sustainable.
- The sexual health information and protection (SHIP) team had been recognised with a national award for their work with patients who were victims of domestic violence.

Outstanding practice and areas for improvement

Outstanding practice

- The senior team in the Jefferiss Wing, including sexual health and HIV services, demonstrated a sustained track record of building staff skill mix and service sustainability through promoting specialist training, practice education and rewarding performance. A skill mix review had restructured the operation of sexual health services, which included each consultant working with a nursing assistant so that nurses could see patients independently. The training and competence profile of this team was evidence of proactive service led by a coherent team of highly skilled practitioners. This resulted in positive impact on the local population because it meant people who were vulnerable or at-risk received timely support and treatment. This included people who experienced substance addiction and domestic violence as well as sex workers and young people under court of protection orders.
- The outpatient improvement programme had begun to deliver results in a relatively short space of time and the process, involving staff consultation and a restructured leadership and governance team, meant clinic delays had been reduced and communication with patients improved. A dedication to utilising technology meant patients had the choice to be contacted by text message, e-mail or letter and these systems were tracked to ensure they were sent accurately. The improvement programme had included patient consultation and feedback was used to inform staff training as part of broader changes to the service.

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

The hospital should ensure all staff working in clinical areas have appropriate fire safety training and an understanding of local evacuation procedures.

The hospital should ensure incidents are fully investigated within a reasonable timescale in such a way that allows trends to be identified so as to ensure the service remains safe.

The hospital should ensure contractors providing services are able to respond within a reasonable time to complaints made by patients against the trust in cases that involved both providers.

The hospital should ensure doctors in training have up to date mandatory training in all required areas.

The hospital should ensure pre-qualification allied health professionals have up to date mandatory training in all areas.

The hospital should ensure each radiology practitioner has a documented local induction for checked competency in working under IR(ME)R guidelines.